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 18 IN THE UNITED STATES DISTRICT COURT  
 19 FOR THE NORTHERN DISTRICT OF CALIFORNIA

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 21 CARLOS PEREZ, et al.,

22 Plaintiffs,

23 v.

24 JAMES TILTON, Acting Secretary, California  
 Department of Corrections and Rehabilitation,  
 25 PETER FARBER-SZEKRENYI, Chief, Health  
 Care Services Division, WILLIAM  
 26 KUYKENDALL, Chief Dentist, Adult  
 Operations and Adult Programs,

27 Defendants.  
 28

CASE NO. C-05-5241 JSW

**AMENDED STIPULATION AND  
 [PROPOSED] ORDER**

[Notice: E-filed without Exhibit, and  
 Manually filed with Exhibits]

INTRODUCTION

1  
2 1. The parties enter into this stipulation to address dental care provided by the  
3 California Department of Corrections and Rehabilitation (CDCR). The Plaintiffs are California  
4 state prisoners who have serious dental care needs. The Defendants are the Secretary of the  
5 California Department of Corrections and Rehabilitation, the Chief Dentist of the Adult  
6 Operations and Adult Programs, and the Chief of the Correctional Health Care Services Division,  
7 who are sued in their official capacities as state officials responsible for the operation of CDCR  
8 and its dental care delivery system.

9 2. This action was filed by Plaintiffs on December 19, 2005. The action alleges that  
10 Plaintiffs are not receiving constitutionally adequate dental care as required by the Eighth  
11 Amendment to the U.S. Constitution.

12 3. The parties have conducted informal negotiations since August 2004, in an effort  
13 to resolve Plaintiffs' demand that dental care services be improved. Those negotiations have  
14 been undertaken at arm's length and in good faith between Plaintiffs' counsel and high ranking  
15 state officials and their counsel. The parties have reached agreement on procedures that the  
16 parties will follow in this case for resolving disputes concerning the constitutional adequacy of  
17 dental care services. The parties freely, voluntarily, and knowingly with the advice of counsel  
18 enter into this Stipulation for that purpose.

19 WHEREAS, a dispute exists between the parties as to the extent to which CDCR's  
20 provision of inmate dental care meets constitutionally mandated standards;

21 WHEREAS, this dispute arose over the course of the last four years, and culminated in  
22 Plaintiffs filing this statewide dental class-action lawsuit; and

23 WHEREAS, this Stipulation is intended to be narrowly drawn to meet applicable  
24 standards.

25 **A. PARTIES.**

26 4. Plaintiff Carlos Perez is a prisoner incarcerated at Salinas Valley State Prison at  
27 Soledad, California.

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1           5. Defendant James Tilton is the acting Secretary of the California Department of  
2 Corrections and Rehabilitation. The Department of Corrections and Rehabilitation oversees the  
3 Adult Operations and Adult Programs Department (AOAP).

4           6. Defendant Peter Farber-Szekrenyi is the Chief of the Correctional Health Care  
5 Services Division of the AOAP. As Chief, Dr. Farber-Szekrenyi is responsible for supervising  
6 the provision of dental care for all prisoners in CDCR's custody.

7           7. Defendant William Kuykendall, D.D.S., is the Chief Dentist for the AOAP. As  
8 Chief Dentist, Dr. Kuykendall is responsible for the provision of dental care for all prisoners in  
9 CDCR's custody.

10           **B. JURISDICTION.**

11           8. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. §§ 1331 and 1343.

12           **C. VENUE.**

13           9. Venue is proper under 28 U.S.C. § 1391(b), because a substantial part of the  
14 events giving rise to Plaintiffs' claims occurred within the Northern District of California.

15           **D. CLASS CERTIFICATION.**

16           10. The parties agree that this action shall be maintained as a class action pursuant to  
17 Rule 23(b)(2) of the Federal Rules of Civil Procedure and that the class consists of all California  
18 state prisoners in the custody of CDCR who have serious dental care needs.

19           **E. TERMS AND CONDITIONS.**

20           11. CDCR shall implement the Health Care Services Division Dental Policies and  
21 Procedures (Policies and Procedures), which are attached to this Stipulation as Exhibit A,  
22 according to the Implementation Plan, which is attached to this Stipulation as Exhibit B.\*

23 Defendants shall make all reasonable efforts to secure the funding necessary to implement the  
24 Policies and Procedures. The Policies and Procedures are designed to meet at least the  
25 minimum level of dental care necessary to fulfill Defendants' obligations under the Eighth  
26 Amendment of the U.S. Constitution. The Implementation Plan is designed to implement the  
27 Policies and Procedures in an efficient manner. It is the intent of this Stipulation to require  
28 Defendants to provide only the minimum level of dental care required under the Eighth

\* The Exhibits to the Amended Stipulation are voluminous and can be found in the Court record manually filed at Docket No. 26. The parties are ORDERED to attach them to this Order for service and publication purposes.

1 Amendment. Nothing in this Stipulation shall be construed to require more of the Defendants  
2 than is necessary under the Eighth Amendment. Disputes whether Defendants' Policies and  
3 Procedures satisfy their obligations under the Eighth Amendment shall be resolved using the  
4 dispute resolution procedures in ¶¶ 36-38.

5 12. CDCR shall develop policies and procedures, make all reasonable efforts to  
6 secure necessary funding, complete necessary construction, hire and train necessary dental  
7 personnel, and audit compliance with the Policies and Procedures according to the  
8 Implementation Plan. The parties agree that the policies and procedures attached at Exhibit A  
9 fulfill Defendants' obligation to develop policies and procedures. Implementation of the Policies  
10 and Procedures at each Reception Center and Mainline shall be accomplished according to the  
11 schedule in the Implementation Plan. For the purposes of this Stipulation and its exhibits,  
12 "Mainline" refers to all prison programs except Reception Center programs. The Implementation  
13 Plan may be modified according to ¶¶ 34-35. Following is the Implementation Plan's schedule:

14 7/1/06 - 12/31/08: Avenal State Prison, Calipatria State Prison, Centinela State  
15 Prison, Chuckawalla Valley State Prison, California State  
16 Prison - Corcoran, Folsom State Prison, Ironwood State Prison,  
17 California State Prison - Los Angeles County, Mule Creek  
18 State Prison, North Kern State Prison - II (Delano II), Pleasant  
19 Valley State Prison, California State Prison - Sacramento,  
20 Substance Abuse Treatment Facility, and Salinas Valley State  
21 Prison.

22 7/1/07 - 12/31/09: California Correctional Center, California Men's Colony,  
23 California Medical Facility, Correctional Training Facility,  
24 Pelican Bay State Prison, Sierra Conservation Center, and  
25 California State Prison - Solano.

26 7/1/08 - 12/31/10: The Mainline facilities of California Rehabilitation Center,  
27 California Correctional Institution, Central California  
28 Women's Facility, California Institution for Men, California  
Institution Women, Deuel Vocational Institution, High Desert  
State Prison, North Kern State Prison, Richard J. Donovan  
Correctional Facility, San Quentin State Prison, Valley State  
Prison for Women, and California State Prison - Wasco.

7/1/09 - 12/31/11: The RC facilities of California Rehabilitation Center,  
California Correctional Institution, Central California  
Women's Facility, California Institution for Men, California  
Institution for Women, Deuel Vocational Institution, High  
Desert State Prison, North Kern State Prison, Richard J.  
Donovan Correctional Facility, San Quentin State Prison,

Valley State Prison for Women, and California State Prison - Wasco.

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3 13. By June 30, 2006, CDCR shall complete a state-wide study to determine staffing  
4 needs related to the Implementation Plan and Policies and Procedures. The results of this study shall  
5 be given to Plaintiffs within 10 days of completion of the study. Failure to complete a state-wide  
6 staffing-needs study by June 30, 2006, shall not delay implementation of the Policies and Procedures  
7 according to the schedule set out in the Implementation Plan.

8 14. Based on the staffing-needs study referred to in ¶ 13, CDCR shall hire sufficient staff  
9 to fulfill its obligations under this Stipulation.

10 15. Defendants shall immediately implement the following practices or procedures at  
11 each institution (Mainline and Reception Centers):

12 a. Dental emergency care shall be available 24 hours per day, seven days per  
13 week. "Dental emergency care" is defined as care that is designed to prevent  
14 death, alleviate severe pain, prevent permanent disability and dysfunction, or  
15 prevent significant medical or dental complications.

16 b. It is anticipated that most dental emergencies will be handled by physicians.  
17 A dental emergency shall be treated in the following manner: Consistent  
18 with most medical emergencies, the physician may send the inmate to a local  
19 hospital for treatment. Should the physician determine that a dentist is  
20 required, the physician will call the chief dentist (or the chief dentist's back-  
21 up) for advice. If the chief dentist or the back-up determines that the inmate  
22 needs treatment by a dentist, the chief dentist or the back-up will go to the  
23 prison to provide that treatment. These procedures are consistent with the  
24 dental emergency procedures found in the Implementation Plan.

25 c. Inmates will have access to fluoridated toothpaste or toothpowder and  
26 floss or interdental cleaners.

27 16. By March 1, 2007, defendants shall complete implementation of the following  
28 practices or procedures at every institution (Mainline and Reception Centers):

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- a. Computerized tracking of requests for dental treatment. Tracking will include dates requests are made, dates inmates are scheduled to be examined by dental personnel, dates inmates are actually examined by dental personnel, and documentation of cancellation or failure to appear for dental treatment or examination.
- b. Examinations, dental treatment plans, and dental treatment shall be conducted according to the Implementation Plan and the Policies and Procedures for inmates who have dental appointments. Before the "roll-out" year (the year the prison at which the inmate is housed implements the Policies and Procedures), inmates shall receive dental treatment that is medically necessary as determined by the treating dentist.
- c. Each mainline inmate shall receive an orientation handbook describing dental self-care education set out in the Implementation Plan and Policies and Procedures by March 31, 2006. After April 1, 2006, each inmate who arrives at a CDCR institution shall receive this orientation handbook within 14 working days of initial arrival on the mainline. A change from one mainline yard to another yard, whether at the same or a different prison, does not necessitate distribution of another handbook.
- d. All inmates who are given a dental screening at the Reception Center or an examination while on the mainline shall have their dental care needs classified according to the priority classification system set out in the Policies and Procedures.

17. The parties understand and agree that the inmate grievance procedure (CDCR Form 602) is an important step in the provision of essential dental care. Accordingly, the parties agree that all complaints regarding dental care provided to an individual inmate, except those requiring emergency care or those classified as priority 1A<sup>1</sup>, shall be submitted to

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<sup>1</sup> Priority 1A is defined in the Policies and Procedures as "Inmates requiring treatment for an acute oral or maxillo-facial condition, which is likely to remain acute, worsen, or become life-threatening without immediate intervention."

1 Defendants after using the inmate grievance procedure. Once the appeal has received the  
2 director's level of review and all administrative relief has been exhausted, should the individual  
3 inmate contend that the grievance procedure failed to adequately address the dental problem,  
4 Plaintiffs' counsel may bring the dental care concern to the attention of appropriate headquarters  
5 staff, who shall respond in writing within 30 days.

6 18. For individual inmates who require emergency dental care or whose dental  
7 condition is classified as priority 1A, Plaintiffs' counsel may bring the concern to the attention of  
8 headquarters staff before the inmate has exhausted the grievance procedure.

9 **F. ACCESS TO INFORMATION.**

10 19. Subject to the limitations set forth in this Stipulation, Plaintiffs' counsel and the  
11 Court's experts shall have reasonable access to the institutions, staff, inmates and documents  
12 necessary to properly evaluate the adequacy of the dental care delivery system and the proposed  
13 remedies, including the Implementation Plan, the Policies and Procedures, and the Audit  
14 Instrument. The parties shall cooperate so that Plaintiffs' counsel and the Court's experts have  
15 access to information reasonably necessary to perform their responsibilities required by this  
16 Stipulation without unduly burdening Defendants.

17 20. Plaintiffs' counsel and Defendants shall negotiate a document production order by  
18 February 28, 2006 that shall provide to Plaintiffs' counsel information from CDCR's  
19 headquarters and from individual institutions about the dental services available to members of  
20 the plaintiff class, the adequacy of Defendants' remedial measures, and Defendants' compliance  
21 with this Stipulation. Defendants' and Plaintiffs' counsel shall meet monthly to discuss  
22 implementation of remedial measures and access to information.

23 21. CDCR shall provide information including, but not limited to, the following  
24 materials, subject to a protective order agreed to by the parties:

- 25 a. The dental care records in the medical files of members of the plaintiff  
26 class as reasonably necessary;
- 27 b. Internal audits of the dental services provided to members of the plaintiff  
28 class conducted according to this Stipulation;

- 1 c. Non-privileged documents relating to money budgeted for providing  
2 dental care to prisoners. No documents reflecting the budget for any  
3 particular upcoming budget year shall be provided until after the release of  
4 the Governor's Budget. This is not intended to prohibit sharing policy and  
5 planning documents, at the discretion of the Defendants.
- 6 d. Documents maintained at individual institutions pursuant to this  
7 Stipulation. Those documents may include:
- 8 (1) Audits of dental care required by this Stipulation.  
9 (2) Dental staff vacancy reports.  
10 (3) Dental staff training statistics.  
11 (4) Records reflecting scheduling and tracking of dental  
12 appointments.  
13 (5) Dental related inmate appeals (602's) and responses.
- 14 e. Plaintiffs' counsel shall not have access to any personnel files.  
15 f. Plaintiffs' counsel shall not be given peer review documents.  
16 g. Plaintiffs' counsel shall be given CDCR training documents related to  
17 implementation of this Stipulation for the first year that any such training  
18 is offered on any dental topic. The training documents will be given to  
19 Plaintiffs' counsel once the documents are ready for use or training.

20 22. Plaintiffs may retain one dental consultant at a time, whose fees and expenses  
21 shall be paid by Defendants. Plaintiffs' counsel and their dental consultant shall be able to tour  
22 dental clinics and facilities during tours conducted pursuant to *Plata v. Schwarzenegger* (U.S.  
23 District Court, Northern District of California, case number C-01-1351 TEH). Plaintiffs' counsel  
24 shall advise Defendants when their dental consultant will accompany them on a prison tour,  
25 before that tour begins. *Plata* tours shall be lengthened as necessary to accommodate Plaintiffs'  
26 additional tour duties. In addition, Plaintiffs may schedule two tours per year at each prison that  
27 plaintiffs are not touring under *Plata*.

28 23. Tours by Plaintiffs' counsel shall include reasonable access to housing units and

1 all facilities where dental services are provided. Defendants shall make reasonable efforts to  
2 make available for interview departmental, custodial, clinical, and program staff that have direct  
3 or indirect responsibility for providing dental services to class members. Defendants shall direct  
4 institution staff to reasonably cooperate with Plaintiffs' counsel. Plaintiffs' counsel shall be  
5 permitted brief discussions with plaintiff-class inmates about their dental care needs during the  
6 tours, and shall be able to give business cards with their name and address to plaintiff class  
7 inmates. Defendants will continuously post notices informing all inmates at each institution that  
8 complaints regarding the provision of dental care may be sent to counsel for the plaintiff class in  
9 this case. Defendants shall provide Plaintiffs' counsel reasonable access to confidential  
10 interviews with members of the plaintiff class before or after the tours, during regular business  
11 hours, without regard to regular visiting hours and days. Upon a request by Plaintiffs' counsel at  
12 least one week prior to the tour, Defendants shall make available for inspection and/or copying  
13 the dental records contained in the medical files of specified plaintiff-class inmates.

14 24. If any party fails to make himself or herself, an employee, or an agent reasonably  
15 available for interview and the parties agree, the other party may depose the party, employee, or  
16 agent who has not been made available. If the parties are unable to agree, the Court may order  
17 such deposition of the party, employee, or agent if the deposition is reasonably necessary to the  
18 conduct of the litigation.

19 25. Plaintiffs' counsel and the Court's experts will cease tours at a particular  
20 institution after that institution has been found to be in substantial compliance as set forth in ¶¶  
21 29-33. Tours may resume at a particular institution if the parties agree that, or the Court finds  
22 that, there has not been substantial compliance by Defendants, provided that such resumed tours  
23 shall be limited to the issue or components found not to be in substantial compliance. Non-  
24 compliance may be corrected by substantial compliance with the existing Policies and  
25 Procedures, or by modifying the Policies and Procedures and Audit Instrument pursuant to ¶¶ 34-  
26 35 and complying with the Policies and Procedures as modified. Any disputes about whether an  
27 institution is in substantial compliance shall be resolved using the procedures in ¶¶ 36-38.

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1           **G.     INDEPENDENT COURT EXPERTS.**

2           26.     The parties request that the Court appoint two experts under Rule 706 of the  
3 Federal Rules of Evidence, to advise the Court on Defendants' compliance with the  
4 Implementation Plan and Policies and Procedures. The parties propose that Exhibit C be adopted  
5 as the experts' duties, according to Rule 706(a). The experts shall be entitled to reasonable  
6 compensation in an amount approved by the Court and the costs for each expert shall be borne by  
7 Defendants. The parties will meet and confer in an attempt to recommend two mutually  
8 agreeable experts to the Court within 60 days after this Stipulation is signed by the Court. If the  
9 parties cannot agree upon the experts, they shall so advise the Court and each party shall submit a  
10 list of four candidates. The Court shall appoint the experts from the list of candidates.

11           27.     In the event that either of the Court-appointed experts can no longer serve, the  
12 parties shall attempt to agree on a replacement within 30 days. In the event the parties cannot  
13 agree, they shall nominate experts in accordance with Rule 706 of the Federal Rules of Evidence.  
14 The parties understand and agree that the Court may appoint a mutually agreeable third expert in  
15 the future. In the event that the parties are unable to agree on a third expert, the Court may  
16 appoint a third expert in accordance with Rule 706 of the Federal Rules of Evidence. The  
17 parties also understand that the Court has the right to appoint a special master in the event the  
18 Court deems it necessary.

19           28.     With reasonable notice and subject to the limitations in this Stipulation, the court  
20 experts shall have reasonable access to all parts of any institution, all relevant documents, all  
21 individuals (including interviews with staff or inmates), dental meetings, dental proceedings,  
22 and dental programs to the extent that such access is reasonably needed to fulfill their  
23 obligations. If both parties agree, the court experts may hire additional support staff, at  
24 Defendants' expense, to assist them in performing their duties. If both parties cannot agree, the  
25 Court may authorize hiring additional personnel upon a showing by the court experts that such  
26 additional personnel are reasonably necessary to the performance of their duties.

27           **H.     COMPLIANCE.**

28           29.     Defendants shall conduct audits in accordance with the Implementation Plan.

1           30. Compliance with the Policies and Procedures shall be audited using an Audit  
2 Instrument. This Audit Instrument will be developed by CDCR in consultation with Plaintiffs'  
3 counsel and the court experts by December 1, 2006. No later than March 15, 2007, the parties  
4 and the court experts shall meet and confer about whether the Audit Instrument needs to be  
5 modified. If the parties agree, the instrument shall be modified. If the parties do not agree, the  
6 Court shall decide whether the proposed modifications shall be adopted, after consulting with the  
7 parties and the court experts. No later than June 30, 2007, the court experts, in cooperation with  
8 the parties, shall determine the necessary passing score that Defendants must achieve in order to  
9 demonstrate successful implementation of the Policies and Procedures. Any disputes about the  
10 need for modification or the necessary passing score shall be resolved according to ¶¶ 36-38 of  
11 this Stipulation.

- 12           31. The audits shall be conducted as follows:
- 13           a. The court experts shall agree on a statistically appropriate number of  
14           inmate dental records that must be audited to assess compliance.
  - 15           b. CDCR auditors will review that number of inmate dental records to  
16           determine whether an institution is in substantial compliance with the  
17           Policies and Procedures.
  - 18           c. Once CDCR auditors determine that an institution is in substantial  
19           compliance, the court experts will conduct another audit at the institution  
20           within 30 days, using the same number of records.
  - 21           d. Choice of Records:
    - 22           (1) Mainline Dental Care: The records shall be randomly selected  
23           from a pool of inmates who have received a dental examination  
24           and/or dental treatment during the previous six months at the  
25           mainline dental clinic.
    - 26           (2) Reception Center Dental Screening and Care: The records shall be  
27           randomly selected.
  - 28           e. If, during audits conducted by the court experts, Defendants disagree with

1 the appropriateness of an expert's answer to any question in the audit  
2 instrument relating to the quality of dental care, the question shall be  
3 reviewed by both court experts and shall count against compliance only if  
4 both experts agree.

5 32. Standards for Monitoring Compliance: In evaluating and reporting on  
6 implementation and compliance with the Policies and Procedures, the Defendants and the court  
7 experts shall use the Audit Instrument. The Audit Instrument shall set out the compliance  
8 indicators for four practice areas for Reception Centers, and ten practice areas for Mainline, as  
9 follows:

10 a. Reception Center:

- 11 (1) Dental screening of newly committed inmates within 60 days of  
12 arrival at Reception Center;  
13 (2) Consistency and completeness of screening form;  
14 (3) Provision of emergency dental care within 24 hours of notification  
15 of emergency;  
16 (4) Adequate provision of emergency care.

17 b. Mainline:

- 18 (1) Provision of dental self-care handbook to newly arrived inmates  
19 within 14 working days of arrival at mainline;  
20 (2) Dental examinations within 90 calendar days of inmate's arrival at  
21 mainline;  
22 (3) Subsequent examinations or treatment as required by the dental  
23 treatment plan;  
24 (4) Consistency and completeness of examinations;  
25 (5) Completion or update of dental treatment plan with each  
26 examination;  
27 (6) Consistency and completeness of dental treatment plan;  
28 (7) Scheduling inmates within three working days of their filing a

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Dental Request for Treatment;

(8) Visit with dentist within 35 calendar days of scheduling based on DRT;

(9) Provision of treatment: within 24 hours (emergency or priority 1A); within 30 calendar days (priority 1B); within 60 calendar days (priority 1C); within 120 calendar days (priority 2); within one calendar year (priority 3);

(10) Adequacy of examinations, treatment plans, and treatment.

33. A prison is in substantial compliance when all of the following conditions are satisfied:

a. It receives a passing score on the audit of the implementation of the Policies and Procedures which shall be conducted by the court experts using the Audit Instrument.

b. In determining substantial compliance, Defendants and court experts will ascertain whether screenings, examinations, treatment plans, and treatment provided to inmates comply with the Policies and Procedures. The dental screenings, examinations, treatment plans, and treatment provided to the inmates shall be in substantial compliance when one of the following conditions are met:

(1) The screening, examination, treatment plan, or treatment is consistent with guidelines in the Policies and Procedures; or

(2) The practitioner documents in the dental notes that he/she is deviating from adopted policies and procedures and that such deviation is consistent with the community standard; or

(3) Where no treatment guidelines are specifically adopted in the Policies and Procedures, the assessment or plan is consistent with the community standard.

(4) "Community standard" is defined as the standard of care required by the National Commission on Correctional Healthcare or the

American Correctional Association.

(5) In those instances in which a court expert finds that a screening, examination, treatment plan, or treatment does not comply with community standards, Defendants may request that the question be reviewed by both court experts, and shall count against compliance only if both experts agree.

c. The prison is conducting quality management proceedings in conformance with the Health Care Services Division's Quality Management Committee's standards.

d. The prison is conducting adequate dental peer review.

e. The prison has tracking, scheduling, and medication administration systems in place.

f. The two court experts agree that no pattern or practice of dental care falls below constitutionally mandated standards that is not being addressed by CDCR.

**I. MODIFICATION.**

34. Defendants may modify the Policies and Procedures or the Audit Instrument at any time, provided that as modified the Policies and Procedures and the Audit Instrument will meet the minimum level of care necessary to fulfill Defendants' obligation to Plaintiffs under the Eighth Amendment. Defendants will provide Plaintiffs' attorneys with a copy of the original Policies and Procedures or the Audit Instrument, the modified version, and a strikeout version with the changes 30 days before implementation. In an emergency or when such delay will adversely affect the provision of dental care, copies will be provided as quickly as possible, but no later than the date the new policy is implemented. Plaintiffs shall have 30 days from the time they receive the changes to meet and confer with Defendants. Plaintiffs shall file objections, if any, through a regularly noticed motion within 90 days from the end of the meet and confer process.

35. Plaintiffs may also seek to modify the Policies and Procedures and the Audit Instrument at any time to secure a constitutionally mandated level of dental care for Plaintiffs. Plaintiffs will provide Defendants with a copy of the original Policies and Procedures or the

1 Audit Instrument, the modified version, and a strikeout version with proposed changes.  
2 Defendants shall have 30 days from the time they receive the proposed changes to meet and  
3 confer with Plaintiffs' counsel. Any disputes shall be resolved using the dispute resolution  
4 provisions set forth in ¶¶ 36-38.

5 **J. DISPUTE RESOLUTION.**

6 36. If Plaintiffs contend that the Implementation Plan, Policies and Procedures, and  
7 Audit Instrument, as written or as modified, or any component thereof will not provide for the  
8 minimum level of dental care necessary to fulfill Defendants' obligations to Plaintiffs under the  
9 Eighth Amendment, Plaintiffs shall provide Defendants with a brief description of the perceived  
10 deficiencies and a request that the parties enter into negotiations to resolve the question as to  
11 whether Defendants' Policies and Procedures and Audit Instrument satisfy the minimum  
12 requirements of the Eighth Amendment. Upon receipt of Plaintiffs' request for negotiations,  
13 any party may inform the Court's experts of the area of disagreement and request that the experts  
14 evaluate the issue and prepare a report. Defendants will respond to Plaintiffs' concerns no later  
15 than 30 days after they receive Plaintiffs' concerns.

16 37. If the parties are unable to resolve the dispute informally, the parties shall conduct  
17 negotiations on the issue in dispute. Such negotiations may include the Court's experts, and a  
18 person satisfactory to the parties may at the election of either party, mediate any unresolved  
19 issues. If the parties cannot agree on a mediator, the administrator of a private dispute resolution  
20 service, such as JAMS, will choose a mediator. The substance of the mediation and any  
21 statements made by a party, an employee of a party, or an agent of a party are confidential and  
22 not admissible in any subsequent proceeding. The Experts' reports shall be admissible as  
23 evidence at the request of any party in any judicial proceeding in this case.

24 38. If the process set forth in the preceding paragraph fails to resolve the issue of  
25 whether Defendants' Policies and Procedures and Audit Instrument, either as written or as  
26 modified, provide for a level of dental care sufficient to meet the minimum requirements of the  
27 Eighth Amendment, either party shall have the option of seeking relief from the Court. If the  
28 Court determines that Defendants' Policies and Procedures and the Audit Instrument, either as  
written or as modified, do not provide a level of dental care sufficient to meet the minimum

1 requirements of the Eighth Amendment, the Court may grant relief as authorized under the  
2 Prison Litigation Reform Act (PLRA), 18 U.S.C. § 3626(a).

3 **K. ENFORCEMENT.**

4 39. The Court shall find that this Stipulation satisfies the requirements of 18 U.S.C. §  
5 3626(a)(1)(A) and shall retain jurisdiction to enforce its terms. The Court shall have the power  
6 to enforce the Stipulation through specific performance and all other remedies permitted by law.  
7 Neither the fact of this Stipulation nor any statements contained in it may be used in any other  
8 case or administrative proceeding, except that Defendants, CDCR, or their employees and agents  
9 may use this Stipulation to assert issue preclusion and res judicata in other litigation seeking  
10 class or systemic relief. When these legal defenses are raised, Defendants will send copies of the  
11 complaints to Plaintiffs' counsel at the Prison Law Office.

12 40. If Plaintiffs believe that Defendants are not complying with this Stipulation, the  
13 Implementation Plan, or the Policies and Procedures, the dispute resolution process in ¶¶ 36-38  
14 shall apply.

15 **L. TERMINATION.**

16 41. Notwithstanding the PLRA or any other law, Defendants may move to vacate this  
17 Stipulation and dismiss the case on the ground that each institution subject to this Stipulation has  
18 been found to be in substantial compliance under ¶¶ 29-33. Non-compliance may be corrected  
19 by compliance with the existing Implementation Plan and Policies and Procedures or by  
20 modifying the Policies and Procedures pursuant to ¶¶ 34-35 and complying with the Policies and  
21 Procedures as modified. The parties shall attempt to negotiate any disputes about Defendants'  
22 compliance pursuant to ¶¶ 36-38. Either party may invoke the enforcement process set forth in  
23 ¶¶ 39-40. The final determination of such a dispute shall rest with the Court.

24 **M. ATTORNEYS FEES' AND COSTS.**

25 42. Plaintiffs are the prevailing party and may apply for attorneys' fees. Defendants  
26 shall pay Plaintiffs' counsel for the work performed in connection with this Stipulation at hourly  
27 rates set forth under the PLRA, 42 USC § 1997e(d). Plaintiffs shall have 60 days from the entry  
28 of this Stipulation to file their motion for attorneys' fees. The PLRA applies to all applications  
for attorneys' fees in this case.

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**IT IS SO ORDERED.**

Dated: August 21, 2006

  
U.S. District Judge

Exhibit

A

# Table of Contents

Current Section with Chapter Number and Name

Previous Chapter Number

## 1.0 Preface and Legal

1.1	Introduction	
1.2	Legal Considerations	1, 2, 3
1.3	The Standard of Medical Autonomy	2
1.4	Medical Autonomy	3
		4

## 2.0 Scope of Services

2.1	Initial Health Screening-Reception Center Services	12
2.2	Dental Screening-Reception Center	12a
2.3	Periodic Dental Examinations	32
2.4	Periodontal Disease Program	30
2.5	Periodontal Prevention Program for Pregnant Inmates	New
2.6	Dental Prosthodontic Services	22
2.7	Dental Restorative Services	33
2.8	Oral Surgery	35
2.9	Endodontics	34
2.10	Fixed Prosthetic (Cast Crown & Bridge)	39
2.11	Implants	40
2.12	Orthodontics	41
2.13	Facility Level Dental Health Orientation/Self-Care	8
2.14	Hygiene Intervention	52

## 3.0 Health and Safety

3.1	Infection Control Procedures	7
3.2	Control of Dental Instruments and Sharps	16
3.3	Radiation Protection	17
3.4	Hazardous Chemical and Waste Management Rules and Regulation	18

## 4.0 Dental Clinic Administrative Procedures

4.1	Dental Clinic Operations Reporting	31
4.2	Licensure and Credential Verification	38
4.3	Dental Peer Review	15
4.4	Health Care Services Division Dental Program Subcommittee	57
4.5	Dental Authorization Review Committee	23
4.6	Dental Radiography & Film Processing, and Quality Assurance	29
4.7	Clinic Space, Equipment, and Supplies	43
4.8	Inmate Dental Workers	42

# Table of Contents

---

Current Section with Chapter Number and Name

Previous Chapter Number

## 5.0 Dental Clinic Operations

---

5.1	Inmate Co-payment (7362 form)	49
5.2	Priority Health Care Services Ducat Utilization	20
5.3	Recording and Scheduling Dental Patient Visits	21
5.4	Dental Treatment Priorities	13
5.5	Dental Treatment Plan	50
5.6	Interpreter Services-monolingual/Non-English Speaking Inmates	25
5.7	Inmate's Right to Refuse Treatment	48
5.8	Medical Emergencies in the Dental Office	55
5.9	Continuity of Care	27
5.10	Dental Emergencies	36
5.11	Direct Medical Orders	26
5.12	Therapeutic Diets	53
5.13	Pharmaceuticals	45
5.14	Access to Care	15
5.15	Dental Care	9

## 6.0 Health Services Record Management

---

6.1	Health Records Organization and Maintenance	46
6.2	Informed Consent Forms	47
6.3	Privacy of Care	44
6.4	Medical/Dental Chronos	54
6.5	Medical/Dental Lay-Ins	24
6.6	Dental Holds and Inmate/Patient Transport/Transfers	19

# CHAPTER 1.1

## Introduction

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### Mission Statement

It shall be the mission of the Division of Correctional Health Care Services (DCHCS) Dental Department to promote, stabilize, and maintain the oral health of all inmates incarcerated in the California Department of Corrections and Rehabilitation (CDCR). Dental services shall be provided to inmates/patients by competent professional healthcare staff who shall make every effort to provide quality dental services for the greatest number of inmates/patients within available resources. All dental services rendered shall be consistent with professional standards, and comply with all federal, state, and CDCR regulations.

### Policy and Procedure Manual

This document is intended to serve as the expected standard in the delivery of dental services and to set forth standards for the CDCR Dental Services. It shall be available in the offices of the Health Care Manager/Chief Medical Officer and the Chief Dentist at each institution. The delivery of quality health care is a dynamic process and it is expected that the Standards and Scope of Services Policy for Dental Services established by this document shall be subject to ongoing deletions and changes. The dental policy and procedure manual shall be reviewed annually and revised, as necessary, under the direction of the Chief Dentist, Dental Program, DCHCS. A committee of institutional dentists shall be established for the purpose of annually reviewing and updating this manual. Input from field operations is critical in the establishment of a current and dynamic dental standard of care. Recommended changes made to specific policies in the manual must be dated, signed, and approved by the Chief Dentist, Dental Program, DCHCS prior to implementation. This process will allow all recommended changes made to be reviewed during the annual review.

### Expectations of Dental Staff

In keeping with the CDCR policy regarding the Treatment of People, it is the expectation that all dental personnel shall adhere to the following behavior standards:

- A. As concerns inmates/patients:
  1. Regard each inmate/patient as an individual human being, to be treated with respect, impartiality, and dignity.
  2. Consider the input of inmates/patients in the provision of their dental care.

3. Take time to explain dental procedures, policies, health care instructions, and methods of preventive dental care to each inmate/patient.
  4. Recognize that each inmate/patient is constitutionally afforded a standard of dental care similar to that of the community at large.
  5. Avoid personal bias in the performance of their duties.
- B. As concerns all communications:
1. Strive to insure effective communications in the performance of their duties.
  2. Support the goals and guidelines of ethical and conscientious health care practices.
  3. Demonstrate integrity, respect, and compassion in both verbal and written communications.
  4. Keep channels of communication open between management and staff to promote effective discussion.
  5. Encourage, develop, and implement culturally sensitive communication with all staff members and inmates/patients in order to improve the work place environment, and the quality of dental services.
- C. As concerns the work environment:
1. Be responsible, reliable, and candid in responding to safety and security concerns, and remain aware at all times of their surroundings in the correctional environment.
  2. Endeavor to provide all staff and all inmates/patients with an environment that is safe, secure, and free of environmental hazard.
  3. Maintain professional decorum at all times.
- D. As concerns relations with co-workers:
1. Treat all staff with respect and dignity.
  2. Strive to create an apprehension-free environment, promoting teamwork, progress, and openness.
  3. Avoid personal bias in the performance of their duties.
- E. As concerns the pursuit of delivering quality dental care:
1. Strive to improve the quality of the dental health care delivery system.
  2. Be innovative in providing quality dental care under all conditions.

## **Development of Standards and Scope of Services**

Development of the Dental Standards and Scope of Dental Services Policy incorporated input from other Health Services disciplines, (e.g., medical, pharmacy, mental health services). This document is intended to serve as an effective guide in the delivery of dental services and to set forth standards for the CDCR Dental Services. The delivery of quality health care is a dynamic process and it is expected that the Standards and Scope of Services Policy for Dental Services established by this document shall be subject to ongoing additions, deletions and changes. A committee of institutional dentists shall be established for the purpose of annually reviewing and updating this manual. Input from field operations is critical in the establishment of a current and dynamic dental standard of care; and comments and recommendations in reference to the standards are welcomed. Please forward all comments and recommendations to the Chief Dentist, Dental Program, DCHCS

The Standards and Scope of Services Policy for Dental Services represents the minimum requirements for the delivery of dental care and services within the CDCR. The term "medical" is used interchangeably with the term "all qualified health care personnel" through this document.

Each standard has been classified as either "essential" (E) or "important" (I). Essential (E) standards are, in general, more directly related to the health, safety, and welfare of inmates/patients and the critical components of a health care delivery system. Important (I) standards are, in general, related to issues that strongly affect the delivery of health care and are significant but not critical. Whether essential or important, these standards may not be applicable in all situations.

It is expected that each institution shall apply these standards and policies and implement the described procedures in directing their dental services' operation.

## CHAPTER 1.2

### Legal Considerations (I)

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Federal law pertaining to an inmate's right to medical care has in recent years been well defined and clarified through case law. The legal standard governing inmates' rights to medical/health care is known as the "Deliberate Indifference" standard. This standard dates back to the 1976 *Estelle v. Gamble* Supreme Court case and established a legal precedent in the delivery of inmate's medical/health care. Both an objective factor and a subjective factor are evident in the court's final decision.

#### LEGAL PRECEDENTS:

##### *Estelle v. Gamble*

The 1976 case, *Estelle v. Gamble*, (429 U.S. 97 (1976)) remains one of the most important Supreme Court decisions pertaining to inmate/patient health care. In *Estelle v. Gamble*, an inmate seeking relief for inadequate medical treatment, had his case dismissed by the federal district judge. When the case reached the Supreme Court, however, the Court held that the Constitution's Eighth Amendment prohibition on "cruel and unusual punishment" applied to medical conditions. The court ruled that the Eighth Amendment placed substantive limitations on what punishment could be imposed on an inmate after sentencing and that this protection included a right to medical care in correctional institutions. Based on the standards of decency, the Court held that the government had an obligation to provide minimally adequate medical care in an appropriate setting to incarcerated inmates and that indifference to inmates' "serious medical needs" violated the Constitution of the United States.

##### Objective Component: Serious Medical Needs

In applying *Estelle v. Gamble* and other precedents, the federal courts have tried to define what constitutes a "serious medical need." In defining the term the courts stated:

- A serious medical need is one that has been diagnosed by a physician as requiring treatment, or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention. (*Hill v. Dekalb Regional Youth Detention Center*, 40 F.3d. 1176, 1186 (11<sup>th</sup> Cir 1994)).
- A condition is serious "if it is obvious to the layperson or supported by medical evidence" (*Simmons v. Coor*, 154 F.3d. 805, 807 (8<sup>th</sup> Cir. 1998)).

Courts have considered a number of factors in defining whether a medical need is serious, including:

- The effect of a delay in medical care.
- Whether the failure to treat could result in further significant injury or unnecessary and wanton infliction of pain.

- Whether a reasonable physician or patient would find the need important and worthy of treatment.
- The fact that a medical condition significantly affects daily activities.
- The existence of chronic and substantial pain.

(See *Hill*, 40 F.3d at 1186; *McGuckin v. Smith*, 974 F.2d 1050, 1059 (9<sup>th</sup> Cir. 1992); *Gutierrez v. Peters*, 111 F.3d 1364 (7<sup>th</sup> Cir. 1997); and *Smith v. Jenkins*, 919 F.2d 90 (8<sup>th</sup> Cir. 1990)).

Specifically, courts have held that inmates have a right of access to timely medical care for their serious medical needs (*Toussaint v. McCarthy*, 801 F.2d 1080 (9<sup>th</sup> Cir. 1986)). With collateral application to delivery of dental care, courts have found additionally that treatment by unqualified staff, long delays in treating serious medical conditions, and denials of access to medical professionals are all actionable.

In finding that a medical need is "serious," the Supreme Court held that an "unreasonable risk to future health" might justify relief even if no harm has yet occurred. Thus, basic communicable disease prevention measures and minimum sanitary standards are constitutionally required (*Helling*, 509 U.S. at 25). Courts have found that some chronic care conditions may also warrant special treatment, as delays in care that exacerbate an inmate's existing medical condition may result in liability (*Chance v. Armstrong*, 153 F.3d 698 (2<sup>nd</sup> Cir. 1998)).

#### **The Subjective Component of Deliberate Indifference:**

In *Wilson v. Seiter* (501 U.S. 294 (1991)), the Supreme Court ruled decisively that a plaintiff must prove that a defendant had a culpable state of mind prior to any finding of liability (501 U.S. at 299-303). In *Farmer*, the Supreme Court further defined the intent standard and adopted a strict interpretation of "deliberate indifference" (511 U.S. at 836-642). The Court held that deliberate indifference requires proof that a defendant "knows of and disregards excessive risk to inmate health or safety" (511 U.S. at 837). The Court noted that it is not enough to show that a defendant was aware of facts suggesting a risk existed. A plaintiff also needs to prove that the defendant actually drew the inference that those facts would expose inmates to such risk and still disregarded those facts.

As Justice Souter noted in his *Farmer* opinion, defendants are on dubious ground if they try to insulate themselves from knowledge of deficiencies in order to avoid a finding of deliberate indifference (511 U.S. at 842-844). If a systemic deficiency is truly obvious, a court may consider such obviousness as circumstantial evidence of actual knowledge about a constitutional deficiency. The fact that a defendant took steps to avoid learning about the problems may itself be an indicator of "deliberate indifference." The *Farmer* decision also makes it clear that the knowledge requirement involved is not so specific that one must await a tragic event or show specifically who would have been harmed by a serious deficiency. It may be enough to show systemic problems likely to result in the type of harm addressed by a particular lawsuit, e.g., *Hunt v. Uphoff*, 190 F.3d 1220 (10<sup>th</sup> Cir. 1999).

## CHAPTER 1.3

### The Standard of Medical Autonomy (E)

#### I. POLICY

Clinical decisions and actions regarding health care services provided to inmates, in order to meet their serious medical needs, are the sole responsibility of qualified health care professionals.

#### II. PURPOSE

To define the standard of medical autonomy in order to ensure that clinical decisions are made solely for clinical purposes without interference from non-qualified personnel.

#### III. PROCEDURE

- A. The delivery of health care is a joint effort of administrators and health care providers and can be achieved only through mutual trust and cooperation. The health care authority, (i.e., the Health Care Manager, Chief Medical Officer, or designee), shall arrange for the availability of appropriate staff, equipment, and supplies, and for the monitoring of health care services to inmates. The official responsible for the facility, (i.e., the Warden or designee), shall provide the administrative support for the accessibility of health services to inmates and the physical resources deemed necessary for the delivery of health care.
- B. Qualified health care personnel include dentists, dental assistants, physicians, mental health professionals, nurses, medical technical assistants, and others who, by virtue of their education, credentials, and experience are permitted by law, within the scope of their professional practice, to evaluate and care for patients.
- C. Non-medical considerations, (i.e., inmates' access to care and the safety and security of the institution, etc.), needed to carry out clinical decisions, shall be made in cooperation with custodial staff. If this cooperation is lacking, the ability of health care providers to perform their professional and legal responsibilities is impaired and medical autonomy is jeopardized.
- D. Any specific problems that arise with medical autonomy generally shall be addressed through revised policies that shall be reviewed as part of the Continuous Quality Improvement (CQI) program.
- E. The following indicators shall be utilized to ensure that each facility is in compliance with the medical autonomy standard:
  1. All aspects of the standard shall be addressed by a written policy and defined procedures.

2. Clinical decisions and their implementation shall be completed in an effective, timely, and safe manner.
3. Custody staff shall support the implementation of clinical decisions.
4. Health care staff shall be subject to the same security regulations as other facility employees.

**F. Definitions**

- a. Custody staff refers to correctional officers, as well as correctional administrators.
- b. Health care staff refers to all qualified health care professionals, as well as health care administrative and support staff.

## CHAPTER 1.4

### Medical Autonomy (E)

---

#### I. POLICY

Each facility's Health Care Department, its agents, and the CDCR DCHCS shall be responsible for providing, and overseeing health care to all inmates incarcerated in the CDCR. Decisions and actions regarding the health care services provided to inmates shall be the sole responsibility of qualified health care personnel and shall not be compromised except for security reasons, (i.e., as in situations in which an inmate's behavior or involvement in an incident may cause harm or injury to correctional or health care staff, him/herself, and/or other inmates).

#### II. PURPOSE

To identify the scope of responsibility and authority of each facility's Health Care Department, its agents, and the DCHCS.

#### III. PROCEDURE

- A. At the facility level, any security policies or practices that contradict direct medical orders shall be addressed by the responsible unit health authority/management team, (i.e., the Chief Dentist (CD) or designee, or the Health Care Manager (HCM) or designee), and the facility administrator, (i.e., the Warden or designee). If conflicts cannot be resolved at this level, the appropriate Regional Medical Director (RMD) shall be notified for resolution.
- B. At the facility level, the CD or designee and the facility administrator or designee shall address any security policies or practices that contradict direct dental orders. If conflicts cannot be resolved at this level, the HCM shall be notified for resolution.

## CHAPTER 2.1

### Initial Health Screening – Reception Center (E)

---

#### I. POLICY

The CDCR DCHCS staff shall screen each inmate for health care needs upon commitment to a CDCR institution.

#### II. PURPOSE

To provide inmates with continuity of health care and to identify health care conditions, (e.g., medical, dental, mental health, etc.), needing treatment and monitoring.

#### III. PROCEDURE

Each newly arriving inmate, including new commitments and parole violators, at Receiving and Release (R&R) shall, prior to being housed, receive an Initial Health Screening performed by health care staff. The screening shall include an evaluation for dental conditions.

The health care staff (Registered Nurse (RN), Medical Technical Assistant (MTA), or Licensed Psychiatric Technician (LPT)) performing the screening shall complete a CDCR Form 7277, *Initial Health Screening*. In addition, a CDCR Form 7277A, *Supplemental Initial Health Screening – Female Patients*, shall be completed for each female inmate. The institutions shall not modify these forms.

All nursing staff, MTAs, and LPTs shall be trained to perform dental screenings and shall demonstrate competency prior to being assigned to work in R&R in the Reception Center (RC). The Supervising RN or designee shall maintain all training and competency records in the proof of practice binder.

MTAs/LPTs shall perform screening duties within the scope of their licensure. Any abnormal findings shall be referred to the RN immediately.

The dental portion of the initial health screening shall consist of a visual observation of the teeth and gingiva including gross abnormalities as defined in the training program. If the intake-screening nurse determines the dental issue to be critical, as defined in the training program, the inmate shall be referred to and evaluated by a dental staff within 24 hours. In the case of a dental emergency, the dentist on duty during normal working hours, or the dentist on call outside of normal working hours, shall be contacted via pager or telephone.

If any questions are answered "yes" on the CDCR Form 7277 or 7277A, the MTA/LPT shall contact an RN for assessment and disposition. Based upon the RN's review of all relevant data, a disposition that includes time frames and referral to an appropriate provider shall be recorded on the CDCR Form 7277.

Referrals shall be completed on the appropriate forms and forwarded to the Office Technician for scheduling as applicable.

The Chief Dentist (CD) or designee, at each institution shall, in consultation with the CD, Dental Program, DCHCS, be responsible for tracking RC screenings, including the date each inmate receives his/her dental screening.

## Chapter 2.2

### Dental Screening – Reception Center (E)

---

#### I. POLICY

Within 60 calendar days of arrival at a Reception Center (RC), each inmate shall receive a dental screening, a dental classification based on priority of dental need, dental health education in the form of a pamphlet on oral health self-care, and appropriate treatment or referral for all inmates determined to have Priority 1 (urgent) dental conditions.

#### II. PURPOSE

To provide inmates with continuity of health care and identify dental conditions needing immediate treatment or monitoring.

#### III. PROCEDURE

##### A. *Dental Screening in Receptions Centers:*

1. A dentist shall perform a screening examination of each newly arriving inmate, including new commitments and parole violators, at an RC within 60 calendar days of the inmate's arrival.
2. Licensed health care staff shall perform screening duties within the scope of licensure.
3. Licensed health care staff shall interview each inmate in a manner that ensures the privacy of their health care information, subject to the safety and security concerns of the institutions.
4. A Reception Center Logbook/Tracking System shall be maintained in the reception area of each RC. The date the dental screening was completed shall be entered into the RC tracking system.
5. The dental screening shall be documented on a CDCR Form 237 A *Health Record – Dental (Reception Center Screening)* and shall include but not be limited to:
  - A review of the inmate/patient's health history.
  - Panographic Film.
  - Head and neck examination.
  - Intra-oral hard and soft tissue evaluation and oral cancer screening.
  - Examination of teeth using mouth mirror and explorer.
  - Charting of decayed, impacted, or missing teeth and charting or recording of other visible pathological conditions.
  - Noting the presence and condition of prosthetic appliance(s).

- Assigning and recording a provisional periodontal type using the Periodontal Screening and Recording (PSR) score.
- Assigning and recording a dental treatment priority based on dental service area, (i.e. periodontics, restorative, endodontics, oral surgery, prosthodontics), and an overall dental treatment priority.
- Distinctive recording or charting of Priority 1 conditions (such as acute infections, severe pain, spontaneous bleeding). The dentist shall review the screening findings with the inmate/patient, advise him or her of any Priority 1 conditions, and recommend that the inmate/patient submit a CDCR Form 7362 *Request for Medical/Dental Treatment*.

The screening dentist shall record additional information as needed on a CDCR Form 237 C *Dental Progress Notes* or a CDCR Form C-1 *Supplement to Dental Progress Notes*.

6. The dentist shall complete a CDCR Form 128 C-1 *Chrono - Medical Clearance/Restrict Information; Reception Center* for each inmate/patient screened.
7. The dentist, or designee, shall provide each inmate/patient with a pamphlet on oral health self-care at the dental screening visit. The dentist shall ensure that each inmate/patient signs an acknowledgement of receipt of the oral health self-care pamphlet, and a copy of the acknowledgement is placed in the inmate/patient's Unit Health Record (UHR). If the inmate/patient refuses to sign an acknowledgement, the dentist shall document the refusal on a CDCR Form 7225 *Refusal of Treatment* and a CDCR Form 237 C or C-1.
8. The dentist, or designee, shall provide each inmate/patient with a *Dental Materials Fact Sheet* at the dental screening visit. The dentist shall ensure that each inmate/patient signs an acknowledgement of receipt of the *Dental Materials Fact Sheet* and a copy of the acknowledgement is placed in the inmate/patient's UHR, (Reference: Business & Professions Code Section 1648.15). If the inmate/patient refuses to sign an acknowledgement, the dentist shall document the refusal on a CDCR Form 7225 and a CDCR Form 237 C or C-1.
9. The screening dentist shall sign all appropriate forms and documents. The dentist, or designee, shall file all appropriate forms and documents in the dental section of the inmate/patient's UHR.

**B. Dental Treatment Priorities:**

1. After the screening, the dentist shall assign each inmate/patient an overall dental treatment priority as listed below, (Reference: Chapter 5.4 *Dental Treatment Priorities*).
  - Priority 1: Urgent Care
  - Priority 2: Interceptive Care
  - Priority 3: Routine Rehabilitative Care
  - Priority 4: No Dental Care Needed
  - Priority 5: Special Needs Care

2. The dentist shall record the overall dental treatment priority on the CDCR Form 237 A and the CDCR Form 237 C or C-1. This dental treatment priority indicates the inmate/patient's priority of need for dental care and will be used to schedule future dental visits.
3. This priority shall be reviewed and appropriately modified after each dental visit.

C. *Management of Dental Conditions (Emergency and Dental Treatment Priority 1) in the RC:*

1. While housed at an RC, a dentist shall provide only limited dental services necessary to meet an inmate/patient's basic needs. Such dental services shall include, but not be limited to:
  - Treatment of Emergency or Priority 1 Urgent Care needs such as injuries, acute infection, severe pain, or spontaneous bleeding.
  - Treatment for any unusual hard or soft tissue pathology.
  - Individual counseling in oral self-care, if required.
2. The dentist shall directly refer inmate/patients with acute oral and maxillofacial conditions, which require specialty consultation or treatment, to the intake facility's Oral and Maxillofacial Surgeon or the facility's contracted preferred provider.
3. In the case of a dental emergency, the dentist on duty during normal working hours shall see these inmate/patients upon their arrival at the clinic, and if needed provide treatment. For dental emergencies outside of normal working hours, the dentist on call shall be contacted as outlined in Chapter 5.10 *Dental Emergencies*.
4. An inmate whose oral screening indicates the likelihood of a Priority 1A condition shall be treated for that condition within 24 hours.
5. The dentist shall record "Priority 1", on the CDCR Form 237 A and the CDCR Form 237 C or C-1 in the *Progress Notes* section, for all inmate/patients with an overall dental treatment priority 1 designation. In addition, the dentist shall record all Priority 1 conditions requiring follow-up, or any dental condition that the screening dentist determines should be brought to the attention of dental personnel at the inmate/patient's facility of assignment, on the CDCR Form 237 A and the CDCR Form 237 C or C-1 in the *Progress Notes* section. Upon the inmate/patient's arrival at his or her facility of assignment, the listed problems are to be brought to the attention of appropriate clinic personnel, (See Chapter 5.9 *Continuity of Care*).

## CHAPTER 2.3

### Periodic Dental Examination – Assigned Facility (E)

---

#### I. POLICY

It shall be the policy of the CDCR that each inmate under 50 years of age at an Assigned Facility shall receive a dental examination at least once every two years, and that all inmates 50 years of age or older at an Assigned Facility shall receive a dental examination annually.

#### II. PURPOSE

To ensure that inmates incarcerated within the CDCR receive a complete dental examination, in a timely manner, upon placement at an assigned facility. The purpose of the dental examination shall be for the identification, diagnosis, and treatment of dental pathology, which impacts the health and welfare of inmates.

#### III. PROCEDURE

- A. All inmates incarcerated within the CDCR shall have a dental examination, completed by a dentist, every two years until the inmate reaches the age of 50.
- B. All inmates 50 years old or older shall have a dental examination, completed by a dentist, annually. Inmates with certain chronic systemic illnesses that could compromise their oral health shall receive an annual dental examination, regardless of their age.
- C. Inmate/patients undergoing active comprehensive dental treatment are not eligible for an additional annual dental examination. Active comprehensive dental treatment is defined as treatment being rendered according to an established dental treatment plan, (e.g. the inmate/patient has a complete examination, radiographs, dental diagnosis, and a written treatment plan on file in the Unit Health Record (UHR), and is receiving treatment in accordance with that written treatment plan).
- D. Emergency visits shall not be considered active comprehensive treatment, and shall not affect the inmate/patient's annual dental examination date.
- E. An inmate/patient's annual dental examination shall be completed during the inmate's birth month, or the month following.
- F. Inmates transferring from one Assigned Facility to another shall be scheduled for an evaluation within 90 days of transferring. During the evaluation, dental staff shall note the date of any previous dental examination(s) and shall schedule the inmate's annual examination according to the policy outlined above.

- G. If an inmate/patient refuses the annual dental examination a CDCR Form 7225, "*Refusal of Treatment Form*" must be completed and signed by the provider and the inmate/patient. The completed 7225 shall be filed in the dental section of the UHR.
- H. Annual dental examinations shall include the following, which shall be documented on the CDCR 237B:
1. Updated charting of the inmate/patient's existing dental restorations and decay.
  2. Radiographs as needed.
  3. Updated charting of the inmate/patient's periodontal status by completing a Periodontal Screening and Recording (PSR).
  4. A review and update of the health history.
  5. Completion of an oral cancer screening.
  6. Updated charting of a dental treatment plan.
  7. A plaque index score.

## Chapter 2.4

### Periodontal Disease Program (E)

---

#### I. POLICY

All dental facilities in the CDCR shall have a Periodontal Disease Program for the diagnosis and treatment of periodontal disease. Diagnosis and treatment of periodontal disease shall be available to all inmates based on periodontal type, classification, priority of need, and eligibility for care as determined by the attending dentist.

#### II. PURPOSE

The purpose of this policy shall be to establish guidelines and procedures for the treatment and management of periodontal disease in the inmate/patient population.

#### III. PROCEDURE

##### A. Diagnosis of Periodontal Disease

##### 1. Periodontal Screening and Recording (PSR).

- a. All inmates shall be provided a PSR at the Reception Center (RC), and full periodontal charting either at the RC or at their assigned facility, depending on the PSR results.
- b. The dentist shall utilize a periodontal probe (see PSR addendum) to determine the PSR code to be recorded for each sextant of the inmate/patient's mouth.
- c. Any sextant that is edentulous shall be indicated with a Code "X".
- d. A Code "0" shall be recorded for the sextant when probing depth is less than 3 millimeters (mm), no calculus or defective margins are detected, and gingival tissues are healthy with no bleeding after probing.
- e. A Code "1" shall be recorded for the sextant when probing depth is less than 3mm, no calculus or defective margins are detected, and there is bleeding after probing.
- f. A Code "2" shall be recorded for the sextant when probing depth is less than 4 mm and supra or subgingival calculus and/or defective margins are detected.
- g. A Code "3" shall be recorded for the sextant when probing depth is greater than 4mm but less than 5.5 mm.
- h. A Code "4" shall be recorded for the sextant when probing depth is greater than 5.5 mm.
- i. Inmates with code readings of "0, 1, or 2" shall receive appropriate preventive care, Oral Hygiene Instruction (OHI), removal of subgingival plaque, and removal of calculus and correction of plaque retentive margins on restorations.

- j. Inmates with a code reading of "3" in one sextant shall receive a comprehensive periodontal examination and charting of the affected sextant to determine an appropriate treatment plan.
  - k. Inmates with two or more sextant code scores of "3," or one sextant code score of "4," shall receive a comprehensive full mouth periodontal examination and charting to determine an appropriate treatment plan.
  - l. In addition to these scores, the asterisk symbol \* shall be added to the sextant score whenever individual findings indicate clinical abnormalities such as furcation involvement, mobility, mucogingival problems, or recession.
  - m. All dentists will utilize the PSR screening system to meet the requirement for early diagnosis of periodontal disease.
2. Comprehensive Full Mouth Periodontal Examination and Charting.
- a. Inmates with two or more sextant scores of Code 3, or one sextant score of Code 4 shall receive a comprehensive full mouth periodontal examination and charting to determine an appropriate treatment plan.
  - b. Inmates shall be classified according to one of the following types of periodontal diseases (either localized or generalized) based on clinical and radiographic examinations. The classification type shall be based on the most severe area of periodontal disease (possibly one tooth).
    1. Healthy Periodontia— no evidence of current periodontal disease, or healthy periodontia are present with evidence of previous loss of support.
    2. Gingivitis – shallow pockets; bleeding in response to gentle probing; changes in gingival form; no evidence of bone loss.
    3. Mild Periodontitis – inflammation; gingival form changes; increased sulcus depth, clinical attachment levels up to 3mm from the cemento enamel junction; minor bone loss.
    4. Moderate Periodontitis – inflammation; gingival form changes; increased sulcus depth, clinical attachment levels 4-6 mm from the cemento enamel junction; moderate bone loss.
    5. Advanced Periodontitis – inflammation; gingival form changes; increased sulcus depth, clinical attachment levels more than 6 mm from the cemento enamel junction; severe bone loss.
3. Methods
- a. Six probing depths per tooth shall be recorded, using the technique of walking the probe around the tooth and recording the deepest measurement for the facial and lingual, and four interproximal measurements in the appropriate box on the periodontal charting record.
  - b. Mobility of the teeth shall be recorded in the appropriate box on the periodontal charting record utilizing the following classifications of mobility:

0 = no mobility

1 = up to 1mm of movement in any horizontal direction.

2 = greater than 1 mm of movement in any horizontal direction.

3 = vertical mobility, tooth is depressible.

- c. The degree of furcation involvement shall be recorded in the selected box. The highest furcal classification for each tooth shall be recorded, (e.g., if tooth #30 has class 1 involvement on the facial and class 2 involvement on the lingual, then a 2 would be placed in the box). The following furcation classification shall be used:

0 = no furcation involvement detected.

1 = incipient furcation involvement detected, penetration into the furcation of 1 mm.

2 = definite furcation involvement, penetration into the furcation of more than 1 mm.

3 = horizontal through and through destruction of furcal bony tissues.

- d. When two or more features of disease are present on the same tooth, the most severe classification for that tooth shall be used.

#### B. Treatment of Periodontal Disease

The treatment of periodontal disease is a major part of dental practice and requires a coordinated effort between the inmate/patient and the dental team. The ultimate responsibility for controlling periodontal disease is that of the inmate/patient.

##### 1. Education

- a. Methods and procedures to control periodontal disease shall be taught and demonstrated to inmate/patients by dental staff. These measures shall consist of individual instructions and training in oral health self-care and plaque control, which may include but not be limited to:
1. The recording of the plaque/index score (PI) on the CDCR Form 237B.
  2. Education on the signs and symptoms of periodontal disease.
  3. Education on the effect of periodontal disease on oral health.
  4. Demonstration and training on the methods of preventing periodontal disease.
  5. Education and training on proper oral health self-care techniques.
  6. Availability of follow-up care at the assigned facility.
  7. All inmate/patients with teeth shall have their PI determined at the initial dental examination appointment. The PI is used to record the percentage of teeth stained with plaque and is determined using the following formula:

$$\frac{\text{Number of Teeth Stained with Plaque}}{\text{Number of Teeth Present}} \times 100 = \underline{\hspace{2cm}} \%$$

Prior to staining all the teeth, the number of teeth present shall be verified and documented on the CDCR Form 237B. Disclosing solution shall be applied to all

surfaces of the teeth. Stain on any or all surfaces of a tooth is counted as one. A PI of 20% or less, (i.e., an 80% plaque free oral environment), represents acceptable oral self-care.

- b. Each eligible inmate/patient who requests routine care shall be provided an initial or updated treatment plan, a baseline PI, and individual counseling in oral health self-care. The baseline PI and oral health self-care education shall be provided within 35-60 calendar days of the treatment plan formulation. All periodontal disease education/training, disease prevention demonstrations, as well as patient compliance as confirmed by acceptable plaque/index scores shall be documented in the Services Rendered Section of the CDCR 237 B dental treatment form.

Inmate/patients with a plaque index over 20% may request re-certification, after completion of a 30 day period of self-care, by submitting an inmate request for health services form CDCR 7362.

## 2. Clinical Treatment

- a. All inmates are eligible for the removal of moderate to heavy supragingival calculus in the presence of documented, acute or subacute gingival conditions (Priority 1).
- b. Inmates with asymptomatic gingival conditions who are incarcerated over six (6) months and who meet oral self-care requirements are eligible for removal of moderate to heavy supragingival calculus (Priority 2).
- c. All inmates are eligible for a routine scaling and prophylaxis after demonstrating acceptable oral self-care and after one-year of incarceration. Inmates are then eligible annually for routine scaling and prophylaxis, with continued demonstration of acceptable oral health self-care. A plaque index will be done when the appearance of the oral cavity indicates non-compliance (Priority 3).
- d. Non-Surgical Deep Scaling and Root Planning.
  1. Inmates with Moderate or Advanced Periodontitis are eligible for deep scaling and root planning procedures (Priority 3) after 12 months of incarceration and with a documented PI of better than 20% for a period of six months. Prior to deep scaling and root planing procedures, the attending dentist shall document a baseline charting of the periodontal status, including:
    - Pocket depths.
    - Mobility of teeth.
    - Areas of furcation involvement.
    - Areas of bleeding upon probing.
    - A radiographic survey taken within the last six months shall also be a part of the periodontal status record.
  2. The attending dentist may, at his or her discretion, utilize subgingival periodontal treatments, (e.g., Atridox, peirodental chips, etc.), in lieu of periodontal surgery.

3. A charting and re-evaluation of the periodontal status shall be accomplished three months following completion of deep scaling and root planning procedures. The inmate/patient shall initiate this visit by submitting a CDCR Form 7362.
4. An inmate/patient's periodontal type may change after treatment. Any such change shall be evaluated and documented by the attending dentist.
5. Dentists who determine that a special need exists for any inmate/patient, regardless of length of incarceration, shall ask for an exception to this policy by submitting a request to the Dental Authorization Review Committee. Documentation to be submitted with the request for special periodontal treatment shall include:
  - A statement outlining the clinical justification for treatment.
  - Legible copies of all pertinent dental records.
  - Current study models.
  - Radiographs including the in-processing panoramic radiograph and full mouth periapical radiographs taken within the past six months.

## Chapter 2.5

### Periodontal Preventive Program for Pregnant Inmates (E)

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#### I. POLICY

Pregnant Inmates shall receive within the second trimester of gestation a dental examination, periodontal evaluation and the necessary periodontal treatment in order to maintain periodontal health during the gestation period.

#### II. PURPOSE

To establish protocols which prevent or treat gingivitis/periodontitis during pregnancy.

#### III. PROCEDURE

Pregnant Inmates shall benefit from the Periodontal Disease program as delineated here and in Chapter 2.4 Periodontal Disease Program.

##### A. Diagnosis of Periodontal Disease

1. Pregnant inmates shall receive a comprehensive full mouth periodontal examination, charting and classification to determine the periodontal condition and an appropriate treatment plan.
2. Pregnant inmates shall have their plaque/index score determined and recorded on the CDCR Form 237B or 237C.

##### B. Treatment of Periodontal Disease

1. Education: Methods and procedures to control periodontal disease shall be taught and demonstrated to pregnant inmates by dental staff as outlined in Chapter 2.4.
2. Clinical Treatment:
  - a. Pregnant inmates shall receive routine scaling and prophylaxis regardless of their ability to comply with acceptable personal oral hygiene procedures during the gestation period. This treatment shall occur within their second trimester of gestation. A re-evaluation shall be accomplished within the first half of the third trimester.
  - b. Pregnant inmates with moderate or advanced periodontitis shall receive non-surgical deep scaling and root planning procedures regardless of their ability to comply with acceptable personal oral hygiene procedures during the gestation period. This treatment shall occur within their second trimester. A charting and

reevaluation shall be accomplished 30 days following completion of deep scaling and root planning procedures and subsequent follow-up care planned.

- c. The attending dentist shall not utilize subgingival periodontal medications (e.g. Atridox, Periostat, etc) in the treatment of pregnant inmates. Tetracycline medications are contraindicated in the treatment of pregnant women.
- d. All pregnant inmates periodontal treatment visits shall be documented by the attending dentist on the appropriate CDCR form (CDCR 237B or 237C)

## Chapter 2.6

### Dental Prosthodontic Services (E)

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#### I. POLICY

The CDCR shall provide limited Dental Prosthodontic Services to inmate/patients in its custody. All dental prostheses, (i.e., all maxillary and mandibular stayplates, complete dentures, and partial dentures), which are fabricated for inmate/patients in the custody of the CDCR, shall have the inmate/patient's name and CDCR number embedded into the prosthesis for identification purposes. Each dental clinic shall maintain a dental prosthetic log for tracking prosthodontic cases. Cases shall be forwarded/stored based on the inmate/patient's incarceration status. Replacement of prosthetic appliances shall be based on the recommendation of the treating dentist.

#### II. PURPOSE

To establish standard guidelines and procedures for the fabrication, tracking, shipping, handling, storage, and replacement of inmate/patient dental prosthetic appliances.

#### III. PROCEDURE

##### A. Dental Prosthodontic Guidelines and Identification

1. An inmate's need for a dental prosthesis shall be based on medical necessity as described in the *California Code of Regulations* Title 15, Article 8, Section 3350 (b) (1).
2. No inmate/patient shall be deprived of a prescribed dental prosthesis that was in his or her possession upon arrival into CDCR custody, or that was properly obtained while in CDCR custody, unless a CDCR dentist determines the appliance is no longer needed or its removal is indicated for reasons of safety or security.
3. If an inmate/patient's dental prosthesis is confiscated for safety and security reasons, a dentist shall be consulted to determine whether the inmate/patient will require any accommodations due to the loss of the prosthesis.
4. A dental prosthesis shall be constructed only when:
  - a. The dentist believes the inmate/patient can tolerate it and can be expected to use it on a regular basis.
  - b. An inmate/patient is edentulous, is missing an anterior tooth, or has less than eight posterior teeth in occlusion.
  - c. All restorative, periodontal, and surgical dental treatments have been completed.
  - d. The inmate/patient has a dental treatment Priority 2 prosthetic need (e.g. complete denture or a transitional anterior partial denture) and a minimum of six months of continuous incarceration remaining before release or parole; or the inmate/patient has a dental treatment Priority 3 prosthetic need (e.g. partial denture) and a minimum of

12 months of continuous incarceration remaining before release or parole, (Reference Chapter 5.4 *Dental Treatment Priorities*).

5. A prescribed dental prosthesis, (including night-guards), shall be provided at state expense if an inmate/patient is indigent. Otherwise inmate/patients shall purchase prescribed appliances through the department, or a vendor of the inmate/patient's choice, as directed by the Chief Dentist (CD). The inmate/patient shall sign a CDCR Form 193, *Trust Account Withdrawal Order* (Rev 1/88) to pay for the prescribed appliance before dental impressions are made for the appliance.
6. Prescribed dental appliances made from precious metal shall not be ordered by CDCR dentists, and repairs to existing dental prostheses made from precious metal shall not be performed by CDCR dentists or CDCR dental laboratories. If an inmate/patient's existing dental appliance made from precious metal needs repair, the dentist shall offer the inmate/patient the option of having a new prosthesis made and shall have him/her sign a CDCR Form 193, *Trust Account Withdrawal Order* (Rev 1/88) to pay for the new appliance.
7. The dentist shall complete a CDCR Form 239, *Prosthetic Prescription*, when impressions for dental prostheses are taken, or when any intermediate step in the fabrication process is initiated. Each dentist shall:
  - a. Write the date, inmate/patient name, and CDCR number at the top of the CDCR Form 239.
  - b. Illustrate the design of the appliance, noting missing teeth, clasps, guide-planes, and rest-seat placement.
  - c. Select the tooth shade.
  - d. Check the appropriate boxes for upper or lower relieved trays or bite blocks.
  - e. Select the type of dental prostheses, (e.g., upper and/or lower full dentures, upper and/or lower partials, or upper and/or lower immediate dentures).
  - f. Indicate whether a flexible resin or titanium frame is to be used in the case of a cast metal or non-metal framework, and make a notation in the assigned box.
  - g. Select acrylic colors, (e.g., pink or pigmented).
  - h. Make a notation in the assigned boxes if the prosthesis is to be surveyed, returned as a finished case, or whether it is a try-in, jump case, or a repair.
  - i. Select the type of clasps to be used, (i.e., cast, wrought wire, or no clasps).
  - j. Note any special instructions in the assigned space.
  - k. Sign the prescription, noting the date, and the institution.
8. All inmate/patients shall sign a CDCR Form 193, *Trust Account Withdrawal Order*, at the time that initial impressions are taken for dental prostheses.
9. The Office Technician (OT) shall ensure the CDCR Form 193 is logged and delivered to the Trust Office for processing.
10. All dental prostheses and stone models shall have the inmate/patient's last name and CDCR number inscribed on them. The dentist shall not deliver any prosthesis before the

proper identification, (i.e., inmate's last name and CDCR number) has been embedded in the resin of the denture or partial.

11. Dental prostheses without the proper identification on them shall be returned to the dental laboratory to have the inmate/patient's last name and CDCR number placed on the prosthesis.

#### B. Dental Prosthetic Tracking Log

1. Each dental clinic shall maintain a single Dental Prosthetic Log (DPL), regardless of the number of dental care providers at the clinic and this log shall be maintained by the OT.
2. All prosthetic cases initiated by the clinic shall be recorded in its DPL. The inclusion of a dental prosthesis in a treatment plan does not constitute initiation of a case. A case is not considered initiated until an initial impression has been taken.
3. All identifying information for each case shall be recorded when the case is initiated, (i.e., inmate/patient's name, CDCR number, case type, and provider's name).
4. Each subsequent step in the fabrication process shall be recorded in the appropriate spaces in the DPL.
5. Dates of case activity, to and from the laboratory, shall be recorded in the DPL for each step of the fabrication process.
6. The date of the final delivery shall be recorded in the DPL.
7. Cases that cannot be delivered for any reason shall be recorded in the final disposition space in the DPL. For example: Patient transferred, case transferred to the new facility of assignment (identify facility), etc.
8. The CD shall maintain completed DPL's on file for five years.

#### C. Dental Prosthetic Cases: Shipping and/or Storage Procedures

1. Inmate/patients who have been paroled or released from the CDCR.

Completed dental prosthetic cases that cannot be delivered because the inmate/patient has been paroled or released, shall be forwarded by mail to a dentist designated by the inmate/patient. The dental department shall store the prosthesis until contacted by the inmate, for a period of time not to exceed 12 months (one year).

2. Inmates Transferred Between CDCR Facilities
  - a. All prosthetic cases in progress, regardless of the stage of completion, shall be forwarded directly by the OT to the inmate/patient's new facility of assignment for completion or delivery. This transfer shall be recorded in the DPL in the final disposition column.
3. General Information
  - a. A case may be forwarded only to a dentist for delivery or completion.
  - b. The sending clinic/dentist and the receiving clinic/dentist shall coordinate by telephone the forwarding of a prosthetic case for completion or delivery.

- c. Prosthetic cases stored by the facility shall be maintained in storage for a period of one year. During this period, an inmate released from CDCR may contact a private dentist who may request that a completed case be forwarded for delivery at the inmate's expense. If no activity has occurred, cases older than one year shall be destroyed.

#### D. Replacement or Repair of Dental Prosthetic Appliances

1. A removable prosthetic dental appliance diagnosed as unserviceable by the providing dentist shall be repaired or replaced as appropriate.
2. A removable dental appliance that has been lost, stolen, or otherwise rendered unserviceable will be replaced according to the following criteria:
  - a. Priority 3 Prosthodontic Replacement
    - Time requirement of one year prior to initiation of new impressions. Time requirement is measured from the date the treatment plan was established.
    - A plaque index score of 20% or less is required.
    - All Priority 3 dental treatment needs must be completed, (i.e., restorations, surgery, periodontal, endodontics etc.), prior to the initial impression.

#### b. Inmates with Special Dental Prosthetic Needs

A Dentist who diagnoses that a special dental prosthetic need exists for any inmate/patient may request an exemption by submitting a request to the Dental Authorization Review (DAR) Committee for review and approval. The request must include the following:

- A copy of the inmate/patient's dental record.
- Current radiographs as appropriate.
- Dental models.
- Inmate/patient history of prior prosthetic needs and replacements.
- Providing dentist's recommendations concerning prosthetic replacement.
- Special circumstances that warrant replacement of appliance.
- Any other pertinent information.

#### E. Dental Prosthetic Services

##### 1. Acrylic Partial Dentures.

Acrylic partial dentures in the anterior regions may or may not involve clasps. Acrylic partial dentures also include prosthesis with both anterior and posterior teeth. Acrylic partial dentures shall be provided if:

- The inmate/patient has a *minimum* of twelve months of incarceration remaining before parole or release.
- The inmate/patient meets established Dental Prosthetic Policy criteria that all restorative, endodontic, extractions and oral surgery procedures have been completed.
- The inmate/patient has a plaque index score of 20% or less.

2. Complete Dentures and Cast Partial Dentures shall be provided if:
  - a. The inmate/patient has a *minimum* of twelve months of incarceration remaining before parole or release.
  - b. The inmate/patient meets established Dental Prosthetic Policy criteria that all restorative, endodontic, extractions and oral surgery procedures have been completed.
  - c. The inmate/patient has a plaque index score of 20% or less.
  - d. The treating dentist diagnoses that there are an insufficient number of teeth to masticate a normal diet. Eight or fewer occluding posterior teeth are considered to be an insufficient number to masticate a normal diet. (Posterior teeth are defined as premolars and molars).
  - e. Any treatment plan that includes a removable partial denture shall also include consideration of a cast removable partial denture.
  - f. The above guidelines may be modified at the discretion of the treating dentist based upon medical necessity.

## CHAPTER 2.7

### Dental Restorative Services (E)

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#### I. POLICY

The CDCR shall provide inmate/patients with conservative dental restorative services utilizing conventional dental restorative materials. Dental restorative services shall be limited to the restoration of carious teeth with enough structural integrity to provide long-term stability.

#### II. PURPOSE

To establish guidelines and parameters for the delivery of dental restorative services to inmates incarcerated within CDCR.

#### III. PROCEDURE

A. Appropriate and current radiographs shall be reviewed before initiating restorative procedures.

B. All materials utilized in CDCR dental clinics shall have the approval of the American Dental Association.

C. Permanent restorations.

1. Amalgam shall be the material of choice for Class I and II restorations of posterior teeth.
2. Amalgam, Light Cured Composite, and Glass Ionomer shall be considered acceptable materials for buccal pit and Class V restorations of posterior teeth.
3. Light cured composite shall be the material of choice for anterior restorations. When indicated, glass ionomer may be utilized.

D. Temporary or Sedative restorations.

1. Temporary or sedative restorations shall be placed when indicated.
2. Temporary polycarbonate or posterior stainless steel crowns shall be utilized on teeth that have been previously prepared for crowns or for teeth requiring a crown.
3. Remineralization temporaries, such as glass ionomer cements that leach fluoride into the tooth structure and promote remineralization of tooth structure, shall be placed into carious lesions for individuals with extensive caries. These sedative restorations are intended to provide holding care for the inmate/patient and shall be placed shortly after completion of the initial examination on inmate/patients who exhibit extensive dental caries.

- E. Severely periodontally involved teeth shall not be eligible for restorative dental treatment.
- F. Although every effort shall be made when restoring anterior teeth to achieve a reasonable esthetic result, cosmetic dentistry shall not be provided.
- G. Routine dental care shall be discontinued if, in the judgment of the providing dentist:
- The inmate/patient is not meeting the standards of oral hygiene necessary for the preservation of his or her dentition, (i.e., an unacceptable dental plaque score).
  - The inmate/patient has a record of failing to keep appointments. Such inmate/patients shall qualify for Emergency and Priority 1 Urgent dental treatment only.

## CHAPTER 2.8

### Oral Surgery (E)

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#### I. POLICY

Dental clinics within the CDCR shall provide comprehensive Oral Surgery services to all inmates/patients.

#### II. PURPOSE

To establish guidelines and parameters whereby inmates/patients in the custody of CDCR receive necessary Oral Surgery services in a timely manner.

#### III. PROCEDURE

- A. A full range of oral surgery procedures shall be available to all CDCR inmates regardless of incarceration time.
- B. Any medically necessary oral surgery that cannot be accomplished at the local institution shall be made available by referring the inmate/patient to contracted oral surgeons, or to outside facilities.
  1. The attending dentist shall request a "Referral for Specialty Services or Consultation" by a Dental Health Care Specialist and shall:
    - a. Document the recommendation for referral on the CDCR Form 237B in the dental section of the inmate/patient's Unit Health Record (UHR).
    - b. Discuss the recommendation with the inmate/patient.
    - c. Obtain the inmate/patient's consent for the referral.
  2. The treating dentist shall submit Referrals for Specialty Services or Consultations to the Chief Dentist (CD), who shall present them for consideration by the Dental Authorization Review (DAR) Committee. The DAR shall approve or deny such requests within 21 days of receipt.
  3. Requests that are approved by the DAR shall be forwarded, along with all supporting documentation, to the Health Care Review Committee (HCRC) for final approval or denial.
  4. The DAR/HCRC approval process may be bypassed if the CD determines that the specialty services or consultation are required because of Emergency or Priority 1 conditions.
  5. The attending dentist shall either arrange the approved specialty appointment or explain the DAR's or HCRC's denial to the inmate/patient.

- C. Routine extraction of asymptomatic third molars is an excluded service and as such shall not be undertaken.
- D. A *Consent for Oral Surgery* Form must be completed and signed by the inmate/patient prior to the initiation of oral surgery services.
- E. All inmates/patients shall have a post-op follow-up oral surgery appointment three to four days after each surgical procedure.

## CHAPTER 2.9

### Endodontics (E)

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#### I. POLICY

Inmates incarcerated within the CDCR shall be eligible for limited Endodontic (root canal therapy) services at CDCR dental clinics. Endodontic services within the CDCR shall be performed in accordance with established criteria, and within the specific guidelines enumerated below and in Section 54050 of the Department Operations Manual.

#### II. PURPOSE

To establish dental treatment parameters for providing inmates with endodontic services in CDCR dental facilities.

#### III. PROCEDURE

- A. Endodontics, or root canal therapy, shall be performed on an inmate for the upper and lower six anterior teeth when, in the dentist's judgment, the retention of the tooth is necessary to maintain the integrity of the dentition and the tooth's prognosis if favorable.
- B. In order to qualify for endodontic therapy, a tooth must have adequate periodontal support and must have a good prognosis for long-term retention and restorability, based on the use of conservative restorative techniques.
- C. A *Consent for Endodontic Treatment* Form must be completed and signed by the inmate/patient prior to the initiation of treatment.
- D. Apicoectomy and posterior root canal therapies on non-vital teeth are excluded procedures and, as such, require the prior approval of the Dental Authorization Review Committee.
- E. Posterior and anterior teeth that would require either pin or post retained core build-ups prior to being crowned shall not be eligible for endodontic procedures.
- F. A non-vital tooth must be restorable with available restorative materials and the inmate's overall dentition must be healthy in order for the tooth to qualify for endodontic treatment.
- G. Root canal therapy shall be available to Priority 1 dental inmates/patients, (i.e., those with less than six months of continuous CDCR incarceration time remaining), on an emergency basis only, (i.e., only emergency pulpotomies and pulpectomies shall be provided).
- H. Root canal therapy shall be available to all Priority 2 and 3 inmates/patients, according to their dental treatment plan, oral health self-care requirements, and with the approval of the treating dentist.

- I. All root canal procedures shall be completed at the dental facility where the procedure was initiated.

## CHAPTER 2.10

### Fixed Prosthetics (Cast Crown and Bridge) (E)

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#### I. POLICY

Fixed prosthetic services, (i.e., cast precious and non-precious metal crowns and bridges) shall be considered an excluded service, and shall not be routinely provided to inmates/patients by dentists employed by the CDCR.

#### II. PURPOSE

To define fixed prosthetics as an excluded service and to establish guidelines for the provision of such treatment procedures.

#### III. PROCEDURE

A. Fixed prosthetics (cast crowns and bridges) shall not be routinely provided to inmates/patients. CDCR dentists who wish to provide fixed prosthetics for an inmate/patient must receive prior authorization from the Dental Authorization Review (DAR) Committee.

#### B. Fixed prosthetics:

1. Shall not be utilized to restore missing or defective teeth if an adequate restoration can be placed, (e.g., a stainless steel crown or an amalgam with cuspal coverage), or if a removable partial denture can be fabricated to replace the missing teeth.
2. May be provided if all of the following criteria are met:
  - a. All the teeth involved in fixed prosthetic therapy have adequate periodontal support, with no mobility other than normally occurring physiologic movement.
  - b. All the teeth involved have a good prognosis of restorability and long term retention.
  - c. All Priority 1, 2, and 3 dental care has been completed prior to commencing Fixed Prosthetic treatment.
  - d. The inmate/patient has demonstrated a plaque index of at least 20% for two consecutive months after the completion of all Priority 3 dental care. At the end of this two-month period a request for Fixed Prosthetics may be submitted to the DAR Committee.
  - e. The inmate/patient has a minimum of at least six months of verifiable continuous incarceration time remaining on his or her sentence.

C. Cast crowns shall be utilized only for teeth that a CDCR dentist determines are critical for maintaining the integrity of the inmate/patient's arch, and only when a pin retained amalgam, stainless steel crown, or bonded amalgam/composite restoration has failed or is contraindicated.

- D. Non-precious metals shall be utilized for Fixed Prosthetics unless the inmate/patient demonstrates sensitivity to those commonly used for crown and bridgework.
- E. Maryland Bridges shall not be utilized because of technique sensitivity and the resultant propensity for failure.
- F. Inmates undergoing fixed prosthetics that are in progress but not completed at the time of their incarceration, shall have their dental needs met with CDCR authorized restorative materials and procedures only, (e.g., removable prosthetics, stainless steel crowns, etc). Such inmates may elect to have their treatment completed by a private practitioner of their choice who must agree to perform the necessary treatment at the expense of the inmate/patient or their family. Any such treatment may be performed only with the prior approval of the DAR Committee. The CDCR shall not be liable for dental treatment completed by a private provider of the inmate's choice.

## CHAPTER 2.11

### Implants (E)

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#### I. POLICY

Dentists employed by the CDCR shall not initiate the placement, completion, or repair of dental implants for inmates.

#### II. PURPOSE

To establish that dental implants are not a dental service provided for inmates by the CDCR, and to provide guidelines for the treatment of inmates/patients with existing dental implants.

#### III. PROCEDURE

- A. An inmate with dental implants begun but not completed at the time of his or her incarceration, may arrange for continuation of such care by a private practitioner of his or her choice, who must agree to perform the necessary treatment at the expense of the inmate/patient or his or her family. Any such treatment may be performed only with the prior approval of the Dental Authorization Review (DAR) Committee.
- B. Inmates/patients with a failing dental implant, or who lack funds for the continuation of dental implant restoration by a private practitioner, and who have at least one year of incarceration time remaining on their sentence, shall have the dental implant removed.
- C. Deviations from this policy shall require the approval of the DAR Committee.

## CHAPTER 2.13

### Facility Level Dental Health Orientation/Self-Care (E)

#### I. POLICY

All CDCR inmates, within 14 days of assignment to a Mainline Facility from a Reception Center (RC), shall receive a Division of Correctional Health Care Services (DCHCS) CDCR *Inmate-patient Orientation Handbook to Health Care Services* containing information regarding dental health care services. Within 90 days of assignment to a Mainline Facility from an RC, CDCR inmates shall also receive dental health and self-care instruction.

#### II. PURPOSE

To ensure that inmates are aware of the dental services provided for them at their assigned institution, and are educated about the dental health and self-care requirements that are part of the dental program.

#### III. PROCEDURE

##### A. General Requirements

1. The Chief Dentist (CD) at each facility shall ensure that all inmates receive the DCHCS CDCR *Inmate-patient Orientation Handbook to Health Care Services* that describes the process used for obtaining emergency and routine dental services, within 14 days of assignment from an RC.
2. The CD at each facility shall ensure that all inmates receive dental health and self-care instruction, within 90 days of assignment from an RC. At the CD's direction, one or more Dental Assistants (DA) at his or her institution will provide the dental health and self-care instruction, once trained as an Institution Dental Health and Self-Care Educator (IDHSCE). The dental health and self-care instruction shall be a component of each inmate's scheduled facility orientation procedure.
3. All inmates/patients must maintain an acceptable level of dental health and oral hygiene self-care, which shall be measured and evaluated for each inmate/patient by the use of the dental plaque index score (PI). A PI score is calculated utilizing the following formula:  
$$\frac{\text{Number of Teeth Stained with Plaque}}{\text{Number of Teeth Present}} \times 100 = \underline{\hspace{2cm}} \%$$
4. Inmate/patients must maintain a PI score of 20% or less in order to qualify for Priority 3 Routine Rehabilitative care. Inmate/patients with a PI score above 20% or who refuse the dental health and self-care instruction, shall receive Emergency, Priority 1, Priority 2, and Priority 5 dental care. For each inmate/patient that refuses the dental health and self-care instruction the dentist, or designee, shall complete and file a CDCR Form 7225, *Refusal of Treatment* in the dental section of the inmate/patient's unit health record. Inmate/patients that refuse the dental health and self-care instruction must submit a

CDCR Form 7362 *Request for Medical/Dental Services* in order to access future dental care, (Chapter 5.14 *Access to Care*).

5. *Tooth Brushing for Inmates:* Inmates shall be allowed to brush their teeth at least once every 24 hours, within the facility's security guidelines, and encouraged to brush after meals.
6. *Dental Floss for Inmates:* Inmates shall be allowed to use dental floss once every 24 hours, within the facility's security guidelines.

#### **B. Plaque Index:**

1. The dentist shall determine an inmate/patient's PI score at the dental exam/treatment plan appointment, and any subsequent appointment at the dentist's discretion. The dentist shall document each inmate/patient's PI score on the CDCR Form 237-E *Health Record - Plaque Index* and the CDCR Form 237 C *Dental Progress Notes*. For inmate/patients administered a PI at the dental exam/treatment plan appointment, the dentist shall document the inmate/patient's PI score on the CDCR Form 237 B *Health Record - Dental (Mainline Examination)* in addition to the CDCR Form 237 E and the CDCR Form 237 C. The CDCR Form 237 C-1 *Supplement to Dental Progress Notes Dental Health Record* may be used instead of the CDCR Form 237 C. When documentation is completed, the dentist shall file all forms in the dental section of the inmate/patient's Unit Health Record (UHR).
2. If a dentist determines that an inmate/patient is not maintaining an acceptable level of oral health self-care, or the inmate/patient has a PI score of greater than 20%, then the dentist shall refer the inmate/patient to the IDHSCE, or designated dental assistant, for further dental health and self-care instruction. After completing the additional dental health and self-care instruction and a 30-day period of self-care, the inmate/patient may request to have his or her PI re-evaluated, by submitting a CDCR Form 7362.
3. If the inmate/patient's PI score remains greater than 20% after completing additional dental health and self-care instruction and a 30-day period of self-care, the dentist shall provide face-to-face oral hygiene instructions to the inmate/patient. After a 30-day period of self-care the inmate/patient may request to have his or her PI re-evaluated by submitting a CDCR Form 7362. The dentist shall provide face-to-face oral hygiene instructions followed by a 30-day period of self-care until the inmate/patient obtains a PI score of less than 20%. After each face-to-face oral hygiene instructions and the 30-day period of self-care, inmate/patients are expected to initiate the requests to have their PI re-evaluated by submitting a CDCR Form 7362.

#### **C. Inmate Dental Health and Self-Care Instruction Program:**

1. The CD, Dental Program, DCHCS, shall develop the Institution Dental Health and Self-Care Educator Training Program, referred to in this policy as the training program, used to train DAs as IDHSCEs. At a minimum, the CD, Dental Program, DCHCS, shall annually review and modify the training program as needed. The CD, at his or her institution, shall implement the training program and ensure that one or more DAs are

trained as IDHSCE(s). The CD shall ensure that only the DAs that have successfully passed the training program provide dental health and self-care instruction to inmate/patients. The CD shall document the completion of the training program along with any subsequent dental health and self-care training provided to the IDHSCE(s). Documentation shall include at a minimum the following: the name of the lesson plan used to train the IDHSCE(s), the name of the trainer, the names and signatures of the IDHSCE(s) trained, the duration of training, and the date of training. The CD shall maintain this documentation, along with a copy of the lesson plan and handouts, for a period of three years.

2. The IDHSCE(s) shall provide dental health and self-care instruction to the following:
  - Each inmate within 90 days of assignment from a RC;
  - Inmate/patients with a PI of 20% or greater referred by the dentist for the purpose of improving the inmate/patient's PI score;
  - Other inmate/patients referred from the dentist, or CD.
3. The IDHSCE(s) shall maintain a master institution Dental Health and Self-Care Instruction (DHSCI) log of inmate/patients that are awaiting and have completed dental health and self-care instruction. The CD shall maintain the DHSCI log for three years.
4. Dental health and self-care instruction for facility level dental orientation shall consist of one or more of the following:
  - A Spanish/English oral self-care demonstration/dental health orientation DVD or video tape.
  - An oral self-care /dental health education lecture-demonstration presented by a dentist or Institution Dental Health Self-Care Educator.
  - A Spanish/English printed handout with diagrams and instructions on dental health self-care techniques.
  - Inmates who do not speak or understand English or Spanish, or who are hearing impaired, shall be provided dental health and self-care education, where resources are available, by utilizing contract interpreting services, or staff who can translate for them.
  - All instructional materials shall be communicated in alternative equally effective means upon request.
5. The facility level dental health and self-care orientation program shall include, but not be limited to, the following topics:
  - Causes of dental disease.
  - Tooth-brushing techniques.
  - Dental flossing techniques.
  - Responsibility of inmate for oral health self-care.
  - Access to dental care.
  - Dental clinic hours of operation.

- Eligibility for care.
  - Dental priority system.
  - Types of dental care provided.
  - The effects of certain systemic illnesses on dental health.
  - Oral hygiene aids.
  - Preventive Dentistry Education.
  - The role of fluoride in dental health.
  - Specialized dental health self-care training for developmentally disabled inmates.
  - The effects of pregnancy on dental health. (Women's Institutions).
6. The IDHSCE shall document in the dental section of the inmate/patient's UHR on the CDCR Form 237 C or C-1 the completion of dental health and self-care instruction. Documentation must include the date of instruction, type of instruction given, and printed name and signature of the IDHSCE providing the instruction.

## CHAPTER 2.14

### Hygiene Intervention (E)

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#### I. POLICY

Inmates who are identified, reported, and documented by any CDCR staff member as having poor hygiene or whose hygiene compromises the sanitation/hygiene of their personal and immediate housing area shall be evaluated by CDCR DCHCS staff.

#### II. PURPOSE

To ensure that inmates who display inappropriate hygiene management shall receive medical and/or mental health care as indicated.

#### III. PROCEDURE

- A. Medical or custody staff who observe an inmate displaying behavior such as refusing to shower for an extended period of time, fecal smearing, urinating on the floor, food smearing, or similar inappropriate actions shall notify the facility clinic Registered Nurse (RN), Medical Technical Assistant (MTA), Mental Health Clinician, and Unit Housing Officer.
- B. The RN shall conduct an evaluation within twenty-four hours of notification and shall refer the inmate to a physician or Mental Health clinician (Case Manager) if indicated.
- C. The physician or Case Manager shall assume the care and treatment of the inmate when there is a medical or mental health cause for the behavior.
- D. When there is no medical or mental health cause for the behavior, the physician or assigned Case Manager shall provide custody staff with a CDCR Form 128-C, Chrono-General, and shall document the results of the assessment in the Unit Health Record.

## CHAPTER 3.1

### Infection Control Procedures (E)

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#### I. POLICY

All CDCR employees shall adhere to the mandates of the Dental Services Infection Control Program (DSICP) in the delivery of dental care to inmates/patients in order to provide the safe delivery of dental services to inmates/patients with communicable diseases, and minimize the possibility of the transmission of infection to other inmates/patients or dental personnel. The CDCR provides testing, treatment, monitoring and reporting of all communicable diseases that fall within state and federal guidelines.

The DSICP infection control program includes, but is not limited to:

- A. Written policies, procedures, and practices that define surveillance procedures to be used to detect inmates with infectious and communicable diseases.
- B. Specifications about appropriate immunizations, procedures, and practices for the purpose of preventing the transmission of infectious and communicable diseases.
- C. Descriptions of appropriate treatment of inmates/patients with infectious and communicable diseases, including isolation, when medically indicated.
- D. A procedure to ensure inmate/patient compliance with prescribed health care treatment regimens.
- E. Specifications for the decontamination of medical equipment, surfaces, and facilities where dental treatment is provided.
- F. Instructions for the proper disposal of sharps and biohazardous waste. Sharps are defined as dental or medical devices with a thin edge or fine point that are capable of cutting or piercing, (e.g., needles, scalpels, dental burs). Biohazardous waste is defined as waste that might contain infectious agents, (e.g. blood, human tissue).
- G. Requirements that health care workers give strict adherence to standard precautions in order to minimize the risk of exposure to blood and other body fluids.
- H. Specifications of work restrictions for health-care personnel infected with or occupationally exposed to infectious diseases.
- I. Requirements for the management of occupational exposures to bloodborne pathogens, including post exposure prophylaxis for work exposures to hepatitis B virus, hepatitis C virus, and human immunodeficiency virus.
- J. Procedures for selecting and using Personal Protective Equipment (PPE) with features designed to prevent injury from sharps.
- K. Procedures for using hand-hygiene products, surgical hand antisepsis, etc.

- L. Procedures for handling health care personnel with contact dermatitis and latex hypersensitivity.
- M. Procedures for the proper sterilization of wrapped and un-wrapped dental instruments.
- N. Procedures for dental water-quality concerns including, but not limited to, the use of sterile water for all invasive dental surgical procedures, (e.g., dental unit waterline biofilms, delivery of water of acceptable biological quality for patient care, usefulness of flushing waterlines).
- O. Infection control procedures for dental radiology.
- P. Specifications for aseptic technique for parenteral medications.
- Q. Specifications for pre-procedural mouth rinsing for patients.
- R. Infection control protocols for oral surgical procedures.
- S. Description of the Tuberculosis (TB) testing programs.
- T. Infection control program evaluations.

## **II. PURPOSE**

The DSICP shall promote a safe and healthy work environment; prevent the incidence and spread of disease; establish procedures to ensure that inmates and staff infected with communicable diseases receive prompt care and treatment; and provide guidelines for the completion and filing of all reports consistent with local, state, and federal laws and regulations regarding infectious and communicable diseases. The infection control program consists of written policies, procedures, and practices designed to prevent or reduce the risk of disease transmission, and to effectively monitor the incidence of infectious and communicable diseases among inmates and staff.

## **III. DISCUSSION**

- A. All institutions shall have an infection control policy and procedures committee to monitor and review the implementation of infection control policy at the institution. The committee shall consist of representatives from various areas of the institution, (custody, health care services, plant operations, etc.), who are involved in facility sanitation and in the control of infections in the institution.
- B. In many facilities, the Quality Improvement Committee (QIC) or a separate Infection Control Committee (ICC) shall be organized to oversee the infection control program. The QIC or ICC shall have monthly or quarterly meetings and shall keep written minutes of those meetings. The QIC or ICC is responsible for infection control policies and procedures; inspection, cleaning, and disinfection techniques; and other matters related to infection control. The QIC or ICC shall be monitored on a regular basis through the Quality Management Assessment Team (QMAT) process.

- C. All institutions shall follow appropriate isolation procedures specific to the infection or communicable disease being addressed, which meet the following guidelines:
1. If medically indicated, the inmate/patient shall be accommodated in a separate room with a separate toilet, hand-washing facility, soap dispenser, and single-service towels.
  2. If used to house individuals with air-borne diseases, the room shall have negative air pressure so that all air currents flowing into the room are properly vented allowing room air to flow safely out of the building to the outside. If such an isolation room is not available, the inmate/patient shall be transferred to a facility that can provide proper isolation.
  3. Procedural techniques shall include, but are not limited to, hand washing upon entering and leaving the isolation area, proper handling and disposal of infectious materials, proper isolation methods, instructions to inmates/patients housed in, and visitors to, the isolation room, proper handling of patient care equipment, and cleaning and disinfecting of isolation accommodations.
- E. CDCR mandates that all inmates and employees shall be screened annually for exposure to Tuberculosis with the tuberculin skin test using the Mantoux method. Positive test results should be followed-up with a radiographic chest examination and, if appropriate, sputum smears and culture. (Ref. Volume 4: Medical Services, Chapter 2: Health Screening - Reception Center, Section III, Item F.e)
- F. Standard precautions require that health care workers consider all patients as potentially infected with blood-borne pathogens and follow infection control precautions intended to minimize the risk of exposure to blood and certain other body fluids. Standard precautions apply to exposure to blood and body fluids, secretions, and excretions (except sweat), regardless of whether they contain blood, which come in contact with non-intact skin or mucous membranes.

#### IV. PROCEDURE

Each CDCR dental services employee shall practice the following dental clinic and dental laboratory infection control procedures. The CD at each Correctional Facility shall ensure that all dental employees receive annual training in the following infection control procedures. Each new dental department employee shall be provided training prior to assignments involving direct or indirect patient care duties. Each CD shall document dates, contents of training, names of persons conducting the training and names of all employees receiving training.

Any unusual or accidental employee exposure to potentially infectious matter is to be reported to the CD or designee, and the exposure control personnel or designee. The CD or designee on duty shall ensure that an incident report, all required Worker Compensation documents, and any other required forms are completed and properly filed. The CD and exposure control personnel shall maintain a record of unusual or accidental exposures and any corrective action plans that result from such exposures.

## A. INFECTION CONTROL IN DENTAL CLINICS

### 1. Health History

A thorough health history shall be compiled for all inmates/patients, including specific questions about medications, illnesses, hepatitis, drug use, previous blood or blood product transfusions, unexplained weight loss, lymphadenopathy, oral soft tissue lesions, and active infections. Inmates/patients with a suspected undiagnosed infectious disease shall be referred to a physician for a follow-up medical evaluation. Health histories on all inmates/patients shall be updated with each new treatment plan and each new provider or at least annually. Health histories shall be reviewed by each treating dentist prior to treatment.

### 2. Protective Gloves

- a. Disposable gloves shall be worn when there is a potential for touching blood, saliva or mucous membranes and when examining oral lesions. Gloves are also imperative when touching blood-soiled items, body fluids, and secretions, or when touching surfaces contaminated with these products. All dental personnel shall wear sterile surgical gloves when performing oral surgery procedures.
- b. Repeated use of a single pair of gloves between patients is prohibited. Staff shall not wash surgical or patient examination gloves before use, or wash, disinfect, or sterilize gloves for reuse. Disposable gloves must be replaced upon the completion of the dental procedure or whenever torn or punctured during the procedure. Gloves that are torn, cut, or punctured shall be removed as soon as feasible, and the health care worker's hands washed before re-gloving.
- b. Dental staff shall wash their hands prior to putting on gloves and immediately upon removing them to avoid transfer of microorganisms to other inmates/patients or environments.
- c. Hypoallergenic gloves shall be available. Hypoallergenic gloves shall only be used by dental staff with documented allergic reactions to standard gloves.
- d. Utility gloves used for cleanup shall be decontaminated for reuse but must be discarded if they are deteriorated or fail to function as a barrier.

### 3. Protective Clothing

Clinic jackets, lab coats, gowns, and other protective clothing shall be made available. Such protective clothing must be removed immediately or as soon as feasible when penetrated by blood or other infectious materials, and prior to leaving the work area. Head and shoe covers shall be available and utilized as necessary

### 4. Utilization and Disposition of Personal Protective Equipment

- a. Gloves, disposable long-sleeve gowns, chin-length face shields in conjunction with a mask, or a combination of a mask and eye protection (such as glasses with solid side shields or goggles) must be worn for any surgical procedure and at all times when

splashes, spray, splatter, aerosols, or droplets of blood, or other infectious materials may be generated.

- b. Chin-length face shields and goggles or eyeglasses with solid side shields shall be cleaned and disinfected with Environmental Protection Agency (EPA) approved products whenever they are visibly soiled and after each procedure that generates splashes, spray, splatter, or aerosols.
  - c. Contaminated personal protective clothing or equipment must be placed in an appropriately designated area or in a labeled infectious waste, or linen container for storing, washing, decontaminating, or discarding.
  - d. Dental personnel shall be provided lockers as well as a suitable venue for changing clothing.
5. Protecting Exposed Surfaces and Covering/Disinfecting Permanently attached Dental Unit Components.

Dental units have components that are heat sensitive or are permanently attached to the unit's vacuum or air/water lines. Other items may not enter the inmate/patient's oral cavity, but are likely to become contaminated with oral fluids during treatment procedures. Impervious-backed paper, aluminum foil, clear plastic wrap or polyethylene covers shall be used to protect surfaces that may become contaminated by blood or saliva and that are difficult or impossible to sterilize, (e.g., light handles or radiographic unit heads). These coverings, if contaminated, shall be removed between patients (while gloved), discarded, and then replaced (after ungloving). Dental unit attachments for saliva ejectors, high volume suction evacuators, slow speed hand piece motors, and air/water syringes shall be covered during use and carefully cleaned and treated after use with a chemical germicide having at least an intermediate level of activity.

6. Minimizing Potentially Infectious Droplets, Spatters, and Aerosols.

Appropriate use of chair side assistants, rubber dams, high volume evacuation, and proper patient positioning should minimize the formation of droplets, spatter, and aerosols during inmate/patient treatment. To achieve maximum reduction in hazardous aerosol production, the use of an air-water spray, high volume evacuation, rubber dam, and a pre-rinse with an anti-microbial mouthwash shall be utilized.

7. Malfunction of High Volume Evacuation Equipment

The malfunction of the high volume evacuation equipment creates a potential risk to employees and inmates/patients. Invasive dental procedures shall be suspended until repair of the high volume evacuation equipment is completed.

8. Hand Hygiene

- a. The use of gloves does not eliminate the need for proper hand hygiene. Dental staff shall wash their hands with regular or antimicrobial soap and water whenever their hands are visibly dirty or contaminated with blood or other potentially infectious material. An alcohol-based hand rub may also be used if hands are not visibly soiled. Improved adherence to hand hygiene, (i.e., hand washing or the use of alcohol based

hand rubs), has been shown to reduce the transmission of antimicrobial resistant organisms, (e.g., methicillin resistant staphylococcus aureus), and to reduce overall infection rates in health care facilities. Hands must be washed before and after treating patients, when hands are visibly soiled, before gloving and after ungloving. Hands must also be washed after touching inanimate objects likely to be contaminated by blood or saliva and before leaving the operatory.

- b. For oral surgical procedures, surgical hand antisepsis shall be performed before donning sterile surgical gloves. This shall be accomplished by using either antimicrobial soap and water according to the manufacturer's instructions or regular soap and water followed by drying of the hands and application of an alcohol-based surgical handscrub product with persistent activity. Extraordinary care must be taken to avoid hand injuries while performing dental procedures.
- c. Hand lotions shall be used to prevent skin dryness associated with repeated handwashing.
- d. Fingernails shall be kept short with smooth, filed edges to allow thorough cleaning and prevent damage to gloves. Artificial fingernails or extenders shall not be worn when having direct contact with patients.
- e. Dental personnel with exudative lesions or weeping dermatitis shall refrain from all direct inmate/patient care and from handling patient-care equipment until the condition resolves.
- f. All inmates/patients shall be screened for latex allergy, (i.e., take a health history and refer for medical consultation when latex allergy is suspected).
- g. The CD shall ensure a latex-safe environment for staff and inmates/patients with latex allergies, and shall ensure that emergency treatment kits with latex-free products are available at all times.

#### 9. Handling Radiographic Film Packets

All dental staff shall wear gloves when exposing or handling intra-oral dental radiographic film. Radiographic film packets shall be handled with disposable gloves using barrier envelopes. Contact with the contaminated film packet shall be avoided. If the barrier envelope is not available, the film packet shall be wiped or sprayed with an antimicrobial disinfectant prior to processing the radiographic film.

#### 10. Sharp Instruments

Sharp instruments, (i.e., needles, scalers, burs, lab knives, scalpels and wires), that are contaminated with blood and saliva are considered potentially infective and must be handled with extraordinary care to prevent unintentional injuries. The CD shall ensure that engineering controls and work practices are in place to prevent injuries.

#### 11. Handling Sharp Instruments

- a. Contaminated disposable syringes, needles, scalpel blades, and other sharps must be placed in a leak-proof, puncture resistant, red or labeled container prior to disposal. The container must be located as close as feasible to the area in which the item is

used. To prevent needle stick injuries, needles shall not be intentionally bent, broken, or otherwise manipulated by hand after being used, unless required by the dental or medical procedure. The use of needle-retraction safety devices is highly recommended. Where engineering controls are not available, work-practice controls that result in safer behavior, (e.g., one-handed needle recapping or not using fingers for cheek retraction while using sharp instruments or suturing), shall be utilized. Unsheathed needles shall not be placed on bracket tables or instrument trays where they may present a hazard for a potential needle stick.

- b. Dental staff shall not recap contaminated needles by using both hands or any other technique that involves directing the point of a needle toward any part of the body. Staff shall use either a one-handed scoop technique or a mechanical device designed for holding the needle cap when recapping needles, (i.e., when administering multiple injections), and when removing contaminated needles from a non-disposable aspirating syringe.

## 12. General Work Practice Requirements

- a. Extreme care shall be used when removing needles from reusable syringes.
- b. Flush mucous membranes immediately, or as soon as feasible, when they are exposed, or potentially exposed, to blood or other potentially infectious materials.
- c. Sharps containers must be easily accessible, maintained upright, and not allowed to overfill. The lid shall be closed when the container is  $\frac{3}{4}$  full and the container taken to the Infectious Waste storage area for disposal.
- d. Eating, drinking, smoking, applying cosmetics, and handling contact lenses is prohibited in occupational exposure areas.
- e. Storage of food and drink in refrigerators, cabinets, or on shelves or countertops where blood or other potentially infectious materials are present shall not be permitted.
- f. The storing, transporting, or shipping of blood or other potentially infectious materials, such as extracted teeth, biopsy specimens, tissue, and impressions that have not been decontaminated, shall be in closed, leakproof containers that are colored red or have a biohazard label affixed.
- g. Single-use disposable instruments, (e.g., prophylaxis angles, prophylaxis cups and brushes, tips for high-speed air evacuators, saliva ejectors, and air/water syringes) shall be used for one patient only and discarded appropriately. These items shall not be cleaned, disinfected, or sterilized for reuse.

## 13. Sterilization Requirement – Critical vs. Non-Critical items

### a. Critical Items

Objects or instruments that enter the skin, mucous membranes, or vascular system, or are in frequent contact with the mucous membranes, and/or skin, or are contaminated by blood and oral secretions are considered to be critical use items. Dental instruments used in the mouth are all critical use items, and the sterilization protocols must be followed in their cleaning and use. With the exception of situations

as outlined in section d. 8) below, critical items shall be packaged prior to sterilization in a self or manual sealing pouch, or a sterilization wrap.

b. Non-Critical Items

Non-Critical items are objects or equipment that do not have contact with the mucous membranes or enter the skin. These include dental operating light handles, dental radiographic equipment, operating cart/unit hoses and surfaces, dental chair surfaces, counter tops, etc. These non-critical items are cleaned using the disinfection protocols.

c. Instrument Processing Area

A designated central instrument processing area shall be established in all dental clinics. The area shall be divided physically or, at a minimum, spatially, into distinct areas for:

- 1) Receiving, cleaning, and decontamination.
- 2) Preparation and packaging.
- 3) Sterilization.
- 4) Storage.

d. Cleaning and Sterilization of Instruments

All re-useable Critical Items including instruments attached to, but removable from, the dental unit air and water lines, such as ultrasonic scaler tips and components parts of air/water syringe tips, etc., shall be sterilized after each use. Instruments shall be cleaned thoroughly to remove debris prior to sterilization. A recommended pre-cleaning or holding solution for surgical instruments shall be made available for use by dental staff. Metal or heat-stable dental instruments shall be sterilized after each use by steam under pressure (autoclaving). Burs to be reused shall be pre-cleaned and sterilized by steam sterilizer. Discarded burs shall be placed in a red, puncture-resistant, sharps container. Dental personnel who clean instruments and perform decontamination procedures shall wear a long-sleeve gown, mask, eye protection, and puncture and chemical resistant/heavy-duty utility gloves to decrease health risks.

- 1) Prior to pre-cleaning, all items shall be placed in an ultrasonic basket until sterilization. A holding, pre-cleaning, instrument soak may be used during, or after, inmate/patient treatment for instruments and items exposed to blood, serum, or other tenacious debris. Allowing debris to dry on items renders cleaning much more difficult, and only items that have been pre-cleaned should be sterilized, making pre-cleaning a mandatory prerequisite for dependable sterilization. Without proper pre-cleaning, sterilization may not be correctly accomplished.
- 2) All items shall be removed from the holding (pre-cleaning) instrument soak, rinsed, and placed in an ultrasonic cleaning unit per the manufacturer's recommended cleaning time. One technique for reducing the need of handling instruments is to use the ultrasonic cleaner instrument basket for both holding instruments in the instrument soak, and for transporting the instruments for rinsing.

- 3) Handling and hand scrubbing instruments should be avoided whenever possible since scrubbing may cause cuts, nicks, and abrasions to fingers and hands. Breaks in the skin are a major route of transmission for pathogenic microbes.
- 4) Ultrasonically cleaned items should be rinsed in cool water to remove soap and other cleaning residues. Placing instruments in a milk bath for 30 seconds after cleaning lubricates and assists in preventing staining, rusting, and corrosion. Instruments should be as clean as possible at this stage. If a residue of dirt, blood, or grease is left in a riveted joint of a surgical instrument, spores encased in that contaminated area may be protected from steam penetration. Under such conditions a normal sterilizer cycle may not destroy these spores completely even though all indicators show that necessary sterilization conditions have been met.
- 5) Drying is necessary before processing in all methods of sterilization.
- 6) Unsterilized instruments that require overnight storage shall be prepackaged and stored in a secure designated area.
- 7) Semi-critical instruments that will be used immediately or within a short time can be sterilized unwrapped on a tray or in a container system, provided that the instruments are handled aseptically during removal from the sterilizer and transport to the point of use.
- 8) Critical instruments intended for immediate reuse can be sterilized unwrapped if the instruments are maintained sterile during removal from the sterilizer and transport to the point of use, (i.e., transported in a sterile covered container).
- 9) Implantable devices shall not be sterilized unwrapped.
- 10) Critical instruments shall not be stored unwrapped.
- 11) Sterilizers shall not be overloaded by stacking packages horizontally or by filling the chambers beyond capacity. Packs shall be placed vertically on edge, leaving adequate space between packs to allow steam to circulate and to allow adequate drying of packs. Sterile packs shall always be stored in a secured area.
- 12) A peel pouch (self-sealing), or non-peel pouch (mechanical sealing), should accommodate several small instruments. It is not necessary to place one instrument per pouch to achieve sterilization. Heavier instruments, such as extraction forceps or hand pieces, should be placed individually in a single pouch. Instruments with sharp tips (i.e., scalers, root tip elevators, etc.), may puncture or break the seal of the pouch. It is therefore recommended that the tips of such instruments be wrapped with a 2 by 2 gauze prior to placing them in the pouch. Instruments shall be placed in the pouch with the handle at the end to be opened. Self-sealing pouches shall be sealed by peeling off the adhesive backing, folding the flap at the perforated line, and sealing with firm pressure. Non self-sealing pouches shall be sealed using the mechanical sealer, according to the manufacturer's recommendations. The outside of the pouch shall be labeled with the date of expiration, which is six months from the date of sterilization if the pouch is sealed appropriately and maintained intact.

- 13) When wrapping instruments with cloth or paper wraps, two wrappers are to be utilized; a wrapped piece within a wrapped piece. The wrapped instrument pack shall be secured with two pieces of sterilizer indicator tape and the expiration date, which is 30 days (one month) from the date of sterilization, recorded on the tape.
- 14) Proper functioning of sterilizers shall be verified by the use of mechanical, (i.e., time, temperature, and pressure), chemical, or biological, (i.e., spore testing), monitors according to the manufacturer's instructions. Heat sensitive chemical indicator pouches, (e.g., those pouches that exhibit a color change after exposure to heat to identify packs that have been processed through a heating cycle), or heat sensitive chemical indicator tape shall be utilized during sterilization.
- 15) All sterilizers shall be monitored at least weekly using a biological indicator with a matching control (i.e., a biological indicator and control from the same lot number). The spore tests may be sent to a medical laboratory for verification and documentation of the proper operation of each sterilizer, or may be processed on site, according to the manufacturer's instructions.
- 16) A Biological indicator shall be used for every sterilizer load that contains an implantable device and the results verified before using the implantable device, whenever possible.
- 17) Following manufacturers' instructions for instruments, hand pieces, and steam sterilizers is critical and therefore mandatory. The integrity of a sterilization process has been shown to be a function of three basic parameters: time, temperature, and the presence of saturated steam (pressure). All three are essential for effective steam sterilization. For high instrument turnover situations, such as clinics used by contract oral surgery specialists, the use of rapid cycling 220V autoclaves rather than slower 110V models may be the most efficient equipment selection.
- 18) Steam Sterilizer Parameter Measurements.
  - a) Temperature: 250° F
  - b) Pressure: 20 Pounds per Square Inch (p.s.i)
  - c) Time: Twenty minutes from the time the temperature and pressure reach the minimum limits. The actual time for some newer computerized models is only 15 minutes.
- 19) Chemical Sterilizer Parameter Measurements (not recommended without proper ventilation or purging of the fumes).
  - a) Temperature: 270° F
  - b) Pressure: 20 p.s.i.
  - c) Time: Twenty minutes from the time the temperature and pressure reaches the minimum limits.
- 20) Biological spore test monitoring and record keeping should be performed at least once a week (Monday, Tuesday, or Wednesday) in all sterilizers:

- a) Prior to placing the spore test into the sterilizer, all required information must be completed on the mailing package. It is critical to note the sterilizer serial number and the date of the test.
  - b) Place the spore test in a pouch and seal. Place the indicator in the center of the first load of the day.
  - c) Process the load as usual.
  - d) Remove the indicator from the sterilizer and allow cooling for ten minutes.
  - e) Place the spore test in the labeled envelope, and send to the laboratory for processing.
  - f) If the laboratory spore test comes back "positive for growth," the following procedures shall be followed:
    - i) The sterilizer shall be removed from service and sterilization procedures reviewed (i.e., work practices and use of mechanical and chemical indicators), to determine whether operator error could be responsible.
    - ii) The sterilizer shall be retested, by using biological, mechanical, and chemical indicators after any identified procedural problems have been corrected.
    - iii) If the repeat spore test is negative, and mechanical and chemical indicators are within normal limits, the sterilizer back may be returned to service.
    - iv) If the repeat spore test is positive:
      - 1) The sterilizer shall not be used until it has been inspected or repaired, and the exact reason for the positive test has been determined.
      - 2) To the extent possible, all items sterilized since the last negative spore test shall be recalled and reprocessed.
      - 3) After the cause of the sterilizer failure has been determined and corrected, and before being returned to service, the sterilizer shall be retested with a biological indicator spore test in three consecutive empty chamber sterilization cycles.
  - g) The monitoring records of all sterilizers are to be maintained by the CD or designee for three years.
- 21) Heat sensitive indicators on the outside of each pouch or each wrapped pack change colors only when the correct temperature is reached. The color change alone does not indicate if the required time or pressure was maintained. Heat sensitive chemical indicators (e.g., those that change color after exposure to heat alone), do not ensure adequacy of a sterilization cycle, but may be used on the outside of each pack to identify packs that have been processed through the heating cycle.

- 22) Cleaning and routine maintenance according to manufacturer's instructions is mandatory and required to assure proper functioning and to extend the life of sterilizers. Sterilizers are to be cleaned, at a minimum, the first and third week of every month per manufacturer's instructions, using an approved cleaning agent.
- 23) Decontamination and disinfection of Environmental Surfaces
- a. After each inmate/patient has been treated, and at the end of each work cycle, counter tops and other operatory surfaces that may have become contaminated with blood or saliva shall be wiped with an absorbent toweling to remove extraneous organic material. The surfaces shall then be disinfected with a suitable chemical germicide. A solution of sodium hypochlorite, prepared fresh daily, is an inexpensive and effective germicide. Concentrations ranging from 5,000 parts per million (ppm) (i.e., 1:10 dilution) of household bleach, to a 500 ppm, (i.e., 1:100 dilution) of sodium hypochlorite are effective, depending upon the amount of organic material present on the surface to be cleaned. An EPA-registered hospital disinfectant with intermediate-level disinfectant capabilities (i.e., tuberculocidal, HIV, and HBV label claims), may be utilized in lieu of sodium hypochlorite. The surfaces must be saturated for at least ten minutes with the disinfectant prior to wiping up the excess. Because it is corrosive to metal, especially aluminum, care must be taken in the use of sodium hypochlorite. The use of other disinfectants should follow manufacturer's recommendations. With any disinfectant, adequate room ventilation, along with the use of gloves, mask, and protective eyewear is required.
  - b) Housekeeping surfaces (i.e., floors, walls, and sinks), shall be cleaned with a detergent and water or with an Environmental Protection Agency (EPA) registered hospital disinfectant/detergent on a routine basis. The frequency of cleaning shall depend on the nature of the surface and type and degree of contamination present, based on the location in the facility. Housekeeping surfaces shall be cleaned when visibly soiled.
  - c) Mops and cloths shall be cleaned after use and allowed to dry before reuse; or single-use disposable mop heads and cloths may be used.
  - d) Cleaning agents or EPA-registered disinfecting solutions shall be freshly prepared on a daily basis or as instructed by the manufacturer.
  - e) Walls, blinds, and window curtains in patient-care areas shall be cleaned when they are visibly dusty or soiled.
  - f) Carpeting and cloth-upholstered furnishings shall not be used in dental operatories, laboratories, and instrument processing areas.
  - g) All dental personnel with contaminated gloves shall avoid contact with objects such as charts, telephones, dental medicaments, and cabinets during patient treatment procedures to limit the field of contamination. Soiled

gloves shall be removed before touching clean surfaces or retrieving needed supplies or instruments.

24) Hand Piece Sterilization

All high-speed dental hand pieces, low-speed hand piece components used intra-orally, and reusable prophylaxis angles shall be sterilized (e.g., steam autoclaved), between patients. Manufacturers' instructions for sterilizing hand pieces shall be closely followed. The following cleaning and sterilization procedures shall be accomplished between each inmate/patient use.

- a) Flush the handpiece air/water spray by discharging it for 20-30 seconds after each inmate/patient treatment.
- b) Consult with the dental unit manufacturer on the need for periodic maintenance of anti-retraction mechanisms.
- c) Thoroughly scrub the hand piece with a detergent and water.
- d) Do not immerse the hand piece unless manufacturer's instructions specifically recommend it.
- e) Follow manufacturer's pre-sterilization lubricating instructions.

25) Sterile Water Use

- a) As mandated by the State of California Board of Dental Examiners in the *Dental Practice Act* (California Business & Professions Code section 1600, *et seq.*), sterile water shall be used in all CDCR dental clinics for invasive dental surgical procedures.
- b) Facilities not currently equipped with dental units that have a built-in sterile water dispensing apparatus, or dental operatories without sterile water available on a stand-by basis, shall be ensured that sterile water dispensing devices are available and that such devices shall be included in dental units being proposed for purchase as a part of this Policy and Procedure.
- c) Sterile water shall be procured from a vendor and kept in the dental clinic storage area for ease of availability.

26) Flushing Water Lines

Water retraction valves within the dental unit may aspirate infectious material back into the hand piece and water lines. It is mandatory that water-cooled hand pieces be run to discharge water for 20-30 seconds after each dental procedure. This is intended to physically flush out infectious material that may have been aspirated into the hand piece or water line. Additionally, there is some evidence that overnight bacterial accumulation in water lines can be significantly reduced by running and discharging water lines for several minutes at the beginning of the clinic day before connecting the sterilized hand piece to the dental unit. In view of this, all dental water lines shall be flushed for several minutes at the beginning and end of each day.

## 27) Handling Biopsy Specimens

Biopsy specimens shall be placed into a sturdy container with a secure lid to prevent leaking during transport. Care shall be taken when collecting specimens to avoid contamination of the outside of the container. If the outside of the container is visibly contaminated, it shall be cleaned and disinfected or placed in a leak-proof bag.

## 28) Disposal of Sharps and Infectious Waste

All sharps (especially needles), human tissue, or blood shall be considered potentially infectious and shall be handled and disposed of with special precautions. Disposable needles, scalpels, or other sharp items shall be placed intact into a puncture-resistant, red sharps container before disposal. Blood, suctioned fluids, or other liquid waste may be carefully poured into a drain connected to a sanitary sewer closed system. Other solid waste contaminated with blood or other body fluids shall be placed into sealed, sturdy, impervious bags to prevent leakage of the contained items (red Biohazard bags shall be available). For reusable laundry, biodegradable laundry bags (sugar bags) shall be used and placed inside yellow Contaminated Linen bags.

## 29) Dental Clinic Disinfection

At a minimum, dental clinic floors and surrounding areas shall be mopped, cleaned, and disinfected daily with an EPA approved disinfectant. This may be done more frequently as required.

## 30) Biohazard Emblem

- a) A biohazard emblem shall appear on all trashcans that are lined with a red biohazard bag.
- b) A biohazard emblem shall appear on the access opening to the area where the central vacuum system is housed. Dental personnel shall ensure that the floor and surrounding area of the central vacuum system is disinfected at least once a week, preferably on a Friday, with an EPA approved disinfectant. When flushing or cleaning the lines from the units to the central vacuum system only an acceptable non-detergent, enzymatic cleaner shall be used.
- c) Once a month, dental personnel shall ensure that the filter on the central vacuum is changed, and that the contaminated filter is disposed of as biohazard waste.

## 31) Mycobacterium tuberculosis (TB)

- a) All dental staff shall receive annual training and testing regarding the recognition of signs, symptoms, and transmission of TB. Dentists shall assess inmates/patients to check for a history of TB as well as symptoms indicative of TB and document their findings on the dental health history form.
- b) The following treatment procedures shall be followed for inmates/patients known or suspected to have active TB:

The inmate/patient shall be evaluated away from other patients and staff. When not being evaluated, the inmate/patient shall wear a surgical mask and/or be instructed to cover their mouth and nose when coughing or sneezing.

Elective dental treatment shall be deferred until the inmate/patient is noninfectious.

Inmates/patients requiring urgent dental treatment shall be referred to a facility with TB engineering controls and a respiratory protection program.

## B. INFECTION CONTROL IN DENTAL LABORATORIES

Infection control can be accomplished most efficiently in the dental laboratory by the use of a barrier system that inhibits passage of infectious diseases between the clinical areas and the laboratory. This shall be accomplished by disinfecting all material coming into and going out of the laboratory. When handling any disinfectant solution, gloves, mask, and eye protection shall be worn. Adequate ventilation of rooms in which a disinfectant spray or solution is used is mandatory to avoid personnel and inmate/patient exposure to noxious gases and fumes.

### 1. Cast and Material Handling in the Dental Clinic and Laboratories

All casts and materials sent from dental clinics to a dental laboratory shall be enclosed in sealed plastic bags or plastic wrap (e.g., Saran Wrap), to avoid contamination of packing materials. Laboratory personnel who handle incoming cases shall wear disposable examination gloves. Casts, prostheses, and all other submitted materials shall be immediately transferred to a disinfection area, such as a sink with an overlying drain board, before they are placed in laboratory case pans. The materials shall be placed on the drain board with the cast standing on end so that the disinfectant will not pool in the palatal and lingual areas. Diluted hard surface iodophors are recommended as the agent of choice for disinfection since they can be used for all necessary laboratory disinfection procedures, are not harmful to the tissues, and are safe if ingested. All surfaces of casts, prostheses, and other materials shall be sprayed with a hard surface iodophor solution (i.e., Biocide or Wescodyne diluted to 213 parts water to one part iodophor, or according to manufacturer's recommendation). The solution shall be permitted to remain on the materials for ten minutes before rinsing with water. Although hard surface iodophors are EPA approved for ambient use, technicians should use a facemask during the spraying procedure.

### 2. Shipping and Receiving Benches

Shipping and receiving benches shall be disinfected daily. The surface shall be pre-cleaned by swabbing with a disposable towel or gauze saturated with disinfectant or by spraying and then spreading the spray with disposable towels. The disinfectant shall be allowed to remain in contact with the surface for at least ten minutes before being wiped away. Identical procedures shall be used to disinfect laboratory case pans.

### 3. Disinfection Processes

- a. Materials leaving the laboratory for the dental clinics shall be disinfected in the same manner as those entering the laboratory. Appliances shall be removed from the casts and placed in a glass beaker containing the iodophor solution. The appliance shall remain in the solution for at least ten minutes. Casts and other materials shall be disinfected in the manner described in the above section on casts and materials. Following removal from the disinfectant, the material shall be rinsed with water and enclosed in a plastic bag or plastic wrap prior to placement in the shipping box.
- b. Non-metal impression trays, casts, prostheses, jaw relation records, etc., shall be disinfected when they enter and leave the laboratory. Technicians performing disinfection shall wear gloves, masks, eye protection and disposable aprons or gowns.
- c. Heat-tolerant items used in the mouth (i.e., metal impression trays and face-bow forks, etc.), shall be cleaned and heat-sterilized.
- d. Pumice pans used for polishing prostheses immediately following clinical adjustment, shall have disposable plastic liners (saran wrap or polyethylene tray covers) and the pumice should be changed at least daily. The pumice shall be mixed with iodophor to further minimize contamination.
- e. Manufacturers' instructions for cleaning, sterilizing, or disinfecting items that become contaminated but do not normally contact the patient (i.e., lab burs, polishing points, rag wheels, articulators, case pans, and lathes) shall be followed. If the manufacturer's instructions are unavailable, items shall be cleaned and heat sterilized (if heat-tolerant) and/or cleaned and soaked overnight in an iodophor or hypochlorite solution. CAUTION – sodium hypochlorite can be corrosive to some metals.
- f. Dental laboratory technicians shall include specific information regarding disinfection techniques used (i.e., solution used and duration), when laboratory cases are sent offsite and when they are returned.

## CHAPTER 3.2

### Control of Dental Instruments and Sharps (E)

#### I. POLICY

All CDCR dental staff shall maintain control of and provide accountability for dental instruments, sharps, and other equipment items that pose a threat to persons or to the security of the institution.

#### II. PURPOSE

To establish guidelines and procedures that will ensure that all CDCR dental staff maintains proper control of and accountability for dental instruments.

#### III. PROCEDURE

- A. CDCR dental staff in all main dental clinics and yard dental facilities shall be held accountable for and maintain an ongoing inventory of all instruments and dental sharps. Dental sharps are defined as needles and scalpels.
- B. All dental instruments and sharps shall be counted at the beginning and end of each work shift, and before any midday break by designated staff. Attending dental staff shall document and initial the count on the *Tool Control Inventory Report* form.
- C. All dental instruments and sharps shall be listed on the *Tool Control Inventory Report* form. Dental staff shall initial the date, and the watch on which the counts were performed.
- D. A visual accounting of dental instruments and sharps shall be completed before and after each dental treatment (e.g., prior to dismissing the inmate/patient).
- E. All dental instruments are to be scribed and, if required (i.e., in a dental group setting), color-coded to meet the requirements of Departmental Operations Manual (DOM) Section 52040.5.
- F. Dental instruments and sharps shall be kept in secured cabinets in each dental facility. An inventory sheet of the tools in the cabinet shall be posted in each cabinet.
- G. Contaminated dental instruments and sharps shall be considered as potentially infectious and must be handled with extraordinary care to prevent unintentional injuries. (Ref: Infection Control Procedures, Chapter 3.1)
- H. In the dental laboratories, inmate workers shall handle dental equipment or tools only under the direct supervision of dental, health care, or custodial staff.
- I. In the dental clinics, inmates shall not handle dental equipment or tools.

- J. When not in use, all dental instruments, syringes, needles, and sharps shall be secured in the dental operatory, or other secure storage area.
- K. All damaged, broken, or worn instruments shall be disposed of as "hot trash." The disposition of such tools shall be annotated in the appropriate block on the tool inventory sheet, and in accordance with each institution's Operation Procedure on Tool Control.
- L. Tool inventory reports shall be routed in accordance with the institution's tool control operational procedures by the Office Technician (OT).
- M. Tool inventory reports shall be maintained on file for one year by the OT.
- N. The loss of any instrument(s) or tool(s) shall be immediately reported to the Chief Dentist (CD), and the Watch Commander at the facility. The CD or designee shall follow the Operations Procedure on Tool Control at the institution, and shall ensure that, after a thorough search of the dental facility has been conducted, a "Lost Tool Report" is prepared and hand carried to the Watch Commander by the dental staff member reporting the lost or missing tool.
- O. Dental impression materials and waxes shall be stored in a secure location and never be left unattended. These materials can be used to create masks and impressions of keys.
- P. All materials deemed to be flammable, toxic, and caustic shall be stored in secure areas that are inaccessible to inmates. An inventory and a system of accountability for their distribution shall be maintained. These materials must be stored in approved, fireproof, locked cabinets, in accordance with manufacturer's and Occupational Safety and Health Administration's (OSHA) guidelines. Inmates shall have access to such items only under the direct supervision of qualified staff.
- Q. Hazardous Dental Materials include, but are not limited to:
- **Flammable Materials** – Liquids with a flash point below 100° F.
  - **Toxic Materials** – Substances that through chemical reaction or mixture can produce possible injury or harm to the body by entering through the skin, digestive tract or respiratory tract.
  - **Caustic Materials** – Substances that can destroy or eat away by chemical reaction.

## CHAPTER 3.3

### Radiation Protection (E)

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#### I. POLICY

CDCR dental staff licensed to take dental radiographs shall comply with all applicable safety and regulatory standards for radiation producing devices utilized by the CDCR. The Chief Dentist (CD) shall establish a Radiation Protection Program, (RPP) in all dental units that contain dental radiographic equipment.

#### II. PURPOSE

The purpose of this policy shall be to establish safety standards and procedures for dental radiographic units in CDCR dental facilities.

#### III. PROCEDURE

The following procedures are designed to provide radiation protection for all occupationally and non-occupationally exposed persons within the dental clinics, with the goal of reducing radiation exposure to as low as reasonably achievable (ALARA) levels. Some methods of protection may not be practical at all locations or in all instances, but the Safety and Operating Procedures must be strictly followed to achieve the ALARA objectives.

- A. Only dental staff licensed in accordance with the State of California Dental Board, *Dental Practice Act* (California Business and Professions Code Section 1600, *et seq.*), shall be allowed to operate dental radiographic equipment.
- B. All operators of radiographic equipment are responsible for radiation safety, and appropriate dental radiology operating and safety procedures must be utilized while exposing all radiographs.
- C. Radiographic film screen combinations shall be of adequate speed to provide minimal radiation exposure to the inmate/patient, while maintaining radiographic detail for interpretation of the examination.
- D. All dental staff working within the vicinity of the ionizing radiation source, (i.e., the dental radiographic units), must wear appropriate radiation monitoring badges or dosimeters. Radiation monitoring badges shall be worn at chest level by all dental clinic staff. The badges are not to be worn outside the dental treatment area.
- E. The safety and welfare of inmates/patients must be considered at all times, and appropriate shielding devices, such as gonad shielding, lead aprons, thyroid shields, portable shields, etc., shall be used at all times for all inmates/patients when dental radiographs are taken.

- F. All protective lead aprons shall contain 0.25 millimeters or more of lead equivalence and shall be stored on an apron rack or on hangers to prevent bending or cracking of the protective lead lining. Aprons shall be regularly checked for holes, cracks or tears. When a lead apron is found to be defective, staff shall cease using the apron and notify the Chief Dentist (CD) or designee to obtain a replacement.
- G. A thyroid shield shall be utilized on all inmates/patients unless it interferes with the examination. (This is not a regulatory requirement, but is a statement of accepted good practice in keeping exposure to a minimum.)
- H. All dental radiographic equipment shall have devices to limit the radiation exposure to inmates/patients and employees. These devices include filters that reduce unnecessary low energy radiation from the primary beam, and collimators, which restrict the size of the X-ray beam. Staff shall not alter, remove, tamper with, or defeat these devices, or in any way cause needless radiation exposure.
- I. All dental staff shall make every reasonable effort to maintain radiation exposure at the lowest possible dosage.
- J. The CD shall review the radiation exposure reports monthly to ensure that personnel do not exceed established regulatory limits on radiation exposure. The CD shall investigate all exposures that exceed established regulatory limits.
- K. The CD shall maintain a file of radiation exposure reports for a period of three years.
- L. All dental staff exposing radiographs must comply with the Division of Correctional Health Care Services (DCHCS) guidelines on dental radiology quality assurance.
- M. All dental radiographic units shall be inspected and calibrated annually in accordance with DCHCS requirements.
- N. Only a licensed medical biomechanical technician shall perform preventive maintenance, repair, and calibration of dental radiographic equipment.
- O. Dental personnel shall not hold a radiographic film in the inmate/patient's mouth while exposing a radiograph.
- P. Dental staff shall immediately report to the CD or designee, any incidental equipment malfunction or condition that may cause any unnecessary radiation exposure.
- Q. Inmate/patient dental radiographs shall be taken only upon the authorization of a dentist.
- R. Dental staff shall maintain the radiograph processing room and radiographic equipment in a sanitary condition and shall strictly adhere to the dental infection control standards.
- S. The lead lining in dental radiographic film packets shall be separated from the film packets when processing the exposed film and shall be stored in the clinic, or other appropriate area, for recycling by the Institution Hazardous Materials Specialist.

- T. A copy of radiographic certificates, rules, and regulations, as required by the DCHCS, shall be posted in each dental clinic in full view of all inmates/patients and staff.
- U. The CD shall establish a Radiation Protection Program (RPP) for the purpose of ensuring staff and inmates/patients do not suffer unnecessary radiation exposure. The RPP shall be reviewed annually regarding program content and implementation by all dental staff. All staff shall be required to know the procedures and requirements of the RPP and to demonstrate proper use of the procedures.
- V. Dental assistants shall not operate dental radiographic equipment unless authorized by a dentist.
- W. A restricted area shall be established in each dental facility for the isolation of scatter radiation. A "Caution Radiation Area" sign shall designate this area.
- X. During each exposure staff shall either stand at least six feet from the useful beam or stand behind a protective barrier. No one besides the inmate/patient being treated shall be allowed within six feet of the useful beam while exposing a radiograph.
- Y. Dental staff shall never hold the tube housing or the support housing of the radiographic unit during any exposure. Dental staff shall not ask the inmate/patient to hold the tube housing or the support housing of the radiographic unit during any exposure. The tube housing must not drift or move during any exposure. If a problem with stability of the suspension arm develops, the radiographic unit shall be taken out of service, and the CD shall be notified immediately. The CD shall arrange for service as soon as possible.
- Z. External Imaging for Panographic Machines.
  - 1. Position the patient and center the beam for cephalometric, parametric, and tomographic machines following the instructions in the operator's manual.
  - 2. If the processed film appears misaligned, the unit shall be taken out of service and the CD shall be notified. The CD shall arrange for service as soon as possible.
  - 3. When utilizing cephalometric and tomographic machines, the X-ray beam shall be adjusted to the size and area specified by the doctor.

## CHAPTER 3.4

### Hazardous Chemical and Waste Management (E)

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#### I. POLICY

All CDCR dental staff shall manage chemical and other hazardous waste generated in each dental facility in compliance with standards mandated by the Environmental Protection Agency (EPA), the Occupational Health and Safety Administration (OSHA), Occupational Safety and Health Standards, Number 1910.120, Parts 1200, 1910, and 1926 of Title 29 of the Code of Federal Regulations, and in accordance with each institution's Local Operating Procedure. The Chief Dentist (CD) shall ensure that all dental facilities have implemented and are in compliance with these regulations.

#### II. PURPOSE

All dental facilities in the CDCR shall develop a comprehensive environmental health program (e.g., a Hazardous Communication Program), as a standard to maintain the health and welfare of all inmates and staff. These policies shall be developed in consultation with the prison administration, and the Health Care Manager (HCM), for the purpose of establishing procedures and regulations for the safe handling and disposal of chemicals and other hazardous waste generated in the CDCR dental facilities.

#### III. PROCEDURE

##### A. *Required training and documentation.*

1. All Hazardous Materials and dental medicaments utilized in each dental unit shall have an individual Material Safety Data Sheet (MSDS), on file in a visible location in the dental unit.
2. The CD shall ensure that all dental staff receives MSDS orientation and training. This training shall be conducted at least annually or as frequently as required.
3. All dental staff MSDS training records shall be kept on file by the CD for a period of three years.
4. To ensure compliance with this standard, environmental inspections or parts of the inspections may be conducted by health services staff, correctional staff, an outside agency (e.g., a local or state health department), or any combination of the above.
5. Inspections, with written reports shall be submitted to the prison administration and the responsible health authority as required by local institutional policy, or more frequently as appropriate to ensure that inmates/patients are receiving dental care in a clean, safe, and healthy environment.
6. All inmates/patients shall, at their initial appointment, receive a copy of the Dental Materials Fact Sheet (DMFS), as mandated by the California State Dental Board. Dental

staff shall document in the Unit Health Record that the inmate/patient received the DMFS and that its contents were discussed with the inmate/patient.

7. All dental departments shall procure the least toxic and environmentally adverse chemicals to perform a required task.
8. The storage and disposal of toxic materials shall be performed in accordance with manufacturer's and institutional regulations, and in a safe and environmentally sound manner.
9. All dental departments shall implement required emergency procedures in the event of a chemical spill or accident.
10. Emergency eye wash stations shall be installed in all dental clinics and dental laboratories in accordance with the mandates of regulatory agencies.

***B. Handling Scrap Amalgam***

1. Non-contact Scrap Amalgam is defined as:
  - Amalgam that was mixed but not used.
  - Damaged, unused amalgam capsules.
2. Non-contact scrap amalgam shall not be covered with water or with used radiographic film fixer.
3. Non-contact scrap amalgam shall be stored in a labeled container in the facility Dental Clinic for the legally allowed period of time until disposed of by the institution's Hazardous Materials Specialist.
4. Empty amalgam capsules shall be discarded in the general trash.
5. All dental clinics shall utilize amalgam capsules and covered amalgamators. Dental departments shall not formulate amalgam (e.g., utilizing the storage of liquid mercury and metal powder to make the amalgam alloy).

***C. Extracted Teeth Containing Amalgam and Drain Trap Amalgam***

1. Extracted teeth containing amalgam shall be handled using universal precautions and shall be stored separately from non-contact scrap amalgam.
2. Extracted teeth shall be stored in a labeled container with a lid and shall be covered with dry powder bleach (i.e., Comet cleanser).
3. Amalgam retrieved from drain traps (contact amalgam) shall be stored in the same container and disinfected in the same manner as extracted teeth containing amalgam.
4. Extracted teeth containing amalgam and drain trap amalgam shall be stored in the dental clinic for the legally allowed period of time until disposed of by the Institution Hazardous Materials (HazMat) Specialist.

***D. Lead Foil***

1. Lead foil from radiographic film packets shall be retrieved and stored in a covered-labeled container for the legally allowed period of time until the disposed of by the institution's HazMat Specialist.

***E. Trash Containers***

1. All dental facilities shall have separate trash containers for general trash, (i.e., non-infectious waste), and for infectious trash. Infectious waste and blood soaked items, (i.e., teeth, oral tissues, gauzes, disposable garments, etc.), shall be placed in a container that is visibly labeled, and lined with a red bag, and shall be handled in accordance with the Hazard Communication Program and institutional procedures. All general trash shall be handled according to the institution general trash disposal procedures.
2. The Office Technician (OT) shall coordinate pick up and delivery of all laundry.

***F. Laundry***

1. Laundry services, whether on-site or contracted, shall assure the availability of a sufficient supply of clean linen (e.g., scrubs, protective gowns, towels, etc.), for all dental facilities. Laundry contaminated with infectious materials shall be handled using precautions (e.g., gloves, long-sleeve gowns, masks, and eye protection), and shall first be placed in a bio-degradable (sugar) bag then in a yellow Contaminated Linen bag and appropriately processed according to regulations.

***G. Housekeeping***

1. All dental facilities shall have a comprehensive housekeeping program that identifies what has to be cleaned, at what frequency, by whom, how it is to be cleaned, and who evaluates cleaning effectiveness.
2. Housekeeping procedures for all dental operatories (e.g., the dental units, counter tops, floors, etc.), shall be performed daily or more frequently if necessary in accordance with infection control procedures.
3. Sufficient and appropriate EPA approved disinfectants, cleaning equipment, and supplies shall be ordered by the OT and available for housekeeping.
4. Refuse, including hazardous refuse and waste shall be handled, stored, and disposed of in a safe and sanitary manner consistent with local, state, and federal regulations.

***H. Risk Exposure***

1. There shall be a sufficient number of electrical outlets available for the operation of equipment and appliances so that extension cords are minimally used in the dental clinics.
2. Fire retardation equipment (e.g., chemical tanks), shall be available in all dental facilities and laboratories. These items shall be kept in working order and fire safety personnel shall conduct and log regular inspections of this equipment according to the institutional policy.

3. All dental facilities shall have self-closing doors, which shall be kept closed and secured when not in use.
4. All highly flammable dental materials (e.g., butane gas, flammable alcohols, etc.), shall be regularly inventoried and stored in an approved fireproof, locked, storage cabinet.
5. Personal protective equipment (e.g., gloves, gowns, lab coats, face shields, etc.), shall be available to all employees who may be potentially exposed to infectious or hazardous materials or objects.
6. All dental lathes, model trimmers, and other similar equipment shall be fitted with protective shields.

***I. Inspections***

1. All dental equipment (e.g., HVAC, radiographic equipment and developers, dental operator units, etc.) shall be inspected and serviced regularly, consistent with manufacturer's specifications and state regulations, to ensure that all systems continue to function properly.
2. Dental facilities shall have sufficient ventilation and temperature control devices in accordance with regulations.
3. Ground fault interrupters (GFI) shall be in place on all outlets in proximity to water (i.e., dental operatories, near sinks, eye wash stations, sterilizers, etc).
4. Any negative pressure areas for the control of infectious disease shall be regularly monitored for air quality.

# CHAPTER 4.1

## Dental Clinic Operations Reporting (E)

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### I. POLICY

Each dental clinic within the CDCR shall maintain daily statistical data on dental care provided to inmates/patients. This data shall be recorded on the Daily Dental Encounter Form (DDEF), tabulated every month and submitted to the Chief Dentist (CD), Dental Program, Division of Correctional Health Care Services (DCHCS)

### II. PURPOSE

To establish and maintain a standardized system for collecting, recording and reporting statistical data on dental clinic operations. The data shall be utilized to evaluate direct dental services rendered to inmates/patients in the CDCR.

### III. PROCEDURE

Each dental treatment provider shall report to the CD on a monthly basis all dental clinic operation's statistical data on the inmate population, including the following:

- Total number of requests received for dental services via the CDCR Form 7362 *Request for Medical/Dental Services*.
- Requests for dental services not resulting in scheduled clinic visits.
- Delays in dental triages.
- Delays in routine appointments with dentists.

Each treating dentist who provides care during a reporting month shall complete a DDEF, in ink, daily. Reportable procedures (i.e., plaque/index score, dental preventive education, etc.), that are provided by a dental assistant shall be recorded on the treating dentist's DDEF.

The following data for specific types of dental visits and services rendered shall be recorded daily on the DDEF which is maintained by the Office Technician (OT):

- A. ***Inmate Category:*** Record each inmate/patient scheduled as either General Population or Administrative Segregation. The number of entries in both categories should equal the daily total number of patients scheduled.
- B. ***Scheduled Visit Failed:*** Record as a failed visit (i.e., the failure to report for any reason of a scheduled inmate/patient).
- C. ***Scheduled Visit Canceled by Clinic:*** Record each scheduled visit that was canceled by the clinic for any reason.

- D. **Dental Visit:** Each visit that resulted in care being provided by a dentist shall be recorded as either a dental triage, routine, or unscheduled dental visit. Unscheduled dental visits are visits that are established on either the day before, or on the same day treatment is rendered, as a "work in" or "walk in" and which are added to the DDEF. The number of visits recorded should equal the total daily number of dental visits.
- E. **Services Rendered:** Each visit that resulted in care being provided by a dentist shall indicate the dental service, or procedure, rendered. For a list of dental procedures see Table 1: *Daily Dental Encounter Form - Services Rendered*.
- F. **Dental Clinic Access to Care Data (DCACD).**

The CDCR Form 7362 Request for Dental Treatment Log (RDTL) and the Daily Dental Treatment/Appointment Log (DDTAL) shall be used to record data regarding inmate/patient access to dental care. The following data shall be derived from the logs on a monthly basis by the OT and shall be maintained by the CD for a period of five years:

- The number of inmate/patient requests for dental services received per month.
- The number of delays in scheduling appointments for inmates/patients per month.
- The number of inmate/patient requests not in compliance with CDCR access to care guidelines that remain unresolved per month.

Delays in scheduling dental triages and appointments during the reporting month shall be determined by a review of the RDTL and the DDTAL.

G. **Submission of Dental Clinic Operations/Access to Care Data**

1. Each DDEF shall be collected daily and submitted to the CD on a weekly basis. The CD shall forward the data described in subsection F by fax or e-mail, to the CD, Dental Program, DCHCS by the fifth day of the month following the reporting month.

The DDEF shall have the Date, Facility, and Dentist's name typed or printed legibly in ink, and shall be signed by the provider. A provider's initials are not acceptable.

2. The priority of care recorded shall be the priority for that inmate/patient at the end of that day's appointment. The appropriate columns for the inmates/patients seen shall be completed according to the definitions provided for dental visits and services rendered, as outlined in Section III. Procedure, subsections A., B., C., D., and E., of this chapter. It is not necessary to subtotal or total procedures on the DDEF.
3. Each CD shall maintain copies of the DDEF on file for a period of five years.

**Table 1: Daily Dental Encounter Form - Services Rendered**

Code	Procedure	Description	Credit
<i>Diagnostic:</i>			
101	In processing Examination	Initial examination provided at Reception Center (RC).	One procedure for each examination.
102	Sick Call Examination	Examination for the diagnosis of a specific complaint.	One procedure for each examination.
103	Treatment Plan	Examination for the purpose of determining overall treatment needs and a sequential plan of treatment.	One procedure for each new or updated treatment plan recorded and dated in the Diseases and Abnormalities section of the CDCR 237B.  Two procedures for each charting of generalized Moderate or Advanced periodontal conditions when the findings are recorded on the Periodontal Examination Chart.
104	Intraoral Film		One procedure per intraoral film.
105	Panographic Film		One procedure per panographic film.
106	Specialty Referral		One procedure per referral.
107	Other Diagnostic Procedure		One procedure per inmate/patient visit. <i>Note: Do not credit in conjunction with any above listed procedure.</i>
<i>Preventative:</i>			
201	Topical Fluoride	Direct topical application of concentrated fluoride substances to the entire dentition. Fluoride in prophylaxis paste does not qualify.	One procedure for each inmate/patient application.
202	Patient Education	Individual counseling/demonstrations in oral health self-care. Counseling may be provided in conjunction with other procedures but time must be spent specifically for counseling/demonstration (incidental references to oral hygiene do not qualify).	One procedure for each individual counseling/demonstration session.
203	Plaque Index		One procedure for each plaque index taken and recorded on the CDCR 237B.
204	Other Preventative Procedure	For example: An inmate/patient clinic visit for verification of his/her oral hygiene status.	One procedure per inmate/patient visit. <i>Note: Do not credit in conjunction with any above listed procedure.</i>
<i>Periodontics:</i>			
301	Prophylaxis	Removal of exogenous stain, plaque, and supragingival and visible subgingival calculus by polishing and/or instrumentation on inmates/patients in good or normal periodontal health.	One procedure per inmate/patient visit.
302	Gross Scaling/Curettage	Non-surgical treatment of acute or sub-acute, generalized gingivitis usually associated with heavy calculus.  Rendered as full mouth, not per quadrant.	One procedure per inmate/patient visit. <i>Note: Not to be credited in conjunction with procedures 301 or 303.</i>

**Table 1: Daily Dental Encounter Form - Services Rendered**

Code	Procedure	Description	Credit
303	Deep Scaling and Root Planing	The complete surgical or non-surgical removal of subgingival root calculus and the smoothing of root surfaces with scalers and curettes, normally requiring local anesthesia. Roots are exposed and Moderate or Advanced Periodontitis is present.	Three procedures per quadrant. <i>Note: This procedure is not to be credited in conjunction with procedures 301 or 302.</i>
304	Occlusal Adjustment	Reshaping the occlusal or incisal surfaces of natural teeth by grinding and polishing to improve functional maxillary and mandibular contact.	One adjustment per visit regardless of the number of teeth reshaped.
305	Periodontal Surgery	Surgical intervention in conjunction with the treatment of localized or generalized periodontal bony defects.	One procedure per inmate/patient visit.
306	Pericoronal Debridement.	Conservative management of pericoronitis associated with an impacted tooth.	One procedure per inmate/patient visit.
307	Other Periodontal Procedures		One procedure per inmate/patient visit. <i>Note: Do not credit in conjunction with any above listed procedures.</i>
<b>Restorative:</b>			
401	Amalgam		One procedure per tooth surface restored.
402	Composite		One procedure per tooth surface restored.
403	Pin Retention		One procedure per restoration.
404	Sedative/Temporary		One procedure per sedative or temporary restoration.
405	Temporary Metal Crown		One procedure per temporary metal crown placed.
406	Recement Bridge/ Crown		One procedure per recementation.
407	Other Restorative Procedures		One procedure per inmate/patient visit. <i>Note: Do not credit in conjunction with any above listed procedures.</i>
<b>Endodontics:</b>			
501	Pulpectomy/ Pulpotomy		One procedure per tooth per inmate/patient visit.
502	Root Canal, Preparation		One procedure per root canal prepared for filling per inmate/patient visit.
503	Root Canal, Completed		One procedure per root canal filling completed.
504	Apicoectomy		One procedure per tooth treated.
505	Other Endodontic Procedures		One procedure per inmate/patient visit. <i>Note: Do not credit in conjunction with any above listed procedures.</i>

**Table 1: Daily Dental Encounter Form - Services Rendered**

Code	Procedure	Description	Credit
<i>Oral Surgery:</i>			
601	Tooth Removal		One procedure per tooth removed.
602	Tooth Removal, Impacted	Surgical removal of a tooth that is partially or completely covered by bone and/or soft tissue. Hemi-section of tooth for removal. Surgical flap procedure for removal of a tooth.	One procedure per tooth removed.
603	Alveoloplasty	Contouring the alveolar structure in combination with multiple extractions or as a separate procedure to facilitate prosthetic rehabilitation.	One procedure per arch sextant.
604	Incision and Drainage	Surgical intervention to establish drainage.	One procedure per inmate/patient visit.
605	Biopsy	Incisional or excisional, hard or soft tissue.	One procedure per separate specimen submitted.
606	Other Oral Surgery Procedures		One procedure per inmate/patient visit. <i>Note: Do not credit in conjunction with any above listed procedures.</i>
<i>Prosthodontics:</i>			
701	Full Denture		One procedure per completed prosthesis delivered.
702	Cast Metal Partial Denture	A removable prosthesis that replaces one or more, but not all, of the natural teeth of the maxilla or mandible and is constructed of cast metal or cast metal with acrylic resin.	One procedure per completed prosthesis delivered.
703	Resin Partial Denture	Functional, all resin with retention clasps.	One procedure per completed prosthesis delivered.
704	Anterior Transitional Partial Denture	Non-functional, all resin with or without retention clasps.	One procedure per completed prosthesis delivered.
705	Reline, Full Denture/ Partial Denture		One procedure for each completed prosthesis delivered.
706	Repair, Full Denture/ Partial Denture	Includes any repair to an acrylic resin base denture, cast metal frame-work, cast metal or wire clasp, and tooth replacement or addition.	One procedure for each completed prosthesis delivered.
707	Impression/Bite/Try-in/Adjustments		One procedure per prosthesis per inmate/patient visit for impressions, bite registrations, try-ins, or adjustments.
708	Other Prosthodontic Procedures		One procedure per inmate/patient visit. <i>Note: Do not credit in conjunction with any above listed procedures.</i>

## CHAPTER 4.2

### Licensure and Credential Verification (E)

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#### I. POLICY

The CDCR shall ensure that all health care services employees and health care contractors, whose positions or job descriptions require licensure or credentialing, are in compliance with all Federal and State licensing and credentialing requirements prior to employment.

#### II. PURPOSE

To ensure compliance with all Federal and State requirements regarding the licensure, registration, and/or certification of health care personnel within the CDCR, and to establish criteria for the granting of privileges to dental personnel employed by the CDCR.

#### III. PROCEDURE

- A. Each applicant, when being interviewed and prior to being hired, must submit a copy of his or her relevant license, registration, and certification, or a letter of verification from the licensing or certifying agency, to the hiring authority. Applicants are not eligible for employment without proof of current licensure or credentials.
- B. The hiring authority shall be responsible for verifying credentials with the appropriate accrediting agency.
- C. Each employee shall thereafter be responsible for keeping his or her credentials current and for providing verification of renewal to his or her supervisor.
- D. Employees who do not maintain current licensure are ineligible for further employment at the time of the expiration of their license.
- E. Verification of current credentials shall be maintained at the facility of assignment by the local personnel section, and the Chief Dentist (CD).
- F. All health care staff and contractors shall comply with the Division of Correctional Health Care Services (DCHCS) Governance and Administration Regulations Professional Screening and Initial Credential Policy.

#### IV. DENTAL PRIVILEGE CATEGORIES AND QUALIFICATIONS

- A. **Category 1** – A Category 1 dentist shall possess a current California Dentist License; a current Federal Drug Enforcement Administration Registration; a current basic life support and cardiopulmonary resuscitation certificate; satisfactory training and/or experience, and professional/personal references.

CATEGORY 1 DENTISTS' PRIVILEGES. A Category 1 dentist may:

1. Perform dental chart reviews.
  2. Provide dental consultations and referrals.
  3. Supervise dental assistants.
  4. Perform routine dental laboratory procedures (i.e., pour and trim models, design removable partial prosthetics, and adjust removable prosthetics).
  5. Follow Centers for Disease Control and Prevention, OSHA, and CDCR dental infection control policies.
  6. Provide emergency, urgent and routine/comprehensive dental care to assigned inmates.
  7. Perform prophylaxis, scaling, root planning, gingival curettage, oral hygiene counseling and patient education, application of topical fluoride and occlusal/interproximal remineralization, as well as other preventive procedures.
  8. Perform oral diagnosis including examinations, the exposure, processing, and interpretation of radiographs, treatment planning, and health treatment evaluation.
  9. Provide treatment of localized oral infections.
  10. Perform routine operative dentistry.
  11. Place splints, including extracoronal and intracoronal periodontal splints, and perform splinting of traumatically mobilized teeth.
  12. Provide routine removable prosthetics.
  13. Perform routine endodontics of anterior teeth.
  14. Perform re-implantation of avulsed teeth.
  15. Perform incision and drainage (intra-oral).
  16. Perform uncomplicated removal of teeth, including soft tissue impacted teeth.
  17. Provide treatment of oral manifestations of systemic disease.
  18. Provide treatment of early and moderately advanced periodontitis.
  19. Perform frenectomies and removal of benign soft tissue lesions.
  20. Perform reductions of Temporomandibular Joint (TMJ) dislocations.
  21. Perform repairs of simple traumatic wounds of the lip and intra-oral region.
- B. Category 2 – A Category 2 dentist shall possess all category 1 qualifications, plus documented/demonstrated acceptable training/experience in the privileges requested.**

**DENTISTS' PRIVILEGES. A Category 2 dentist may:**

1. Perform apicoectomies.
2. Provide non-surgical treatment of TMJ abnormalities.
3. Provide treatment for complicated periodontitis.
4. Perform complicated endodontics.
5. Perform complicated exodontias including removal of bony impacted teeth.
6. Perform removal of exostoses.
7. Perform soft tissue grafts of the intra-oral region.
8. Perform vestibuloplasties.
9. Provide full mouth occlusal rehabilitation.

10. Perform complicated prosthetics including dentures on surgically augmented ridges, and the design and construction of over-dentures.
  11. Perform routine enucleation of intra-oral cysts.
  12. Perform alveoplasties with or without extractions.
  13. Perform occlusal adjustments.
  14. Design and fabricate occlusal guards and bite guides.
  15. Perform routine intra-oral, and oropharyngeal biopsies.
- C. **Category 3** – A Category 3 dentist shall possess all category 1 and 2 qualifications, plus documented full-time postgraduate dental training applicable to CDCR requirements as evidenced by Board certification in oral surgery, or successful completion of an approved residency in oral surgery.

**DENTISTS' PRIVILEGES.** A Category 3 dentist may:

1. Perform inmate/patient admissions to CDCR hospitals or to local contract hospitals where staff privileges for oral surgery services are maintained.
2. Perform closed and/or open reductions under general anesthesia of maxillo-facial fractures.
3. Perform surgical ridge augmentations.
4. Perform repairs of complex traumatic wounds to the lips, intra-oral, and oropharyngeal regions.
5. Perform Caldwell-Luc procedures.
6. Perform sialography and TMJ arthrograms.
7. Provide treatment of dental and alveolar pathology, trauma, and/or abnormalities.
8. Provide treatment of diseases of the oral mucous membranes.
9. Provide treatment of infections and/or inflammation requiring access from the facial, intra-oral, and oropharyngeal regions.
10. Provide non-surgical treatment for facial pain, Temporomandibular Joint Dysfunction (TMD), including neurectomies and alcohol injections.
11. Provide treatment of atrophic and hypertrophic conditions of oral tissue.
12. Provide treatment of cysts and tumors of the lips, intra-oral, and oropharyngeal region.
13. Perform repairs of acquired or congenital craniofacial deformities of the maxilla or mandible that interfere with the health of the inmate/patient.
14. Provide treatment of intra-oral, and oropharyngeal anomalies.
15. Provide treatment using extra-oral maxillofacial prostheses.

## V. ACKNOWLEDGEMENT OF PRACTITIONER

All CDCR dental health care employees or dental health care contractors must sign an *Acknowledgment of Practitioner*, which shall state:

**ACKNOWLEDGEMENT OF PRACTITIONER**

I understand that in exercising any dental clinical privileges granted to me, I am constrained by any California Department of Corrections and Rehabilitation and Division of Correctional Health Care Services policies and rules that are generally applicable, including any that apply to the particular situation.

Signature of Practitioner: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Practitioner: \_\_\_\_\_

## CHAPTER 4.3

### Dental Peer Review (E)

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#### I. POLICY

The CDCR DCHCS Statewide Professional Practices Program Committee shall maintain a Peer Review Subcommittee (PRS) for the purpose of providing oversight and coordination of statewide professional peer review processes in order to achieve the DCHCS's strategic objectives. The DCHCS PRS shall plan, develop, manage, and improve the peer review process in order to assist the institution PRS in fostering the continuous professional development and training of the clinical workforce. The Dental Peer Review process shall adhere to all aspects of the DCHCS Governance and Administration Policy on Peer Review Subcommittees.

#### II. PURPOSE

To achieve and maintain the highest possible standards of professional, ethical, dental health care delivery through peer review of the quality of professional services provided. The review process shall assure inmate/patient safety and quality of care and shall not be construed as punitive. The process shall be viewed as educational, with the ultimate goal of continuously improving the quality of inmate/patient care. Proceedings of peer review committees are protected by Section 1157 of the *Evidence Code* and Section 2318 of the *Business and Professions Code*.

#### III. PROCEDURE

Peer review is a process whereby licensed practitioners such as dentists and physicians evaluate the professional activities of their colleagues. Peer review is intended to ensure that acceptable dental care is provided to inmates/patients. The peer review process attempts to promote good dental practice culminating in consistently positive outcomes from the dental care provided. Within the CDCR, peer review shall be performed by organized medical staff, functioning within a set of written by-laws, overseen by the CDCR and the DCHCS governing bodies.

- A. Each CDCR facility shall establish a Dental Peer Review Committee (DPRC) composed of:
1. A staff dentist elected as chairman of the Committee by the other staff dentists at the facility.
  2. A staff dentist elected as vice-chairman of the Committee by the other staff dentists at the facility.
  3. Whenever a DPRC member has a possible conflict of interest or potential difficulty with impartiality due to his or her involvement in a case currently under review, they shall be temporarily replaced by a staff dentist at the facility or from another facility, selected by the DPRC at the facility, or from another facility.
  4. Meeting minutes shall be recorded by the Office Technician (OT).

B. Organized medical staff at the institution shall implement a direct peer review process to exercise concurrent and direct observation in the following operations:

1. Privileging

The committee's focus shall be on aspects of the candidate's behavior, professional ethics, and performance. The committee shall have a set of written goals and objectives directed towards:

- Identifying desirable qualities for organized staff membership and privileges.
- Identifying a conflict between privileges requested and actual education, training, or recent practice experience.
- Identifying any candidate's demands or expectations that are beyond the capacity of CDCR policies and mandates.
- Identifying values and attitudes that are in conflict with those of the CDCR and the DCHCS.
- Identifying conflicts with a peer review process.
- Identifying gross mental and physical disabilities that are inconsistent with requested privileges.

2. Proctoring and Mentoring

The Chief Dentist (CD), or designee, shall utilize the process of proctoring and mentoring to assess a dentist's skills and to ensure he or she has the capabilities needed to adequately perform the privileges granted. Reports of cases used for proctoring shall be included in the dentist's supervisory file. If proctoring cases fail to satisfy the DPRC's requirements, the privileges granted may be denied and further training/action may be required, with consideration of the candidate's judgment, skills, recognition and management of complications and treatment outcomes. The proctoring policy for the DPRC shall include:

- Both inmate/patient and procedural management review.
- Cases sufficient in complexity and in number to demonstrate the dentist's competency in a representative sample of privileges requested.
- Procedures that ensure that the proctor shall function as an observer of the case, not a consultant or assistant.
- Provision for all dentists to be proctored without exceptions.
- Provision for dentists outside of the local facility to be utilized by the DPRC as proctors.
- Procedures that ensure that a minimum of six chart review cases and three clinical review cases shall be required during the proctoring period and that allow for the proctoring period to be extended in 30-day increments up to a total of 12 months.
- Provision for proctors to complete a mandatory Peer Chart Review Worksheet for each chart reviewed.

- Procedures stipulating that proctors shall complete a Dental Proctoring Clinical Review Worksheet for each clinical case reviewed.
  - Procedures stipulating that all proctors shall complete a Dental Proctoring Evaluation – Dental Staff Appointment worksheet at the conclusion of the proctoring period.
3. Consultation
- The DPRC may utilize an outside consultant for an independent evaluation of a case.
4. Investigation Monitoring
- Cases suggestive of marginal or delinquent care may be identified by the DPRC for investigation monitoring. The purpose of investigation monitoring is not to punish, but to collect additional data about the overall skills of a dentist whose practice is being questioned. Investigation monitoring is intended to make judgments about the general exercise of privileges in cases not otherwise identified as questionable, or to determine whether there is an emerging pattern of poor performance.
- C. The peer review process shall be utilized in evaluating inmate/patient care using generic screening criteria and methodologies such as chart reviews and patient outcome data as well as other logs and reports. During the evaluation process each procedure and service shall be reviewed to determine:
- Appropriateness – were the right tests and examinations selected? Were the correct conclusions drawn? Were the appropriate treatments applied?
  - Competence – Was the care delivered in a professional, competent manner? Were interventions timely, well performed, and free of technical error? Were changes correctly perceived and followed by appropriate modification in the diagnosis or treatment plan?
  - Outcome – Given the severity of the patient's illness at the time of treatment, the acuity of its progression and complexity of co-morbid conditions, did the patient achieve the optimal outcome that could be reasonably expected?
- D. Definitive Review and Action – if an issue is identified during the screening process, the observations and the records shall be sent to the DPRC for definitive review and action. All peer review records shall be kept confidential with anonymous references to the treating dentists and the inmates/patients in order to remain privileged and immune from disclosure.
1. All definitive reviews and actions shall conclude with one of the following general recommendations:
- Care was appropriate.
  - The indicators were not met and appropriate policy or education is recommended.
  - The indicators were not met and corrective action is recommended.
2. Criteria for Definitive Actions include:
- Variables associated with dentist technique and judgment.

- Variables associated with inmate/patient death.
  - Variables associated with major iatrogenic injury.
  - Variables associated with the dentist exceeding clinical privileges.
  - Variables associated with lawsuits.
  - Series of variables associated with the same dentist.
  - Variables associated with complications requiring significantly increased care.
3. Corrective actions – Corrective actions are based on authority granted to the medical staff by its by-laws, CDCR and DCHCS policies and regulations. The corrective action must be individualized, consistent, and fair.

**Dental Proctoring Evaluation Worksheet  
For Dental Staff Appointment**

Dentist's Name: \_\_\_\_\_

**I. PROCTORING RESPONSIBILITIES:**

Proctoring requirements have been satisfactorily completed. Practitioner has demonstrated competency in performing the clinical privileges he or she was provisionally granted.

Proctoring requirements are not considered complete. The following reports are still incomplete:

**II. BASIC MEMBERSHIP:**

	YES	NO
A. Able to perform all procedures for which they have requested privileges without reasonable accommodation and according to accepted standards of professional performance, without posing a direct threat to inmates/patients	<input type="checkbox"/>	<input type="checkbox"/>
B. Has conducted himself/herself in a cooperative, friendly, and professional manner.	<input type="checkbox"/>	<input type="checkbox"/>
C. Has complied with the by-laws, rules, policies, and regulations of the CDCR and the DCHCS.	<input type="checkbox"/>	<input type="checkbox"/>
D. Has maintained timely and complete medical/dental records	<input type="checkbox"/>	<input type="checkbox"/>

**III. RECOMMENDATIONS:**

Advancement from provisional staff to active staff YES  NO

Extend provisional status for \_\_\_\_\_ months  
Reasons: YES  NO

Remove from staff  
Reasons: YES  NO

This is to verify that the above-mentioned practitioner has completed the minimum proctoring requirements established per DCHCS policies and the local Correctional Treatment Center (CTC) by-laws. I hereby release the practitioner from basic observation and proctoring requirements per DCHCS policies and the local CTC by-laws, having reviewed satisfactory proctoring.

This is to verify that the above-mentioned practitioner has completed the minimum proctoring requirements established per DCHCS policies and the local CTC by-laws. Having reviewed the proctoring, the following unacceptable areas are noted:

\_\_\_\_\_

Proctor's Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date \_\_\_\_\_

## DENTAL PEER REVIEW WORKSHEET

Treating Dentist Name: \_\_\_\_\_ Date of Review: \_\_\_\_\_

CDCR # of Chart Reviewed: \_\_\_\_\_ Date of Service(s) Start: \_\_\_\_\_ Stop: \_\_\_\_\_

	Below Average					Above Average				
	1	2	3	4	5	6	7	8	9	10
1. Subjective (SOAPE) Notes <small>(Did the notes clearly describe the subjective findings?)</small>										

Comment: \_\_\_\_\_

2. Objective (SOAPE) Notes <small>(Did the notes clearly describe the objective findings?)</small>										
---	--	--	--	--	--	--	--	--	--	--

Comment: \_\_\_\_\_

3. Assessment (SOAPE) Notes <small>(Did the assessment seem appropriate for the conditions described in the Subjective (S) and Objective (O) notes?)</small>										
---	--	--	--	--	--	--	--	--	--	--

Comment: \_\_\_\_\_

4. Plan (SOAPE) Notes <small>(Did the plan seem appropriate for the assessment?)</small>										
---	--	--	--	--	--	--	--	--	--	--

Comment: \_\_\_\_\_

5. Education (SOAPE) Notes <small>(Did the education notes seem to reflect the patient's understanding of the important issues during the health care visit?)</small>										
--	--	--	--	--	--	--	--	--	--	--

Comment: \_\_\_\_\_

6. Health History <small>(Was the health history of the patient reviewed?)</small>										
---	--	--	--	--	--	--	--	--	--	--

Comment: \_\_\_\_\_

7. Diagnostic Tests Including X-ray <small>(Was there adequate diagnostic tests including x-rays used in the diagnosis?)</small>										
---	--	--	--	--	--	--	--	--	--	--

Comment: \_\_\_\_\_

8. Medication <small>(Did the medication that was prescribed seem appropriate?)</small>										
--	--	--	--	--	--	--	--	--	--	--

Comment: \_\_\_\_\_

9. Follow-Up <small>(Was or could a follow-up be appropriate in this case and was it timely?)</small>										
--	--	--	--	--	--	--	--	--	--	--

Comment: \_\_\_\_\_

10. Legibility <small>(Was the documentation legible?)</small>										
---	--	--	--	--	--	--	--	--	--	--

Comment: \_\_\_\_\_

11. Complexity (circle one) <small>(How complex was this case?)</small>	Simple	Average	Difficult
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Comment: \_\_\_\_\_

<b>Scoring:</b>	<b>Total Score:</b> _____
75-100	No further action required. (Any single score(s) of 5 or below will be referred to the Dentist for discussion and review and/or correction or aftercare.)
50-74	Referred to Dentist for discussion and review. (Any score(s) of 5 or below will be referred to the Dentist for discussion and review and/or correction or aftercare.)
Below 50	Referred to Dentist for discussion and review and/or correction or aftercare. (The Chief of Staff may be notified.)

<b>Reviewing Dentist Signature</b> _____	<b>Print Name</b> _____	<b>Date</b> _____
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During the peer review, a minimum of five chart review cases per staff dentist shall be reviewed. The identity of the reviewing dentist shall remain anonymous and kept confidential.

## DENTAL PROCTORING - CLINICAL REVIEW WORKSHEET

Treating Dentist Name: \_\_\_\_\_ Date of Review: \_\_\_\_\_

CDCR # of Chart Reviewed: \_\_\_\_\_

	Below Average					Above Average					
1. Pre-clinical (Were appropriate dental records completed and reviewed including the health history?)	1	2	3	4	5	6	7	8	9	10	
Comment: _____											
2. Subjective and Objective (SOAPE) (Was there adequate discussion of the subjective and objective findings including diagnostic tests and x-rays?)	1	2	3	4	5	6	7	8	9	10	
Comment: _____											
3. Assessment and Plan (SOAPE) (Was there adequate discussion of the assessment and plan?)	1	2	3	4	5	6	7	8	9	10	
Comment: _____											
4. Education (SOAPE) (Was there adequate discussion and understanding by the patient of the important issues during the health care visit?)	1	2	3	4	5	6	7	8	9	10	
Comment: _____											
5. Clinical – Dental Practice (Was there proficiency in using the dental equipment and materials during the procedure as well as in applying infection control procedures?)	1	2	3	4	5	6	7	8	9	10	
Comment: _____											
6. Clinical – Patient Care (Was the procedure performed with proficiency so that patient comfort was kept in mind?)	1	2	3	4	5	6	7	8	9	10	
Comment: _____											
7. Clinical Interaction With Auxiliary Staff (Was the auxiliary dental staff given clinical direction in an adequate manner?)	1	2	3	4	5	6	7	8	9	10	
Comment: _____											
8. Clinical Complications (If complications occurred, was there adequate discussion of the complications?)	1	2	3	4	5	6	7	8	9	10	
Comment: _____											
9. Medication (Was there adequate discussion of the medication prescribed?)	1	2	3	4	5	6	7	8	9	10	
Comment: _____											
10. Follow-Up (Was there adequate discussion of a follow-up visit?)	1	2	3	4	5	6	7	8	9	10	
Comment: _____											
11. Complexity (circle one) (How complex was this case?)	Simple			Average				Difficult			
Comment: _____											

## Scoring:

Total Score: \_\_\_\_\_

75-100 No further action required. (Any single score(s) of 5 or below will be referred to the Dentist for discussion and review and/or correction or aftercare.)

50-74 Referred to Dentist for discussion and review. (Any score(s) of 5 or below will be referred to the Dentist for discussion and review and/or correction or aftercare.)

Below 50 Referred to Dentist for discussion and review and/or correction or aftercare. (The Chief of Staff may be notified.)

Reviewing Dentist Signature \_\_\_\_\_

Print Name \_\_\_\_\_

Date \_\_\_\_\_

During the proctoring period, a minimum of 6 chart review cases and 3 clinical review cases shall be reviewed. The proctoring period may be extended in 30-day increments up to a total of 12 months.

## CHAPTER 4.4

### Dental Program Subcommittee

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#### I. POLICY

The DCHCS Quality Management Committee (QMC) shall maintain a Dental Program Subcommittee (DPS) to provide oversight and coordination of statewide dental programs in order to achieve the DCHCS's strategic objectives and to ensure compliance with the DCHCS Subcommittee General Policy. The DCHCS DPS shall plan, develop, and manage timely access to effective and appropriate dental services consistent with the standards of the CDCR.

#### II. PURPOSE

To ensure that CDCR inmates/patients are provided with quality dental services that are cost effective and in compliance with all applicable laws, regulations, policies, and procedures.

#### III. RESPONSIBILITIES

The DCHCS DPS shall be responsible for the following as they relate to the performance of CDCR dental clinical programs:

- A. Developing annual strategic objectives for the programs.
- B. Implementing initiatives to achieve the programs' objectives.
- C. Developing statewide program standards and policies.
- D. Developing clinical indicators to assess whether program standards are being met.
- E. Reviewing program performance based on compliance with the clinical indicators.
- F. Monitoring compliance with program standards using the clinical indicators and other selected audit tools.
- G. Recommending strategies for improvement to the DCHCS QMC.
- H. Developing standardized management reports presenting analysis and results of the programs' performance.
- I. Developing training curricula and plans.

#### IV. MEMBERSHIP

- A. The members of the DCHCS DPS shall be selected so as to represent the program and functional areas of the DCHCS that are necessary for the appropriate and coordinated delivery of health care services.
- B. The DCHCS Governing Body shall select the DCHCS DPS Chairperson, who shall serve for at least one year.
- C. The DCHCS DPS shall include the following members:
  1. Chief Dentist, Clinical Standards and Services Unit, DCHCS.
  2. Chief Medical Officer, Clinical Standards and Services Unit, DCHCS
  3. Nurse Consultant III – Supervisor, DCHCS
  4. Facility Captain, Quality Management Assessment Team (QMAT)
  5. Health Program Manager, Program and Policy Coordination, DCHCS

6. Staff Services Manager, Information Services, DCHCS
7. Staff Services Manager, Fiscal Management, DCHCS
8. Staff Services Manager, Risk Management Unit, DCHCS
9. Staff Services Manager, Clinical Program Support Unit, DCHCS
10. A designated alternate for any of the above members may attend when necessary.

**V. MEETING SCHEDULE AND QUORUM**

- A. The DCHCS DPS shall meet at least monthly.
- B. The presence of at least one-half of the committee members shall constitute a quorum.
- C. Meeting minutes shall be recorded by the Office Technician.

## Chapter 4.5

### Dental Authorization Review Committee (E)

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#### I. POLICY

Each CDCR institution shall establish a Dental Authorization Review Committee (DAR).

#### II. PURPOSE

The DAR shall be established for the purpose of approving or disapproving requests for otherwise excluded dental services, determining the appropriateness of treatment provided by the institution's dentists, reviewing treatment recommendations for special dental care needs, and evaluating the cost efficiency and effectiveness of the dental services provided at the institution.

#### III. PROCEDURE

##### A. MEMBERSHIP

The permanent membership of the DAR shall consist of the:

- The Chief Dentist (CD), or designee
- A Staff Dentist as Chairman.
- A Staff Dentist as Vice-Chairman.

Representatives from other institution services or divisions shall be invited, when appropriate, to committee meetings.

##### B. MEETINGS

1. The committee shall regularly meet on a monthly basis, but may meet more often if deemed necessary by the CD.
2. A written agenda shall be formulated and distributed by the Office Technician (OT) to all attendees prior to each meeting. Requests for items to be placed on the agenda must arrive to the Chairman ten (10) working days prior to the regularly scheduled committee meeting.
3. The CD shall maintain written minutes recorded by the OT of all committee meetings, which shall contain specific recommendations for action, when appropriate. A draft of the minutes shall be distributed to all attendees as promptly as possible by the OT.
4. Each recommendation shall be reviewed as part of old business at subsequent meetings and shall continue to be monitored until resolved. A copy of all approved minutes shall be forwarded to the Health Care Manager (HCM)/Chief Medical Officer (CMO) by the OT.

##### C. COMMITTEE FUNCTIONS

1. Review of Requests for Excluded Dental Services

- a. Committee decisions concerning requests for excluded dental services shall be based on criteria established in the *California Code of Regulations* Title 15, Section 3350.1 (d), and shall be documented in the inmate's Unit Health Record.
- b. Cases approved by the committee shall be forwarded, along with all supporting documentation, to the Health Care Review Committee (HCRC).

## 2. Quality Review Functions

The Committee shall conduct audits of each institution dental clinics:

- Infection control practices.
- Treatment planning for all priorities.
- Basic preventive services.
- Dental care provided based on each inmate/patient's eligibility for care and priority of need. This shall be accomplished by a review of monthly reports in order to:
  - Ensure that all inmates/patients are receiving equal and timely access to dental care.
  - Identify factors that contribute to a facility's ability to consistently report data that indicates a high level of efficiency and productivity.

## 3. Review of Dental Health Records and Evaluation of Clinic Records Management

The Committee shall review the following aspects of Dental Health Records:

- Contents, organization, and maintenance.
- Record storage.

## 4. Review of Appropriateness of Treatment Provided

- Evidence or information brought to the attention of the CD concerning a possible unacceptable standard of care being provided by a dental care provider shall be reviewed by a subcommittee appointed by the DAR. A member of the DAR, appointed by the CD, shall chair the Subcommittee.
- The committee shall review all relevant findings, allegations, records, and interview available staff, and shall make proposals to the CD, which may include a recommendation for an investigation.

## 5. Review of Dental Resource Utilization

### a. Budget

1. Dental laboratory expenditures.
2. Personnel expenditures.
  - Continuing education and professional development.
  - Administrative travel.
  - Personal services, contracts, and off-site specialty referrals.
3. Pharmaceutical costs.

- Non-formulary requests.
  - Annual review of formulary/non-formulary nomenclature.
4. Supply costs.
- b. Dental Staff
1. Audit findings – verification of monthly reports and data submitted.
  2. Provision of equal and timely access to care.
    - General population and Ad. Seg. population data.
    - Sick call/routine care delays.
  3. Monthly reports/encounter forms (quantity of care).
    - Number of inmate/patient visits.
    - Procedures per visit.
    - Number of treatment procedures provided.
    - Adherence to treatment priorities.
  4. Staff assignments.
  5. Credentialing, and licensing.
- c. Supplies.
1. Supply usage.
  2. New product needs.
  3. Annual update of supply inventory list.
- d. Equipment
1. Annual update of equipment inventory.
  2. Major equipment requirements/needs.
  3. Telemedicine usage.
  4. Repair and maintenance.
  5. New technology (e.g., computers).
  6. Spore test and sterilizer maintenance logs.
- e. Physical plant.
1. Space requirements.
  2. Satellite clinics.
  3. New construction/repairs.
  4. Clinic environment, i.e., heating, air-conditioning, ventilation.
- f. Special Dental Care Needs Review.

Special dental care needs are excluded treatments, or treatment procedures not identified and described as a Priority 1, 2, or 3 procedure. They also include procedures in which the treating dentist recommends an exception to policy based on a documented oral condition.

- Providing special dental care needs to inmates/patients requires pre-authorization by the CD and review by the DAR. Pre-authorization by the CD is also required prior to beginning any treatment beyond that necessary to relieve symptoms.
- Requests for special dental care needs shall be submitted by the treating dentist to the CD for consideration by the DAR.
- Cases submitted for review and approval shall, at a minimum, include the following:
  - Copy of inmate/patient dental record.
  - Current radiographs (i.e. Panorex, peri-apical, full mouth series) as appropriate.
  - Patient dental study models.
  - Any other relevant documents.
- Requests for excluded dental care or special dental care needs shall be evaluated by the DAR and forwarded with a written recommendation to the HCRC for approval or disapproval.

## Chapter 4.6

### Dental Radiography & Film Processing and Quality Assurance (E)

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#### I. POLICY

It shall be the policy of the CDCR that all employees shall adhere to Dental Radiography and Film Processing mandates and procedures when taking and processing dental radiographs. The Chief Dentist (CD) shall be responsible for the implementation of a quality assurance program for the purpose of monitoring environmental radiation safety procedures, and staff compliance to State and Federal mandates when taking and processing dental radiographs.

#### II. PURPOSE

To establish guidelines and procedures that result in dental radiographs that are of high diagnostic quality and are produced and processed in a safe manner, and to ensure the safety of staff, inmates/patients, and the workspace environment.

#### III. PROCEDURE

##### A. Basic Procedures

1. Unexposed radiographic film shall be stored, in accordance with manufacturer's recommendations, in an area in the dental department that is free of radiation.
2. Exposed radiographic films shall be processed according to the specifications supplied by the film manufacturer and the film processor manufacturer.
3. All radiographic film and the chemicals used in the processor shall be checked for expiration dates. Film and chemicals shall not be used after the expiration date.
4. Chemicals shall be replaced by dental employees according to the manufacturer's recommended interval, which is bi-weekly, or when other test limits are exceeded.
5. Automatic Dental Radiographic Film Processing Equipment:
  - a. The temperature of processor chemicals shall be checked at the beginning of the workday. Radiographic films shall not be processed until the developer temperature is between 70 to 82° F (for Peri Pro Processors), and 74 to 76 °F (for Peri Pro II Processors). If another brand of processor is utilized, the manufacturer's specifications shall be verified and utilized. The temperature of processor chemicals shall be rechecked throughout the workday, as necessary.
  - b. Cleanup or blank radiographic films shall be run daily or more often as specified by the manufacturer, to verify correct operation of the processing equipment.
  - c. The processor shall be maintained according to the instructions in the manufacturer's operating manual. (Refer to Peri Pro solution and processor maintenance.)
6. Automatic processors ensure more consistent radiographic film quality and shelf life, therefore, the manual processing of dental radiographs is not recommended.

7. Each dental department shall have, at a minimum, one functioning back-up automatic dental radiographic film processor for use in the event that one of the facility's dental automatic processors malfunctions or is taken out of service.
8. A cleaning and maintenance schedule for panoramic equipment, intensifying screens, and cassettes shall be followed each quarter, or more often if indicated, in accordance with the manufacturer's instructions. Certain conditions of the intensifying screens will result in eventual wear and replacement.
9. Schedules and coordinates with vendors for contracted maintenance of machines.
10. Shall coordinate with institutions Haz-Mat for pick up of hazardous waste.

#### B. Quality Assurance (QA) Tests

1. A staff member selected by the Chief Dentist (CD) or designee shall perform QA testing procedures at specified intervals on all automatic dental radiographic film processors. The QA test shall be performed bi-weekly before processing patient films. (Refer to Peri Pro Solution and Processor maintenance in section F of the Owner's Manual). Data from QA tests shall be recorded in the Dental Radiology QA log.
2. Records of QA tests shall be stored and maintained by the CD for a period of three years.
3. All dental staff members shall sign and adhere to the radiographic certification statement found at the end of this chapter.

#### C. Leaded Protective Equipment Inspection and Testing

1. All leaded protective equipment (i.e., aprons, thyroid shields, gonad shields), shall be inspected annually.
2. Annual testing of lead protective equipment shall be performed by manually feeling the equipment to detect any tears, cracks, or holes in the lead. The method of inspection, date inspected, and inspector's name shall be documented in the Dental Radiology QA log.
3. Defective or damaged protective equipment shall be replaced.

#### D. Daily Start-up of Peri Pro Automatic Dental Radiographic Film Processors

1. Prior to start-up, the processor transport assembly shall be checked to ensure that it is properly installed in accordance with the manufacturer's recommendations.
2. Prior to startup, the solution levels shall be checked and chemicals or water added to the appropriate solution tanks, if necessary.
3. After the processor has been turned on and a sufficient warm-up period has elapsed, the developer temperature shall be manually checked.
  - **RADIOGRAPHIC FILM SHALL NOT BE PROCESSED UNTIL DEVELOPER TEMPERATURE IS:**  
Peri Pro – 70 to 82 ° F                      Peri Pro II – 74 to 76 ° F
4. The processor temperature shall be recorded in the QA log and the entry initialed. Corrective actions, according to manufacturers recommendations, (i.e., Peri Pro Manual,

Peri Pro II Manual) must be taken if the temperature is not within tolerable range. Note: If the Peri Pro II's heater bar malfunctions the unit may be unplugged, the heater bar removed and the unit operated like the Peri Pro. If this is done it must be documented in the comment section of the QA Log. The action taken and the results must be recorded in the log and the entry initialed.

5. Prior to processing actual films, a clean-up film shall be processed to verify the equipment is working properly.
6. All films shall be processed according to the manufacturer's recommendations.

E. Peri Pro Solution and Processor Maintenance

1. On a weekly basis or after processing 100 to 125 films, whichever is sooner, staff shall:
  - a. Unplug the unit from the electrical outlet.
  - b. Put on protective gear, (eyewear or shield, gloves, etc.)
  - c. Remove the film receptacle and cover.
  - d. Lift transport and hold to drain. \*CAUTION MUST BE TAKEN TO AVOID SPLASHING CHEMICALS, OR CONTAMINATION MAY RESULT.
  - e. Place transport on service tray.
  - f. Rinse transport thoroughly with hot water. \*CAUTION MUST BE TAKEN TO KEEP INLET AND SHUTTER AREA DRY.
  - g. Scrub the grooves with a toothbrush. Special attention should be given to the chemistry line where build-up occurs. Rinse to remove deposits.
  - h. Scrub and rinse gears at rear of transport.
  - i. Remove water tank and discard water.
  - j. Clean water tank. \*IF THERE IS AN ALGAE-LIKE OR SLIMY COATING IN THE TANK, A SMALL AMOUNT OF CHLORINE BLEACH MAY BE HELPFUL IN CLEANING THE TANK. THE TANK MUST BE RINSED THOROUGHLY TO REMOVE ALL BLEACH.
  - k. Refill water tank with 70 to 80° F water.
  - l. Check developer and fixer levels and restore to proper levels.
  - m. Reinsert transport slowly into place.
  - n. Reinstall cover and film receptacle.
  - o. Plug electrical cord into outlet.
  - p. Record maintenance in log and initial entry.
  - q. Proceed with Daily Start-up before processing films.
2. On a bi-weekly basis, or after processing 300 to 350 films, whichever is sooner, staff shall:
  - a. Follow the first ten steps of the Weekly Maintenance schedule.

- b. Remove heater bar assembly (if utilizing the Peri Pro II).
- c. Place the heater bar on support of service tray.
- d. Gently wipe residue with damp cloth. \*CAUTION MUST BE TAKEN TO KEEP THE BROWN SECTION OF THE BAR DRY WHEN CLEANING HEATERS.

F. Peri Pro and Peri Pro II tank maintenance

1. Remove Developer and Fixer tanks.
2. Used Developer and Fixer shall be poured into separate, labeled, Biohazard storage containers.
3. The tanks shall be rinsed and sponged clean.
4. Insert Fixer tank only.
5. Carefully pour Peri Pro Fixer into Fixer tank (red). \*CAUTION MUST BE TAKEN TO AVOID CONTAMINATING THE DEVELOPER.
6. Insert developer (black) tank and fill with Peri Pro Developer.
7. Insert water tank and fill with 70 to 80 ° F water.
8. Slowly reinsert the transport into place.

G. Peri Pro II

1. Reinstall heater bar assembly.
2. Reinstall cover and film receptacle.
3. Plug electrical cord into outlet.
4. Record maintenance in log and initial entry.
5. Complete Daily Start-Up procedures before processing film.
6. A bi-weekly QA test, shall be performed before processing patient films, as follows:
  - a. Process an unexposed film.
  - b. Momentarily expose a film to room light and process.
  - c. The unexposed film should be completely clear.
  - d. The light exposed film should be completely black.
  - e. If the results differ from the previous two steps, the trouble shooting section of *Air Techniques Instruction Manual* for Peri Pro Processors shall be consulted.
  - f. Test results and any corrective actions taken shall be recorded in the QA log and the entry initialed.
  - g. The test films shall be dated and retained as proof of test, subject to audit. Test films may be disposed of after the completion of an audit.

### CERTIFYING STATEMENT

The dental radiography policies and procedures (P/P) have been developed to ensure safe radiological working conditions. I will implement and follow the P/P and will obtain prior approval from the Dental Authorization Review Committee for any deviation from the P/P.

\_\_\_\_\_

Dental Staff Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Chief Dentist Signature

\_\_\_\_\_

Date

## CHAPTER 4.7

### Clinic Space, Equipment, and Supplies (E)

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#### I. POLICY

All CDCR dental departments shall be provided with sufficient suitable space, equipment, and supplies to provide and maintain an adequate dental health care delivery system in each institution. Major and minor dental equipment (e.g., dental operator system chair and delivery system, handpieces, x-ray units, sterilizers, vacuums and compressors) shall be standardized statewide in all dental clinics to ensure safety and allow for a consistent level of care, facilitate in the training of all staff, and increase the efficiency in the delivery of dental care. All staff shall receive training on the proper operation and maintenance of major and minor dental equipment.

#### II. PURPOSE

To establish guidelines and basic requirements for adequate space, equipment, and supplies in order to deliver dental services in CDCR facilities.

#### III. PROCEDURE

- A. Examination and treatment rooms for dental care shall be large enough to accommodate the equipment and fixtures needed to deliver adequate dental services.
- B. Each dental clinic shall have pharmaceuticals, medical supplies, and mobile emergency equipment (i.e., crash carts, oxygen, resuscitator, etc.) available.
- C. Each dentist shall have access to adequate office space that is separate and apart from clinical treatment areas.
- D. Offices shall be large enough to accommodate administrative files, phones, computers, and a writing desk.
- E. If laboratory, radiological, inpatient, or specialty services are provided on site, the area(s) devoted to any of these services shall be appropriately constructed in accordance with State and Federal guidelines for health and safety, and be of sufficient size to accommodate all necessary equipment, records, supplies, tools, etc.
- F. The following major and minor dental equipment shall be replaced according to the indicated replacement cycle date or, if applicable, according to the manufacturer's instructions, whichever is sooner:

• Dental Operator System	Every 10 years
• Panoramic Unit	Every 15 years
• Intraoral Radiographic Unit	Every 15 years
• Vacuum/Compressors	Every 5-7 years
• Autoclave	Every 5 years

- G. The Chief Dentist (CD), or designee, at each institution shall be involved in the development of the scope of services and the interviewing of vendors offering to service and/or repair major dental equipment, in order to ensure that the maintenance personnel are currently certified to service and/or repair the equipment in need of such services.

The evaluation and selection of major and minor dental equipment shall be determined by the CDCR DCHCS Dental Program. The research and evaluation process shall include, but are not limited to: (1) product evaluation reports from the United States Air Force, American Dental Association; (2) evaluation and analysis of the quality and performance factors of existing dental equipment in CDCR, and other agencies (eg., Veterans Administration, Dental Schools, Military Armed Forces) by DCHCS Dental Program Administrators. After a period of five (5) years or longer, depending on the replacement cycle of the equipment, a re-evaluation, analysis and selection of major and minor dental equipment shall be conducted by CDCR DCHCS Dental Program Administrators.

- H. The Selection of major dental equipment manufactures for the years 2006-2011 are:

- ADEC corporation for dental operatories and chairs
- Planmeca for dental x-ray units
- ADEC LISA for dental sterilizers
- AirTechniques for dental compressors and vacuum units

## CHAPTER 4.8

### Inmate Dental Workers (E)

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#### I. POLICY

Dental departments within the CDCR may utilize inmates as dental laboratory technicians, dental clerks, and dental porters. The utilization of inmate dental workers shall require the prior approval of the Institution's Associate Warden for Health Care Services.

#### II. PURPOSE

To establish guidelines for the utilization of inmate workers in CDCR dental departments.

#### III. PROCEDURE

A. Inmates shall be prohibited from performing the following duties in all CDCR dental departments:

1. Providing direct patient care services.
2. Scheduling health care appointments.
3. Determining inmates' access to dental services.
4. Handling or having access to surgical instruments, syringes, and needles.
5. Operating medical/dental equipment.
6. Handling or having access to medications or health records.

B. CDCR dental departments may utilize inmate workers as dental laboratory technicians, clerks, and porters only after the inmate workers have met the following requirements:

1. Successfully completed training in Blood Borne Pathogens Regulations. Minutes of all inmate-training sessions and a statement of completion of the training, signed by the inmate, shall be documented and kept on file by the inmate supervisor prior to the inmate performing any work assignments.
2. Been offered a Hepatitis B vaccination series.

C. All inmate workers shall have signed duty statements listing the job performance requirements and health and safety regulations.

D. Dental inmate workers shall adhere to all safety, security, and custodial regulations while working in the dental department.

E. All dental inmate workers shall be assigned to the dental department by the facility's Inmate Work Incentive Program (IWIP) Coordinator.

- F. All supervisors of dental inmate workers shall adhere to and enforce the rules and regulations of the IWIP in the supervision of inmate workers.
- G. All dental inmate workers shall be under the direct supervision of a CDCR staff member at all times excluding the Office Technician.
- H. All dental inmate workers shall receive annual training in Blood Borne Pathogens Regulations and monthly training in SB 198 *Injury and Illness Prevention Program*. Training may be provided more frequently if necessary.

## CHAPTER 5.1

### Inmate Co-payment for Health Care Services (E)

#### I. POLICY

The CDCR, its agents, and the DCHCS, shall adhere to the requirements set forth in *California Code of Regulations* Title 15, Article 8, Section 3354.2 "Inmate Co-payment for Health Care Services." In accordance with those requirements, inmates shall be charged a five dollar (\$5.00) co-payment fee for each inmate-initiated health visit.

#### II. PURPOSE

To establish procedures and guidelines for determining and implementing the mandated co-payment per the following definitions:

*"Inmate Initiated"* is defined as treatment sought by an inmate through CDCR staff, or a condition that is reported, on behalf of an inmate, to health care staff for consultation and/or treatment without the inmate having first been contacted or scheduled for treatment by health care staff.

*"Health Care Services"* is defined as medical, mental health, dental, pharmaceutical, diagnostic, and ancillary services provided to inmates/patients to identify, diagnose, evaluate, and treat a medical, psychiatric, or dental condition.

*"Health Care Staff"* is defined as those persons licensed by the State of California to provide health care services who are either employed by CDCR, or are under contract with CDCR, to provide health care services to inmates.

#### III. PROCEDURE

- A. All inmates shall initiate their health care visits by submitting a CDCR Form 7362 Health Care Service Request and shall be provided an opportunity to report an illness or any other health problem. Inmates/patients shall receive an evaluation of the condition as well as medically necessary treatment and follow-up treatment by CDCR health care staff.
- B. Inmates shall pay a co-payment fee of five dollars (\$5.00) for each inmate-initiated health care visit. The co-payment fee for each inmate-initiated dental visit shall:
  1. Cover the evaluation, assessment, and medically necessary treatment of the condition, including follow-up services that relate to the initial condition and that are determined by health care staff to be necessary.
  2. Be charged to the trust account of the inmate. Inmates without sufficient funds at the time of the charge, and who remain without sufficient funds for 30 days after the date of the charge, shall not be charged for any remaining balance of the co-payment fee.

3. Be waived for the following:
  - a. Emergencies – any medical or dental condition that, as determined by health care staff, requires immediate evaluation and therapy to prevent death, severe or permanent disability, or to alleviate or lessen objectively apparent and disabling pain. Signs of objectively apparent and disabling pain may include, but are not limited to, visible injuries, high blood pressure, rapid heart rate, sweating, pallor, involuntary muscle spasms, nausea and vomiting, high fever, and facial swelling. Emergencies also include, as determined by health care staff, necessary crisis intervention for inmates suffering from situational crises or acute episodes of mental illness.
  - b. Diagnosis and treatment of communicable disease conditions as outlined in Title 17, Chapter 4, Subchapter 1, Section 2500 of the *California Code of Regulations*, including Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS).
  - c. Diagnosis and necessary mental health treatment for which there is a clinical determination of mental illness.
  - d. Follow-up health care services defined as any request or recommendation by a member of the health care staff to provide subsequent needed health care services.
  - e. Health care services necessary to comply with state law and/or regulations that shall include, but not be limited to, annual testing for tuberculosis and mandated examinations.
  - f. Reception Center (RC) health screening and evaluations.
  - g. Inpatient services, extended care, or skilled nursing service.
- C. All inmates shall be charged a co-payment for dental services on a per visit basis. The \$5.00 co-payment program shall not affect the amount of services provided during each dental visit. If more than one dental visit is needed to complete an inmate's dental treatment on a specific tooth, and the subsequent visit is NOT related to the initial condition, the subsequent visit shall also be charged a co-payment fee.
  1. Dental services provided in accordance with a prescribed dental treatment plan are not to be considered as a follow-up dental visit.
  2. Dental procedures considered as follow-up dental visits, which are not charged a co-payment include, but are not limited to:
    - a. Suture removals.
    - b. Post-operative dental procedures of any type, as long as the procedures are initiated by the dentist and documented in the progress notes indicating the need for the return visit.
    - c. Denture adjustments following the delivery of a new or repaired denture.
    - d. Postponement of any dental procedure that the dentist believes is clinically necessary.
    - e. Any visit initiated by a health care staff member.

3. Processing of CDCR Form 7362:
  - a. Ensure that the form is signed by the dental provider.
  - b. Ensure that the inmate is given the yellow copy.
  - c. Send the pink copy to the Inmate Trust Office for payment deduction from the inmate's trust account if there is a charge for the visit.
  - d. Place originals in the Unit Health Record.

## Chapter 5.2

### Priority Health Care Services Ducat Utilization (E)

#### I. POLICY

The CDCR shall develop and utilize a system of priority ducats to provide inmates timely access to dental care.

#### II. PURPOSE

To develop a process that provides all inmates with access to dental care through the successful implementation of a dental ducat delivery process within CDCR.

These procedures shall be used to establish a method of distributing and delivering of dental ducats that:

- Provides inmates with timely access to dental care.
- Provides a system of accountability for the distribution and delivery of dental ducats.
- Provides a process for documenting and processing an inmate/patient's refusal or failure to report for scheduled dental appointments.

#### III. PROCEDURES

##### General Requirements

- A. Each institution shall establish procedures that document the processing and delivery of dental ducats. These procedures shall include:
  1. A written methodology for the distribution of ducats within the institution, which shall include instructions that, upon receipt, the facility or program unit custodial supervisor or designated custodial staff shall be responsible for delivering the ducats to the inmates in a timely manner, in accordance with the correctional facility's operational procedures.
  2. A written methodology for documenting the delivery of the dental ducats to the inmates.
  3. A written methodology for re-routing dental ducats to inmates who have received intra-facility bed/cell moves, which ensures that inmates will receive the ducats with sufficient time to report for scheduled appointments.
  4. Development Disability Program (DDP)/Disability Placement Program (DPP) designated inmates shall be given specific instructions concerning the time and location of their scheduled appointment(s). Custody staff delivering the ducats to such designated inmates shall utilize effective forms of communication to ensure that the inmate(s) arrive at the designated appointment location.

5. A notation that Health Care Services ducats shall be treated as Priority ducats and be of a separate and distinct color from the other ducats (e.g., not goldenrod or green). For the purpose of this policy, priority ducats indicate dental necessity.
6. The inmate/patient is responsible to report to the dental appointment as indicated on the priority health care ducat.
7. Custody staff shall deliver priority health care ducats to inmates/patients prior to his/her scheduled dental appointment.
8. The custody officer shall instruct the inmate/patient to report to the dental appointment as indicated on the ducat.

**B. Dental Ducat Cancellation or Rescheduling**

1. In the event an inmate/patient informs the Correctional Officer (CO) delivering the ducat that he/she wishes to cancel or reschedule his/her appointment, the CO shall attempt to determine the inmate's reason for canceling or rescheduling the appointment.
2. Upon completion of ducat distribution and delivery, the custody supervisor shall inform the Chief Dentist (CD) or dentist, or their designee, of the inmate/patient's cancellation or request for rescheduling an appointment and their stated reason for doing so. The inmate/patient's cancellation or request for rescheduling an appointment will be regarded as an intentional failure to report and is subject to the provisions outlined in Section III.C.3 of this policy.

**C. Failure to Report for Dental Ducats**

1. If an inmate/patient has not cancelled a scheduled dental appointment but fails to report for the appointment, the Dental Assistant (DA) or Office Technician (OT) shall immediately contact the designated custody supervisor. If the DA or OT is not available then the dentist shall immediately contact the designated custody supervisor.
2. *Unintentional Failure:*
  - If it is determined that the inmate/patient failed to report for reasons beyond his or her control, the matter shall be referred to the CD, who shall seek to ensure that corrective measures are taken.
  - The dentist, or designee, shall reschedule the inmate/patient, and record the new appointment in the Daily Dental Treatment/Appointment Log (DDTAL), (Reference: Chapter 5.3 *Recording and Scheduling Dental Patient Visits*). If an inmate/patient unintentionally fails to report to a dental appointment, then the dentist shall see the inmate/patient within 35 days following the unintentional failure or within the established timeframe for the inmate/patient's dental treatment priority, whichever is sooner. If an inmate/patient unintentionally fails to report to a dental triage, then the inmate/patient shall be seen by a dentist for a dental triage within the following 72 hours, excluding weekends and holidays.
  - The DA or OT shall document the reason for the inmate/patient's failure to report to the scheduled appointment, as well as the date, and time, of the

rescheduled appointment on the CDCR Form 237 C *Dental Progress Notes* or the CDCR Form 237 C-1 *Supplement to Dental Progress Notes* in the "Services Rendered" section. Upon completion, the DA or OT shall file either the CDCR Form 237 C or 237 C-1 in the dental section of the inmate/patient's Unit Health Record (UHR).

3. *Intentional Failure:*

- If it is determined that the failure to report was intentional on the part of the inmate/patient, then the dentist, or designated DA or OT shall request that the inmate/patient be sent or escorted to the dental clinic. If the inmate/patient refuses to go to the dental clinic, then the custody staff shall notify the dentist, or designated DA or OT. The dentist shall record the intentional failure to report as a refusal on the CDCR Form 237 C or C-1, and complete a CDCR Form 7225, *Refusal of Treatment*. The dentist, or designee, shall file both forms in the dental section of the inmate/patient's UHR. The dentist, or designee, shall also document the failed appointment in the Daily Dental Treatment/Appointment Log (DDTAL), (Reference: Chapter 5.3 *Recording and Scheduling Dental Patient Visits*).
  - In the event licensed dental staff (i.e., the Primary Care Provider, (PCP), the staff who initiated the ducat, an outside consultant, etc.) have concerns related to the effect of the cancellation or postponement on the inmate/patient's health, a face-to-face interview and counseling session will occur with the inmate/patient. This interview shall include counseling the inmate/patient about any risk involved in canceling or postponing the clinic visit. The inmate/patient interview and counseling shall be documented on either a CDCR Form 237 C or 237 C-1 and the form filed in the dental section of the inmate/patient's UHR. If the inmate/patient refuses the face-to-face interview and counseling session, then the dentist shall record this refusal as indicated previously in this policy Section III.C.3.
  - The inmate/patient shall be required to submit a CDCR Form 7362 *Request for Medical/Dental Services* in order to access future dental care.
4. Dental staff and/or custodial staff, as appropriate, shall initiate progressive inmate disciplinary action, as necessary, based on the factors of the inmate/patient's failure to report, (Refer to *California Code of Regulations*, Title 15, Section 3312).

## Chapter 5.3

### Recording and Scheduling Dental Visits (E)

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#### I. POLICY

All inmate/patient requests for dental treatment, via the CDCR Form 7362 *Request for Medical/Dental Services*, shall be recorded on the CDCR Form 7362 Request for Dental Treatment Log (RDTL) and scheduled on the Daily Dental Treatment/Appointment Log (DDTAL). The Chief Dentist (CD) shall maintain a file and keep all records of the RDTL and the DDTAL for a period of five years.

#### II. PURPOSE

To standardize the recording and scheduling of dental inmates/patients visits.

#### III. PROCEDURE

The CDCR Form 7362 Request for Dental Treatment Log (RDTL)

A. The RDTL is used for recording inmate/patient requests for dental treatment via the CDCR Form 7362 *Request for Medical/Dental Services*, and scheduling dental triages.

1. All inmates/patients shall be scheduled in advance, based on treatment priority, on an equal basis and after having met oral self-care and length of incarceration eligibility requirements.
2. Inmates/patients with Routine Rehabilitative treatment needs (i.e., Priority 3 needs), normally shall not be seen ahead of scheduled inmates/patients. Exceptions would include inmates/patients who need to be scheduled for post-operative/follow-up care, or inmates/patients who had a previous Routine Rehabilitative (Priority 3) appointment canceled by the clinic.
3. The dentist, or designee, shall record each request for dental services via a CDCR Form 7362 in the RDTL. A CDCR dentist shall review, initial, and date each CDCR Form 7362, within one day, with the exception of weekends and holidays, of the dental clinic's receipt of CDCR Form 7362. The dentist, or designee, upon completing the review, shall schedule a dental triage based on the urgency of the request. Inmates/patients who indicate Priority 1 dental needs shall be seen for a dental triage within 72 hours, excluding holidays, of the dental clinic staff receiving the CDCR Form 7362. All other inmates/patients shall be seen for a dental triage within ten days, with the exception of weekends and holidays, after the receipt of the CDCR Form 7362 in the dental clinic.
4. If an inmate/patient fails to appear for a dental triage, then the dentist, or designee, shall follow the policy for "Failure to Report for Dental Ducats" as outlined in Chapter 5.2 *Priority Health Care Services Ducat Utilization* Section III.C.

5. If an inmate/patient's dental triage is cancelled by the dental clinic, then the inmate/patient shall be seen by a dentist within the following 72 hours, excluding weekends and holidays.

The Daily Dental Treatment/Appointment Log (DDTAL)

B. The DDTAL is used for recording daily inmate/patient dental visits.

1. The dentist, or designee, shall be responsible for entering the treatment provided to the inmate/patient in the *Treatment/Disposition* column. The dentist, or designee, is also responsible for documenting the current disposition of each inmate/patient. There shall be no blanks left in this column at the end of the day.
2. For inmates/patients with a dental treatment Priority 1 or Priority 2, as recorded in the *Dental Priority After Appointment* column, the dentist shall ask the inmate/patient, at the end of the appointment, if he or she would like to initiate another request for dental services via the CDCR Form 7362.

If the inmate/patient wishes to request another dental appointment, then he or she shall complete and submit another CDCR Form 7362 at the end of the dental appointment. At this time, the dentist shall initial and date the CDCR Form 7362 and the dentist, or designee, shall schedule these inmates/patients for the next available appointment for the inmate/patient's indicated dental priority. The dentist, or designee, shall enter the inmate/patient's next appointment date in the *Date of Next Appointment* column. These inmates/patients shall be assessed a co-payment at the following appointment, subject to provisions as outlined in Chapter 5.1 *Inmate Co-payment for Health Care Services*, (Authority: Title 15, Section 3354.2). The dentist, or designee, shall file the CDCR Form 7362 in the dental section of the inmate/patient's Unit Health Record (UHR).

If the inmate/patient refuses to request dental services via the CDCR Form 7362 at the end of the dental appointment, then the dentist shall record the refusal on the CDCR Form 237 C *Dental Progress Notes* or the CDCR Form 237 C-1 *Supplement to Dental Progress Notes* in the "Services Rendered" section, and complete a CDCR Form 7225 *Refusal of Treatment*. Upon completion, the dentist, or designee, shall file the CDCR Form 7225 and either the CDCR Form 237 C or 237 C-1 in the dental section of the inmate/patient's UHR. The inmate/patient shall submit a CDCR Form 7362 in order to access future dental care.

3. For inmates/patients with a dental treatment Priority 3, Priority 4, or Priority 5, as recorded in the *Dental Priority After Appointment* column, at the dentist's discretion, the dentist may ask the inmate/patient, at the end of the appointment, if he or she would like to initiate another request for dental services via the CDCR Form 7362. Based on the inmate/patient's response, the dentist, and designee, shall follow the aforementioned provisions in Section III.B.2 of this policy. All inmates/patients not asked about initiating another request for dental services at the end of the appointment, shall submit a CDCR Form 7362 in order to access future dental care.
4. The dentist, or designee, shall record "Failed" in the *Treatment/Disposition* column for each inmate/patient who did not honor his or her dental visit, or "Cancelled by Clinic" for

appointments cancelled by dental staff. Additionally, the reason for the inmate/patient's failure to appear for his or her appointment, or for the clinic's cancellation of the appointment, shall be recorded in the *Treatment/Disposition* column.

5. If an inmate/patient needs to be rescheduled, a notation in the *Treatment/Disposition* column should reflect the reason for the change, and the new appointment date entered into the *Date of Next Appointment* column. At the rescheduled appointment date, the *Treatment/Disposition* column should reflect the reason why the inmate/patient was moved. The dental staff shall initial after each entry required to reschedule an inmate/patient.
6. Unscheduled inmate/patient visits, those resulting from an indication of an emergency or urgent dental need, shall be recorded on the DDTAL. The abbreviation "U/S" (unscheduled), shall be recorded in the *Patient Name* column of the DDTAL, along with the inmate/patient's last name and the CDCR number.
7. If an inmate/patient fails to appear for a scheduled appointment, then the dentist, or designee, shall follow the policy for "Failure to Report for Dental Ducats" as outlined in Chapter 5.2 *Priority Health Care Services Ducat Utilization* Section III.C.
8. If an inmate/patient's scheduled appointment is cancelled by the dental clinic, then the inmate/patient shall be seen by a dentist within the following 35 days or within the established timeframe for the inmate/patient's dental treatment priority, whichever is sooner.

C. General requirements for maintaining the DDTAL and the RDTL.

1. Inmates who request care, require care, and are eligible for care, shall be scheduled for a dental visit.
2. A separate DDTAL and RDTL shall be maintained for each dental care provider (i.e., each Dentist, Contractor, Consultant, etc). Additionally, one master DDTAL and one master RDTL shall be used per clinic regardless of the number of dentists assigned to the clinic.
3. All information shall be entered in black or blue ink. Changes or error corrections are made by drawing a single line through the information being changed or corrected. The individual making such changes shall initial, date, and note the reason for the changes.
4. A separate page shall be used for scheduling each dentist's appointments, and a separate page shall be used for each day. The number of scheduled inmates/patients on a single page should not exceed the number of lines available. If necessary a continuation page should be used to complete the day's scheduled appointments.
5. Every column for every inmate/patient entry shall be completed.
6. At the end of each day, indicated columns shall be totaled and the number entered at the bottom of the page.

## CHAPTER 5.4

### Dental Treatment Priorities (E)

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#### I. POLICY

The dental treatment needs of CDCR inmates shall be addressed based on the priority of need, length of incarceration, and the inmate's demonstrated willingness to engage in oral health self-care. A CDCR dentist shall assign an objective dental priority score to each newly admitted inmate upon entering the CDCR and after each dental visit.

#### II. PURPOSE

To ensure that all inmates have equitable access to dental services based upon the occurrence of disease, significant malfunction, or injury, and medical necessity.

#### III. PROCEDURE

- A. All inmates/patients shall be assigned a dental treatment priority at the Reception Center screening and again at the time of their complete dental examination at a Mainline Institution. This priority shall be reviewed and appropriately modified after each dental visit.

Dental treatment shall be prioritized as follows:

- Priority 1: Urgent Care
- Priority 2: Interceptive Care
- Priority 3: Routine Rehabilitative Care
- Priority 4: No Dental Care Needed
- Priority 5: Special Needs Care

Emergency dental treatment shall be available on a 24 hour, seven days per week basis.

- B. In general, dental visits shall be scheduled based on the inmate/patient's dental treatment priority, as determined by a CDCR dentist.
- C. The dentist may vary the dental treatment priority if he or she judges it to be necessary for the protection of the inmate/patient's overall health.
- D. Once a dentist has completed a dental triage, treatment shall be provided within the timeframes indicated for each dental treatment priority.
- E. Inmates/patients with less than one year of incarceration time remaining on their sentence in a Mainline Facility shall receive only Emergency, Priority 1, and Priority 2 dental care. Inmates/patients with less than six months of incarceration time remaining on their sentence in a Mainline Facility shall receive only Emergency and Priority 1 dental care.

- F. Inmates/patients whose treatment status, as a result of their own neglect, reverts to pre-treatment conditions, shall receive only Emergency and Priority 1 dental care, and shall not be eligible for Priority 2, or Priority 3 levels of care.
- G. All inmates/patients must maintain an acceptable level of dental health and oral hygiene self-care, which shall be measured and evaluated for each patient by use of the dental plaque index score (PI). Inmates/patients must maintain a PI of 20% or less in order to qualify for Priority 3 care. Inmates/patients with a PI above 20% shall receive Emergency, Priority 1, Priority 2, and Priority 5 dental care. (Reference: Chapter 2.13 *Facility Level Dental Health Orientation/Self-Care*).

DENTAL TREATMENT PRIORITIES		
PRIORITY LEVEL	DESCRIPTION OF NEED	ELIGIBILITY <sup>1</sup>
<b>Emergency Care:</b> Immediate Treatment	Inmates requiring treatment of an acute oral or maxillo-facial condition, which is likely to remain acute, worsen, or become life threatening without immediate intervention.	All inmates are eligible for Emergency Care regardless of length of incarceration or oral health self-care.
<b>Priority 1A – 1C</b> Urgent Care:		All inmates are eligible for Priority 1 Care regardless of length of incarceration or oral health self-care.
<b>1A:</b> Treatment within 72 hours.	Inmates with dental conditions of sudden onset or in severe pain, which prevents them from carrying out essential activities of daily living.	
<b>1B:</b> Treatment within 30 days.	Inmates requiring treatment for a sub-acute hard or soft tissue conditions that are likely to become acute without early intervention.	
<b>1C:</b> Treatment within 60 days.	Inmates requiring early treatment for any unusual hard or soft tissue pathology (e.g., acute ulcerative necrotizing gingivitis, severe localized or generalized periodontitis).	
<b>Priority 2</b> Interceptive Care: Treatment within 120 days	Advanced caries or advanced periodontal pathology requiring the use of intermediate therapeutic or palliative agents or restorative materials, mechanical debridement, or surgical intervention. Edentulous or essentially edentulous, or with no posterior teeth in occlusion. Moderate or Advanced Periodontitis requiring non-surgical deep scaling and Root Planning procedures (see Chapter 2.4 <i>Periodontal Disease Program</i> ). Chronically symptomatic impacted tooth requiring removal or specialty referral, surgical procedures for the elimination of pathology, or restoration of essential physiologic relationships.	Inmates must have over 6 months remaining to serve on their sentence within a CDCR institution and are eligible for Priority 2 Care regardless of oral health self-care.
<b>Priority 3</b> Routine Rehabilitative Care: Treatment within one year.	An insufficient number of posterior teeth to masticate a regular diet (seven or fewer occluding natural or artificial teeth) requiring a maxillary and/or mandibular partial denture; one or more missing anterior teeth resulting in the loss of anterior dental arch integrity, requiring a transitional anterior partial denture. Carious or fractured dentition requiring restoration with definitive restorative materials or transitional crowns. Gingivitis or Mild Periodontitis requiring routine prophylaxis. Definitive root canal treatment for non-vital, single rooted teeth, which are restorable with available restorative materials. The inmate's overall dentition must fit the criteria in Chapter 2.9 <i>Endodontics</i> . Non-vital, non-restorable erupted teeth requiring extraction.	Inmates must have over 12 months remaining to serve on their sentence within a CDCR institution and must meet oral health self-care requirements as specified in Chapter 2.13 <i>Facility Level Dental Health Orientation/Self-Care</i> .
<b>Priority 4: No Dental Care Needed</b>	Inmates not appropriate for inclusion in Priority 1, 2, 3, or 5.	
<b>Priority 5:</b> Special Needs Care	Inmates with special needs (see Chapter 4.5, Dental Authorization Review Committee for methods of recommending treatment).	All inmates with special needs are eligible for Priority 5 Care regardless of length of incarceration or oral health self-care.

<sup>1</sup>Treatment to be provided within the specified timeframe, from the time of completion of the dental triage.

<b>DENTAL TREATMENT PRIORITIES</b>		
<b>PRIORITY LEVEL</b>	<b>DESCRIPTION OF NEED</b>	<b>ELIGIBILITY**</b>

\*\*Eligibility determined by length of incarceration and level of oral self care.

## CHAPTER 5.5

### Dental Treatment Plan (E)

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#### I. POLICY

All Mainline Facility inmates whose reception center (RC) examinations indicate the need for dental treatment shall have an individual treatment plan developed by a CDCR dentist and shall be provided an explanation of its advantages and disadvantages.

#### II. PURPOSE

To establish guidelines for the development of individual dental treatment plans for Mainline Facility inmates in the CDCR.

#### III. PROCEDURE

- A. Treatment plans shall be documented in the Treatment Plan Section on the front side of the CDCR Form 237B.
- B. All inmates/patients receiving routine comprehensive dental care shall have a Dental Treatment Plan recorded on CDCR Form 237B, prior to receiving routine dental treatment.
- C. Appropriate radiographs shall be available and interpreted by the attending dentist when developing a dental treatment plan.
- D. The dental treatment plan shall:
  1. Be prioritized by listing the most urgent Priority 1 treatment needs first followed by Priority 2, 3, and 4 treatment needs.
- E. A complete scaling and prophylaxis shall be performed at the beginning of the dental treatment plan unless emergent or urgent needs are of higher priority.
- F. The schematic tooth chart located on the front of the CDCR 237 B must be completed utilizing *black ink*.
- G. Each individual tooth indicated for restoration shall have the surface(s) noted. As the restoration/procedure is completed, it shall be noted in the Treatment Rendered section of the CDCR 237B.
- H. Once treatment is completed on a tooth, dental staff shall fill in the restoration or procedure rendered on the schematic tooth chart using *black ink*, in the "Restoration and Treatments Completed during Incarceration" section, on the reverse side of the CDCR Form 237B.
- I. All dental care provided to inmates/patients, including radiographs, examinations, prophylaxis, restorations, endodontic therapy, prosthetics, periodontal therapy, oral surgery,

follow-up care, and other treatment indicated, shall be noted in the Treatment Rendered section of the CDCR Form 237B.

- J. All services rendered, written procedures, and medication orders shall be signed and dated by the attending dentist.
- K. A complete examination of the head and neck region shall be completed as part of the examination and treatment plan, and shall be documented on the CDCR Form 237B.
- L. The results of the Periodontal Screening and Recording (PSR) shall be completed during the initial dental examination, and shall be filed in the UHR.
- M. The inmate information block located in the lower portion of the CDCR Form 237B shall be completed on each form for each inmate. This information must be completed if any entry is made on any part of the form.
- N. Any additions or corrections to the original dental treatment plan made during the course of treatment shall be entered on the back of the CDCR Form 237B in the "Additions to Dental Treatment Plan" section.
- O. If an inmate is transferred to another institution and assigned a new treating dentist, that dentist shall review the dental treatment plan and indicate the review in the "Dental Treatment Plan Review" section of the CDCR Form 237B. A review is not required if the inmate is being seen by the new institution's dental staff for only one appointment, or is being treated on a specific referral basis.
- P. All CDCR Form 237B's shall be maintained in chronological order in the UHR.

## Chapter 5.6

### Interpreter Services – Monolingual/Non-English Speaking Inmates (E)

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#### I. POLICY

It shall be the policy of the CDCR to utilize language assistance services to assist in providing dental health care to inmates/patients who are monolingual/non-English speaking.

#### II. PURPOSE

To establish guidelines for the appropriate utilization of interpreter services when providing dental care to monolingual/non-English speaking inmates/patients.

#### III. PROCEDURE

A. Custody shall be responsible for identifying monolingual/non-English speaking inmates/patients and shall provide, upon request, a list of all such inmates/patients eligible for qualified interpreter services to the dental department.

B. Eligible inmates/patients must be provided qualified interpreter services during all phases of the provision of health care.

C. Available medical translation services for eligible non-English speaking inmates/patients shall be utilized as follows:

1. Qualified bilingual health care staff at the institution.
2. Contracted language translation services. Certified medical interpretation services in over 140 languages are provided by, among others, the following companies.
  - Merino Language Line (360) 693-7100 ext. 118
  - Language Line Services (831) 648-7189
  - AT&T Translation Services (800) 752-0093 ext. 196
3. Inmates/patients may request that non-health care staff be used as interpreters. The inmate/patient *must* sign a confidentiality release form in order for non-health care staff to serve as interpreters.
4. Inmates/patients may request that a cellmate or other inmate serve as interpreter. The inmate/patient *must* sign a confidentiality release form in order for a cellmate or other inmate to serve as an interpreter.
5. An interpreter list is to be available from the Office Technician (OT).

6. The OT will maintain supply of confidentiality releases forms in the operatory.
7. Inmates shall only be allowed to serve as interpreters when bilingual health care staff or certified medical interpretation services are not available for the needed language.
8. When urgent/emergent health care must be provided to a non-English speaking inmate, and a qualified interpreter is not available in a timely manner, any available interpreter may be utilized. In such situations, a qualified interpreter must be summoned, and upon arrival immediately replace the non-qualified interpreter.
9. Use of interpreter services shall be noted in the Unit Health Record on CDCR Form 237B in the "Services Rendered" section.

**Definitions.**

**Eligible Inmates:** Monolingual/non-English speaking inmates who are not able to communicate effectively in spoken English including:

- Inmates who speak only languages other than English and who have no speaking ability in English.
- Inmates who are able to speak their native language, and are able to speak some English, but are not fluent enough in English to understand basic facility activities and proceedings.

**Qualified Interpreter:** Any CDCR employee who has been determined to have a satisfactory level of competency in both English and the inmate's language, and is thereby qualified to perform interpretation services.

**Interpretation:** The processes of orally assisting an eligible inmate to communicate in the English language for facility-based proceedings; and to orally interpret into the inmate's spoken language, written documents or spoken responses in English to the inmate.

## CHAPTER 5.7

### Inmate's Right to Refuse Treatment (E)

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#### I. POLICY

The CDCR, its agents, and the Division of Correctional Health Care Services (DCHCS), shall adhere to the requirements set forth in *California Code of Regulations* Title 15, Article 8, Section 3351 "Inmate Refusal of Treatment."

#### II. PURPOSE

To set forth procedures to ensure and document that an inmate's right to refuse medical treatment is observed.

#### III. PROCEDURE

- A. Refusal of dental care must be documented by completing form CDCR 7225 *Refusal of Examination and/or Treatment*.
- B. All refusals of dental services must be reviewed and countersigned by a dentist prior to being placed in the inmate's Unit Health Record (UHR).
- C. A complete and thorough documentation of the inmate's refusal is to be entered in the Dental Treatment Record, including:
  1. A description of the dental service(s) being refused.
  2. Health consequences of refusing the dental service(s).
  3. Alternative treatment options, if any.
- D. An inmate may accept or decline any or all portions of a recommended dental treatment plan.
- E. An inmate's decision to refuse treatment is reversible at any time and shall not prejudice future treatments.
- F. The completed CDCR 7225 *Refusal of Examination and/or Treatment* shall be placed in the appropriate area of the Dental Section in the Unit Health Record.
- G. For each instance of an inmate's refusal of treatment, a CDCR 128C *Chrono* must also be completed and a copy placed in the inmate's central file.
- H. The Office Technician (OT) will maintain a supply of CDCR Form 7225 *Refusal of Examination and/or Treatment*.

## CHAPTER 5.8

### Medical Emergencies in the Dental Clinic (E)

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#### I. POLICY

The CDCR shall ensure that emergency medical services are provided in the dental clinic as necessary, that each dental clinic maintains an up to date emergency kit containing supplies and equipment to be used in treating inmates/patients during medical emergencies, and that all dental personnel receive annual training on the use of these kits.

#### II. PURPOSE

To provide inmates/patients prompt access to emergency medical care as needed in the dental clinic, to establish the requirement that all dental clinics have a standardized emergency kit that might be used in treating inmates/patients during medical emergencies, and to establish training requirements on the use of these kits.

#### III. PROCEDURE

##### A. Definitions:

1. *Medical Emergency*: An emergency exists when there is a sudden, marked change in an inmate's condition so that action is immediately necessary for the preservation of life or the prevention of serious bodily harm to the inmate or others, and it is impracticable to first obtain consent, (Reference: California Code of Regulations Title 15, Article 8, Section 3351). An emergency, as determined by dental staff, includes any medical or dental condition for which evaluation and treatment are immediately necessary to prevent death, severe or permanent disability, or to alleviate or lessen disabling pain. Examples may include visible injuries, high blood pressure, rapid heart rate, sweating, pallor, involuntary muscle spasms, nausea and vomiting, high fever, and facial swelling, (See attached Table 1: *Medical Emergency Situations/Common Treatment Guidelines*). An emergency, as determined by dental staff, also includes necessary crisis intervention for inmate/patient's suffering from situational crises or acute episodes of mental illness.
2. *Dental Staff*: Includes dentists, dental hygienists, and any other personnel in the dental clinic that are qualified to provide Basic Life Support (BLS), including Cardiopulmonary Resuscitation (CPR).
3. *First Responder*: The first dental staff member, certified in BLS, on the scene of a medical emergency in the dental clinic whose priority is the preservation of life and to proceed with necessary basic first aid.

##### B. General Requirements:

1. The first responder to a medical emergency in the dental clinic shall take immediate action to preserve life and is responsible to complete the CDCR Form 7219 *Medical Report of Injury or Unusual Occurrences*. In addition, the first responder shall record the

medical emergency on the CDCR Form 237 C *Dental Progress Notes* or the CDCR Form C-1 *Supplement to Dental Progress Notes* in the Subjective, Objective, Assessment, Plan, Education (SOAPE) format. Upon completion of the CDCR Form 237 C or C-1 the first responder, or designee, shall file these forms in the dental section of the inmate/patient's Unit Health Record (UHR). The first responder, or designee, shall submit a copy of the CDCR Form 7219 and any other required incident reports to the Chief Dentist (CD) within 24 hours of the incident.

2. All dental staff shall be trained in BLS, including CPR, and in the proper use of the Automated External Defibrillation (AED) equipment.
3. Dental staff trained in BLS shall initiate CPR in all cases of cardiac/respiratory arrest.
4. Dental staff and emergency responders who initiate CPR shall continue resuscitation efforts until one of the following occurs:
  - Effective spontaneous circulation and ventilation have been restored.
  - Resuscitation efforts have been transferred to other trained staff who continue BLS.
  - Care is transferred to a physician who determines that resuscitation should be discontinued.
  - The emergency responders are unable to continue resuscitation because of exhaustion or safety and security issues that could jeopardize the lives of others.
  - A valid Do-Not-Resuscitate order is presented to the emergency responders.
5. If an inmate/patient is unable to be resuscitated, the decision to terminate CPR shall be made by a physician or community emergency medical service. Pronouncement of death shall be made by a physician, according to acceptable medical standards.
6. While preservation of a crime scene is a valuable investigatory tool, this shall not preclude or interfere with the delivery of health care.
7. Custody requirements shall not unreasonably delay medical care in a life-threatening situation.
8. The CD at each institution shall ensure that a Local Operating Procedure (LOP) for medical emergencies in the dental clinic is developed and approved. This LOP, at a minimum, shall indicate who is responsible for notifying the medical department, and who is responsible for calling an ambulance, if needed. The CD shall be responsible for implementing and annually reviewing this LOP.
9. Dental staff shall receive annual training and review of response procedures for medical emergencies in the dental clinic.
10. Required emergency equipment, supplies, and emergency medications shall be maintained and readily available in the dental clinic.

**C. Emergency Response:**

1. All dental staff, within the dental clinic, shall immediately respond to an inmate/patient having a medical emergency in the clinic.
2. Most life threatening medical emergencies in the dental clinic are initiated by the inmate/patient's inability to withstand physical or emotional stress; by their reaction to drugs; or as a complication of a pre-existing systemic disease. Cardiopulmonary systems are likely to be involved, requiring some emergency supportive therapy.

In such circumstances it is imperative that the first responder place the inmate/patient in a supine position (if possible), and initiate the following ABC's of Emergency First Aid:

A – Airway – Open passage and clear if necessary.

B – Breathing – Assure patient is breathing (provide artificial respiration if necessary).

C – Circulation – Check carotid pulse. If present, check blood pressure. If pulse is absent, give cardiopulmonary respiration and call the medical clinic.

3. The dentist shall assume responsibility of the medical emergency, and ensure that a dental staff member notifies the medical department of the emergency as soon as possible.
4. The dentist shall continue to assume responsibility of the medical emergency, pending the arrival of a physician.
5. The physician, upon arrival to the medical emergency, shall assume responsibility for any further treatment. The dental staff shall provide assistance to the medical staff when directed.
6. The inmate/patient shall not be released from the dental clinic until it is determined that he/she is out of danger or until the medical department either releases or transports the inmate/patient.
7. The dentist, if not the first responder, shall record the medical emergency on the CDCR Form 237 C or the CDCR Form C-1 in the Subjective, Objective, Assessment, Plan, Education (SOAPE) format. Upon completion of the CDCR Form 237 C or C-1 the dentist, or designee, shall file these forms in the dental section of the inmate/patient's UHR. In addition, the dentist shall assist in the completion of any other required incident reports and forward a copy of the aforementioned documents to the CD within 24 hours of the incident.

**D. Emergency Equipment and Supplies:**

1. Each dental clinic at each facility shall have emergency kits that contain at least the following supplies and equipment:
  - Portable oxygen tank with tubing and mask.
  - Ambu-bag.

- Cardiopulmonary Resuscitation (CPR) one-way pocket mask.
  - Brook Airway.
  - Blood pressure cuff.
  - Stethoscope.
  - Alcohol sponges or gauze.
  - At least two 3cc syringes.
  - Drugs:
    - Benadryl 50mg Ampoules (2)
    - Hydrocortisone sodium succinate (Solucortef) 250mg Ampoules (2)
    - Epinephrine 1:1000 Ampoules (2), (0.3cc)
    - Nitroglycerine Tablets 0.4mg (1 bottle of 25 tablets)
    - Ammonia Inhalant Buds (5)
    - One tube of Glucose Gel in applicator tube, 10 gm. Per dose
    - Ventolin or Proventil Metered-Dose Inhaler (MDI)
2. On a monthly basis, a dentist shall review the contents of the emergency kit, including the expiration dates and clarity of all drugs, and record this review along with the review date on a sign-off sheet. This sign-off sheet shall be kept in the emergency kit.
  3. The CD shall keep a copy of the sign off sheet on file for a period of five years, as documentation of this review.
  4. Upon completion of the review, the dentist shall notify the CD and the institutional pharmacist of any drugs in the emergency kit requiring replacement, including expired drugs. The institutional pharmacist shall replace all drugs as needed. In addition, the pharmacy shall keep a documented record of the expiration dates of the emergency kit drugs.

**E. Medical Emergency Response Training:**

1. The CD shall ensure that all dental personnel receive initial training on the assigned responsibilities and specific tasks to be completed during a medical emergency in the dental clinic, and in the use of the dental emergency kit. The CD shall ensure that all dental personnel are retrained annually on the aforementioned topics. The CD shall document and kept a record of this training on file for a period of five years.

Table 1. MEDICAL EMERGENCY SITUATIONS/ COMMON TREATMENT GUIDELINES

Situation	Symptoms	Treatment Guidelines
<b>SYNCOPE/ PSYCHOGENIC SHOCK</b>	<p><b>EARLY:</b> Pallor. Sweating. Nausea.</p> <p><b>LATE:</b> Pupillary dilation. Yawning. Decreased blood pressure. Bradycardia (slow pulse). Convulsive movements. Unconsciousness.</p>	<p>Lower head slightly, elevate legs and arms, (except in pregnancy; roll on left side). Administer Oxygen. Administer Spirits of Ammonia. Record vital signs. If no response, call for medical assistance. If blood pressure is too low: Lower head, raise arms, and legs. Vasopressor drugs – EPINEPHRINE 0.3cc 1:1,000 SC.</p>
<b>HYPOVOLEMIC SHOCK</b>  <i>NOTE:</i> Surgical blood loss accompanied by dehydration may readily precipitate hypovolemic shock	<p>Weak, thready, rapid pulse. Decreased blood pressure. Pallor. Coldness. Cyanosis.</p> <p><i>NOTE:</i> Fluid loss in the surgical patient may be secondary to: Surgical blood loss. Pre-op apprehension and poor fluid intake. Post-op oral discomfort and poor fluid intake. Certain hypertensive medications (diuretics).</p>	<p>Administer Oxygen. Encourage oral fluid intake. Record vital signs. Contact the medical department for assistance.</p>
<b>MILD ALLERGIC REACTION</b>	<p>Skin Reactions: Mild pruritus (itching). Mild urticaria (rash).</p>	<p>Diphenhydramine HCL (Benadryl) 25 – 50 mg IM. Refer to the medical department for follow-up.</p>
<b>SEVERE ALLERGIC REACTION</b>	<p>Skin Reactions: Severe pruritus (itching). Severe urticaria (rash).</p> <p>Swelling of lips, eyelids, cheeks, pharynx, and larynx, (angioneurotic edema): Cardiovascular – fall in blood pressure. Central Nervous System – loss of consciousness, dilation of pupils. Respiratory – Wheezing, choking, cyanosis, hoarseness.</p>	<p>EPINEPHRINE 0.3cc 1:1000 SC (Contraindication: severe hypertension). Benadryl 50 mg. IM. Contact the medical department for assistance. Steroids – Hydrocortisone Sodium Succinate (Solucortef) 100 mg. IM. Record vital signs. Cardiopulmonary resuscitation (if indicated).</p>

Table 1. MEDICAL EMERGENCY SITUATIONS/ COMMON TREATMENT GUIDELINES

Situation	Symptoms	Treatment Guidelines
<p><b>LOCAL ANESTHETIC DRUG INTOXICATION (TRUE OVERDOSE)</b></p> <p><b>CAUSE:</b> Too large a dose of local anesthetic. Rapid absorption of drug or inadvertent IV injection. Slow detoxification or elimination of drug.</p>	<p><b>EARLY:</b> Talkative, restless, apprehensive, excitement. Convulsion. Increased blood pressure and/or pulse rate.</p> <p><b>LATE:</b> Convulsion followed by depression. Drop in blood pressure. Either weak, rapid pulse or bradycardia. Apnea. Unconsciousness and/or death.</p> <p><b>NOTE:</b> The stimulation is followed by depression of central nervous system (CNS).</p> <p><b>NOTE:</b> Lidocaine is the one local anesthetic that on occasion has been documented to exhibit only the CNS depression without the usual prodromal excitatory phase.</p>	<p>(SYMPTOMATIC)</p> <p>Protect patient during the convulsive period.</p> <p>Contact the medical department.</p> <p>Record vital signs.</p> <p>Supportive Therapy – Oxygen.</p>
<p><b>EXTRA-PYRAMIDAL REACTIONS</b></p> <p><b>ETIOLOGY:</b> Side reaction to certain drugs <i>Phenothiazides</i>, (i.e., Compazine, Thorazine, Phenergan, Sparine, Stelazine, Trilafon, and Mellaril). <i>Butyrophenones</i> [i.e., Haldol and Innovar (General Anesthetic)]. <i>Thioxanthenes</i>, (i.e., Navane and Taractan).</p>	<p>Acute Dystonic Reaction: Rapid in onset. Involuntary movement of the tongue, muscles of mastication, and muscles of facial expression. Neck muscles frequently affected (torticollis). Arms and legs less frequently affected. Greater frequency in the young. Greater frequency in females.</p> <p>Akathisia (constant motion).</p> <p>Parkinsonism.</p> <p>Tardive dyskinesia, (bucco-linguomasticatory triad), sucking, smacking, chewing, fly-catching movement of tongue.</p>	<p>Diphenhydramine HCL (Benadryl) 25-50 mg. IM.</p> <p>Refer to medical department.</p>
<p><b>BRONCHIAL ASTHMA</b></p>	<p>Sense of suffocation. Pressure in chest. Non-productive cough. Prolonged expiratory phase with wheezing. Respiratory effort increased. Chest distended. Thick, stringy, mucous sputum. Cyanosis (in severe cases).</p>	<p>Beta-Adrenergic Agonist (Ventolin, Proventil) by metered dose inhaler (MDI), 2-4 puffs initially followed by 1-2 puffs every 10-20 minutes until improvement or toxicity is obtained.</p> <p>Oxygen.</p> <p>Contact medical department for assistance.</p> <p>Epinephrine 0.3cc 1:1000 SC. Repeat every 20 minutes p.r.n.</p> <p>Hydrocortisone sodium succinate (Solucortef) 100mg IV or IM.</p> <p>Record vital signs.</p>

Table 1. MEDICAL EMERGENCY SITUATIONS/ COMMON TREATMENT GUIDELINES		
Situation	Symptoms	Treatment Guidelines
<b>ANGINA PECTORIS</b>	Substernal pain or pain referred to any area above the waist. Pain lasts less than 15 minutes. Usually responds to nitroglycerine. May have history of previous episodes.	Nitroglycerine 0.4 mg sublingual; repeat at 5 minute intervals if needed; maximum 3 tablets in 15 minutes. Oxygen. Contact medical department for assistance. Rest. Record vital signs.  <b>CAUTION:</b> Once the container of nitroglycerine tablets has been opened the remaining tablets have a poor shelf life and a new supply should be obtained.
<b>MYOCARDIAL INFARCTION</b>	Pain: More sever than angina. Lasts longer than 15 minutes. Not relieved by nitroglycerine tablets. Cyanosis, pallor, or ashen appearance. Weakness. Cold sweat. Nausea, vomiting. Air hunger and fear of impending death. Pulse rate may be increased, irregular, and of poor quality.	Oxygen. Contact medical department. Record vital signs.  <b>NOTE:</b> Maintain patient in most comfortable position – this may well NOT be the supine position since the air hunger may be associated with orthopnea.
<b>CARDIAC ARREST</b>	No pulse or blood pressure. Sudden cessation of respirations (apnea). Cyanosis. Dilated pupils.	Contact medical department. Maintain patients' ABCs. Perform CPR. Continue Resuscitation until spontaneous pulse returns.
<b>CEREBROVASCULAR ACCIDENT</b>	Variable early warning signs: Vertigo. Nausea and vomiting. Transient paraesthesia or weakness of body.  General Symptoms: Headache. Nausea. Vomiting. Convulsion and/or coma.	Contact medical department for assistance. Supportive: Oxygen. Transport to hospital. Avoid sedatives. Record vital signs.
<b>CONVULSIONS</b> CAUSE: Syncope. Drug reaction. Insulin Shock. Cerebrovascular Accident. Convulsive disorders.	Aura – flash of light or sound. Excessive salivation. Convulsive movements of extremities. Loss of consciousness.	Protect patient from personal damage. Place patient on side if excessive salivation could compromise airway. Contact medical department for assistance. After convulsion, make sure airway is open. Oxygen. Record vital signs.

**Table 1. MEDICAL EMERGENCY SITUATIONS/ COMMON TREATMENT GUIDELINES**

Situation	Symptoms	Treatment Guidelines																											
<b>RESPIRATORY ARREST</b> <b>CAUSE:</b> Physical obstruction of airway. Drug induced apnea. Cardiac arrest.	Cessation of breathing. Cyanosis.	Open Airway – tilt head back – remove any obstruction. Breathing – Ventilate patient 12-15 times per minute. If apnea is secondary to sedative, barbiturate or diazepam overdose: Oxygen or artificial respiration. Keep patient awake. Contact medical department for assistance. Support blood pressure. Position of patient. Fluids.  NOTE: There is no reversal agent for sedative/barbiturate or Valium overdose.																											
<b>ASPIRATION OR SWALLOWING A FOREIGN OBJECT</b>	Coughing or gagging associated with the loss of a foreign object. Possible cyanosis due to airway obstruction.	Keep patient supine. Establish airway (open and evaluate breathing). If foreign object has occluded the airway use the Abdominal Thrust Maneuver (firm abdominal pressure). Basic Life Support. If necessary, contact the medical department for assistance.																											
<b>ORAL INTRA-ARTERIAL INJECTION OF DRUG</b>	Pain and burning sensation distal to the injection site. Cold and blotching hand or fingers distal to injection site.	Hydrocortisone sodium succinate (Solu-cortef) IM 100 mg. Contact medical department for assistance and follow-up.																											
<b>UNKNOWN RESPONSE</b>	If you cannot rationally identify a cause for the patient's response, a period of observation is justified.	Contact the medical department for assistance. Record vitals. If necessary, Basic Life Support.																											
<b>DIABETIC COMA/ INSULIN SHOCK</b>	<table border="1"> <thead> <tr> <th data-bbox="358 1358 548 1442">DIAGNOSTIC FACTORS:</th> <th data-bbox="553 1358 743 1442">DIABETIC COMA</th> <th data-bbox="748 1358 938 1442">INSULIN SHOCK</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="358 1449 938 1480"><b>A: HISTORY</b></td> </tr> <tr> <td data-bbox="358 1486 548 1549">Food Intake</td> <td data-bbox="553 1486 743 1549">Normal or Excessive</td> <td data-bbox="748 1486 938 1549">May be insufficient</td> </tr> <tr> <td data-bbox="358 1556 548 1587">Insulin</td> <td data-bbox="553 1556 743 1587">Insufficient</td> <td data-bbox="748 1556 938 1587">Excessive</td> </tr> <tr> <td data-bbox="358 1593 548 1625">Onset</td> <td data-bbox="553 1593 743 1625">Gradual: days</td> <td data-bbox="748 1593 938 1625">Sudden: hours</td> </tr> <tr> <td colspan="3" data-bbox="358 1652 938 1684"><b>B: PHYSICAL EXAM</b></td> </tr> <tr> <td data-bbox="358 1690 548 1722">Appearance</td> <td data-bbox="553 1690 743 1722">Extremely Ill</td> <td data-bbox="748 1690 938 1722">Very Weak</td> </tr> <tr> <td data-bbox="358 1728 548 1791">Skin</td> <td data-bbox="553 1728 743 1791">Dry and flushed</td> <td data-bbox="748 1728 938 1791">Moist and pale</td> </tr> <tr> <td data-bbox="358 1797 548 1829">Infection</td> <td data-bbox="553 1797 743 1829">Frequent</td> <td data-bbox="748 1797 938 1829">Absent</td> </tr> </tbody> </table>	DIAGNOSTIC FACTORS:	DIABETIC COMA	INSULIN SHOCK	<b>A: HISTORY</b>			Food Intake	Normal or Excessive	May be insufficient	Insulin	Insufficient	Excessive	Onset	Gradual: days	Sudden: hours	<b>B: PHYSICAL EXAM</b>			Appearance	Extremely Ill	Very Weak	Skin	Dry and flushed	Moist and pale	Infection	Frequent	Absent	Give one 10 gm tube of Glucose Gel orally. Contact medical department for assistance. Record vital signs. <b>RESPONSE TO TREATMENT</b> Insulin Shock Rapid improvement following carbohydrate administration. Diabetic Coma No improvement following carbohydrate administration. Slow improvement (6-12 hours) following insulin administration.
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**Table 1. MEDICAL EMERGENCY SITUATIONS/ COMMON TREATMENT GUIDELINES**

Situation	Symptoms			Treatment Guidelines
	Fever	Frequent	Absent	
	<i>C: GI SYMPTOMS</i>			
	Mouth	Dry	Drooling	
	Thirst	Intense	Absent	
	Hunger	Absent	Occasional	
	Vomiting	Common	Rare	
	Abdominal Pain	Frequent	Absent	
	Breathing	Acetone Odor	Normal	
	Blood Pressure	Low	Normal	
	Pulse	Weak and rapid	Full and bounding	
	Tremor	Absent	Frequent	
	Convulsions	None	Intake stages	

## Chapter 5.9

### Continuity of Care (E)

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#### I. POLICY

It shall be the policy of the CDCR DCHCS to ensure that inmates/patients are continually provided necessary health care services, in keeping with State and Federal regulations, and commensurate with community standards of care.

#### II. PURPOSE

To provide guidelines to assist in ensuring that CDCR inmates/patients receive continuity of health care.

#### III. PROCEDURE

- A. Inmates/patients' dental health care information shall be recorded in a Unit Health Record (UHR) or other clinically appropriate media. The UHR shall be established during intake and shall accompany the inmate/patient when the inmate/patient is transferred or moved within the system.
- B. All health care encounters are to be recorded in the UHR (i.e., specialty clinics or discharge summaries from inpatient admissions).
- C. For Mainline institutions, the Institution Dental Health and Self-Care Educator (IDHSCE), or designated Dental Assistant (DA), shall review the UHR of each newly arriving inmate/patient (including transfers) within 72 hours, excluding holidays, of the inmate/patient's arrival at the receiving CDCR facility.
  1. *Priority 1 and 2:*

The IDHSCE, or designated DA, upon review of the inmate/patient's UHR shall identify and schedule each inmate/patient with a documented dental treatment Priority 1 and 2 designation for a dental triage. Inmates/patients with a documented dental treatment Priority 1 and 2 designation shall be seen for this dental triage within 72 hours, excluding holidays, of the IDHSCE's, or designated DA's, review. All other inmates/patients shall follow the facility's procedure for requesting and accessing dental care, (Reference: Chapter 5.14 *Access to Care*).
  2. *Dental Examinations:*

The IDHSCE, or designated DA, upon review of the inmate/patient's UHR shall identify the last date of dental examination as indicated on the CDCR Form 237 B *Health Record Dental (Mainline Examination)* and shall schedule the following inmates/patients for a dental examination:

    - If the inmate/patient is under 50 years of age and it has been two years or longer since the last date of dental examination.

- If the inmate/patient is 50 years of age or older and it has been one year or longer since the last date of dental examination.

These inmates/patients shall be seen for a dental examination within 72 hours, excluding holidays, of the IDHSCE's, or designated DA's, review.

#### Reception Center

The IDHSCE, or designated DA, upon review of the inmate/patient's UHR shall schedule all inmates/patients transferring from a Reception Center for a dental examination. These inmates/patients shall be seen for a dental examination within 90 days of assignment to a Mainline Facility.

All other inmates/patients shall follow the facility's procedure for requesting and accessing dental care, (Reference: Chapter 5.14 *Access to Care*).

#### 3. *Medical conditions:*

Medical conditions such as diabetes, Human Immunodeficiency Virus (HIV), seizures pregnancy, or other conditions often affect the oral cavity. Dental pathology related to such medical conditions should be ruled out or identified at the earliest opportunity in order to receive definitive dental care.

The IDHSCE, or designated DA, shall review the CDCR Form 7371 *Confidential Medical/Mental Health Information Transfer – Sending Institution* and standardized dental health history forms and identify each inmate/patient with one of the following medical conditions:

- Diabetes
- HIV
- Seizure
- Pregnancy

- D. The ICHSCE, or designated DA, shall schedule each inmate/patient with at least one of the aforementioned medical conditions recorded on the bus screening or standardized dental health history form for a dental triage within 72 hours, excluding holidays, of the IDHSCE's, or designated DA's, review. All other inmates/patients shall follow the facility's procedure for requesting and accessing dental care, (Reference: Chapter 5.14 *Access to Care*).
- D. If the dental treatment priority, the date of last dental examination, or medical conditions are not clearly recorded, or the IDHSCE, or designated DA, is unable to locate this information then the Chief Dentist (CD), or designee, shall be contacted to provide direction.
- E. For each inmate/patient UHR reviewed, the IDHSCE, or designated DA, shall record on the CDCR Form 237 C *Dental Progress Notes* or a CDCR Form C-1 *Supplement to Dental Progress Notes* the following information, at a minimum:
- The date of review.
  - The result of the review, including the scheduled date of the dental triage or examination, if needed.
  - Documentation of any direction provided by the CD, or designee.

- The printed name of the reviewing IDHSCE, or designated DA.
- The signature of the reviewing IDHSCE, or designated DA.

All information shall be recorded in black ink using one line per entry, and not skipping lines between entries. Changes or error corrections are made by drawing a single line through the information being changed or corrected. The individual making such changes shall initial, date, and note the reason for the changes.

- F. The IDHSCE, or designated DA, shall record each inmate/patient UHR reviewed in the Intake Dental Unit Health Record Review Log.
- G. The IDHSCE, or designated DA, shall schedule the dental triage for each inmate/patient with a documented dental treatment Priority 1 and 2 designation and/or medical condition (as indicated in Section III.C.3 of this policy) in the Daily Dental Treatment/Appointment Log (DDTL). In addition, the IDHSCE, or designated DA, shall schedule the dental examination for each inmate/patient meeting the criteria established in Section III.C.2 of this policy in the DDTL.
- H. The dentist shall be charged with the duty of "case management" to monitor the following: timely scheduling of appointments, rescheduling of canceled or failed appointments, necessary lab blood work, referrals to specialists, follow-up care ordered by specialists, and intermediate appointments for prosthetic cases. The Office Technician (OT), upon direction of the dentist, shall track all referrals and medical/dental laboratory procedures to ensure their completion.
- I. When a dental staff member (e.g., chief dentist, dentist, dental assistant, or office technician), becomes aware that an inmate/patient has transferred to a new housing unit within the facility that is served by a different dental clinic, the OT, or designated dental staff member, shall notify a dental staff member at the new clinic of the inmate/patient's transfer, and the CD in order to ensure continuity of care.
- Upon notification, the dental staff member at the new clinic shall request the transferred inmate/patient's UHR. A dentist at the new clinic shall review the UHR upon receipt, for documentation of any urgent dental needs. After reviewing the UHR, the dentist, or designated staff member, shall schedule the inmate/patient for follow-up dental care, if needed.
- J. Health care staff shall prepare a care plan, including provisions for referrals, special diets, medications, and other appropriate regimens for inmates/patients who have special dental needs and are being released from the CDCR.

## Chapter 5.10

### Dental Emergencies (E)

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#### I. POLICY

Every CDCR facility shall ensure the availability of emergency dental care 24 hours a day, seven days a week.

#### II. PURPOSE

To provide cost-effective, timely, and competent emergency dental care to every inmate/patient consistent with adopted standards for quality and scope of services within a custodial environment, and to establish procedures and guidelines for managing and responding to dental emergencies in CDCR facilities.

#### III. PROCEDURE

##### A. Definitions:

1. *Dental Emergencies*: A dental emergency, as determined by health care staff, includes any medical or dental condition for which evaluation and treatment are immediately necessary to prevent death, severe or permanent disability, or to alleviate or lessen disabling pain.

Examples of dental emergencies include acute oral and maxillofacial conditions characterized by trauma, infection, and pain, swelling, or bleeding that is likely to remain acute or worsen without immediate intervention. Additional conditions that always constitute dental emergencies include, but are not limited to:

- Airway/breathing difficulties resulting from oral infection.
- A rapidly spreading oral infection, such as Ludwig's angina, cellulites (characterized by a firm swelling of the floor of the mouth, with elevation of the tongue), and acute abscess, (including an abscess at root end or a gingival abscess).
- Facial injuries and trauma to the jaws or dentition that threatens loss of airway.
- Suspected shock due to oral infection or oral trauma.
- Uncontrolled or spontaneous severe bleeding of the mouth.
- Head injuries (including stabbing or gunshot wounds) that involve the jaws or dentition.
- Moderate to severe dehydration associated with alteration in masticatory function due to obvious dental infection or dental trauma.
- Clear signs of physical distress (e.g., respiratory distress), related to infection or injury to the jaws or dentition.

- Suspected or known fractures involving the nasal bones, mandible, zygomatic arch, maxilla, and zygoma.
  - Temporomandibular joint (TMJ) disorders and Temporomandibular joint dysfunction (TMD) that results in any of the following: acute TMJ pain, "closed-lock" TMJ, or dislocation of the TMJ.
  - Aspiration or swallowing of a tooth or teeth that threatens loss of airway.
  - Acute, severe, debilitating pain due to obvious or suspected oral infection, oral trauma, or other dental-related conditions.
  - Infections, including infected third molars (wisdom teeth), and acute infections with a fever of 101° F or above, infections not responsive to antibiotic therapy, and acute pulpitis.
  - Injuries from trauma, such as an avulsed tooth, or fractured tooth.
  - Postoperative complications including alveolar osteitis, bleeding or infection.
  - Facial swelling.
2. *Emergency Dental Services:* Emergency dental services are services designed to prevent death, alleviate severe pain, prevent permanent disability and dysfunction, or prevent significant medical or dental complications. Emergency dental services include the diagnosis and treatment of dental conditions that are likely to remain acute or worsen without immediate intervention.

The following dental procedures shall **not** be considered or performed as emergency dental services.

- Minor elective surgery.
- Elective removal of dental wires, bands, or other fixed appliances.
- Routine dental restorations.
- Routine removable prosthodontic appliance adjustments or repairs.
- Administration of general anesthesia.
- Routine full-mouth scaling and root planing.
- Periodontal treatments involving sub-gingival curettage and root planing unless required in order to abate the dental emergency condition.
- Treatment of malignancies, cysts, neoplasms, or congenital malformations unless directly related to abatement of the dental emergency.
- Biopsy of oral tissue unless there is an immediate need to perform this procedure as a result of the dental emergency condition.
- Occlusal adjustment unless directly related to the abatement of the dental emergency condition.
- Root canal therapy.

- Any corrective dental treatment that can be postponed without jeopardizing the health of the inmate/patient.
- 3. *Dental Clinic Operating Hours:* Dental clinic operating hours is defined as at least eight hours per day, Monday through Friday, excluding holidays in which dental services are available to inmates/patients.
- 4. *Working Day:* For purposes of this policy a working day is defined as Monday through Friday, excluding holidays.
- 5. *Health Care Staff:* Medical or dental personnel (e.g., physician or dentist), who within their scope of licensure is able to assess an inmate/patient's condition and determine if a dental emergency exists.

**B. General Requirements:**

1. Inmates/patients requiring treatment for a dental emergency shall be seen immediately.
2. Emergency dental services shall be provided first to those most in need, to attempt stabilization and prevent deterioration of an inmate/patient's condition.
3. Emergency dental services shall be the responsibility of the Chief Dentist (CD) at that institution. The CD's duties shall include, but not be limited to:
  - Developing and maintaining approved written policies and procedures for emergency dental services. Implementing and annually reviewing approved policies and procedures to ensure they are current with the required State regulations.
  - Ensuring the availability of emergency dental services coverage 24-hours a day, and that a Dentist On Call (DOC) is available by telephone or electronic paging device at all times.
  - Ensuring that supervising RN and other physicians working the medical clinic receive continuing education in emergency dental services procedures.
  - Ensuring that equipment and supplies necessary to provide emergency dental services are available.
4. The CD, or designee, at each institution shall be responsible for initiating and managing a list of CDCR dentists providing on call services at their institution. The CD, or designee, shall ensure that the medical department has on file a current list of the on-call dentist's contact phone and/or pager numbers.
5. The Health Care Manager at each institution shall ensure that a Registered Nurse (RN) with current training in first aid and cardiopulmonary resuscitation is available 24-hours a day to assess inmates/patients with dental emergencies.
6. All inmates/patients shall provide authorization for treatment via informed consent for emergency dental services prior to treatment being rendered. All inmates/patients who

have life-threatening conditions, as determined by the Medical Officer of the Day (MOD), or treating dentist (including the CD and the DOC), and who are unable to provide informed consent shall be treated regardless of whether or not authorization for treatment is provided. The effort to obtain authorization for treatment shall continue simultaneously with the treatment. The MOD or treating dentist shall document in the inmate/patient's Unit Health Record (UHR) the life-threatening condition that requires treatment without authorization.

7. No treatment shall be forced over the objection of the inmate/patient, or his or her legally authorized representative or responsible relative except, in emergencies where immediate action is imperative to save the life of the inmate/patient or in such cases as are provided for by law as noted in Title 15 of the California Code of Regulations, Section 3351. If, after adequate explanation of the necessity for treatment and possible adverse effects that may result as a consequence of refusal, the inmate/patient maintains his or her desire to refuse treatment, the inmate/patient shall be required to sign a CDCR Form 7225 *Refusal of Examination and/or Treatment*, and the refusal of emergency dental treatment documented in the inmate/patient's UHR.
8. An appropriate entry shall be recorded in the UHR for every inmate/patient receiving emergency dental treatment. Such entries shall include:
  - The time of the inmate/patient's assessment.
  - A health history. If a condition reported during this health history presents a problem to the provision of dental treatment, the medical chart shall be reviewed, and if needed, a medical clearance obtained before dental treatment is initiated.
  - A CDCR Form 237 F *Dental Pain Profile* completed by the inmate/patient and reviewed by either the dentist or Registered Nurse (RN).
  - The pertinent history of the inmates/patients illness or injury.
  - Details of emergency or first aid provided to the inmate/patient.
  - Description of significant clinical, laboratory, and X-ray or other imaging studies.
  - Provisional diagnosis.
  - Informed consent for any invasive dental procedure or treatment other than routine.
  - Any treatment provided or ordered by the MOD or treating dentist.
  - Condition on transfer to an acute hospital, if applicable.
  - Instructions given to inmate/patient.
  - Any planned follow-up care.
9. The dentist providing either consultation, evaluation, or treatment for dental emergencies shall sign each UHR entry regarding such services.
10. Emergency dental services shall be performed only by, or as ordered, by a dentist, within the scope of his or her license.
11. Emergency first aid shall be rendered as necessary.

12. Nursing staff may insert oropharyngeal airways and shall provide care only within the scope of their license.
13. Inmates/patients shall be allowed to participate in their dental care whenever possible. Inmates/patients shall receive instruction from the dentist or RN regarding their care, the nature of the illness or injury, and any follow up care that is necessary. The dentist or RN shall document in the inmate/patient's UHR, any instructions given to the inmate/patient.
14. Any inmate/patient needing emergency dental services at another health care facility shall be transported in a safe, secure, and efficient manner.
15. The DOC shall be available 24-hours a day, seven days a week for dental emergency consultation. The R.Ns. shall have current training in first aid, cardiopulmonary resuscitation, and dental assessment criteria.
16. When a dental emergency requires the use of a medical transport vehicle, the clinic RN shall be notified via the institutional telephone system.

**C. Dental Emergencies *During* Dental Clinic Operating Hours:**

1. Inmates/patients initiating dental emergency requests during dental clinic operating hours shall contact an available or accessible CDCR staff member, who shall then notify the dental clinic of the emergency. Upon notification, this CDCR staff member, in conjunction with the dental clinic staff, shall make arrangements to have the inmate/patient report to the dental clinic on their own, or be escorted to the dental clinic for evaluation. If an inmate/patient is unable to walk, arrangements shall be made to have the inmate/patient transported to the dental clinic or Triage and Treatment Area (TTA) as appropriate.
2. The CDCR staff member shall contact the CD, or designee, to provide direction in those instances when there is not a dentist in the clinic.
3. The dentist shall see these inmates/patients upon their arrival at the dental clinic or TTA to establish the inmate/patient's disposition, and if needed provide treatment. The dentist shall ensure that the inmate/patient is scheduled for any needed follow-up care relating to the dental emergency.
4. The dentist shall record each dental emergency on the CDCR Form 237 C *Dental Progress Notes* or the CDCR Form C-1 *Supplement to Dental Progress Notes* in the Subjective, Objective, Assessment, Plan, Education (SOAPE) format. Each entry shall include at a minimum the information outlined in section III.B.8 of this policy. The dentist, or designee, shall file all of the required documentation, upon completion, in the dental section of the inmate/patient's UHR.
5. The dentist shall review and sign a CDCR Form 237 F for each inmate/patient with a dental emergency. If an inmate/patient is unable or refuses to complete the CDCR Form 237 F, the dentist shall complete the form on behalf of the inmate/patient, documenting the complaint and the reason the inmate/patient did not personally complete the form.

The dentist, or designee, shall file the CDCR Form 237 F, upon completion, in the dental section of the inmate/patient's UHR.

6. Inmates/patients with a life threatening illness or injury shall receive immediate medical attention.
7. All dental interviews shall be conducted in a confidential manner, subject to security concerns.

**D. Dental Emergencies *Outside* Dental Clinic Operating Hours:**

1. The medical department shall manage dental emergencies occurring outside of dental clinic operating hours. RNs, who have received training in specific emergency protocols under the direction of the CD, shall be notified of dental emergencies by institutional staff, and shall assess inmates/patients to determine the need for emergency dental treatment. The assessment process shall include, but not be limited to:
  - Obtaining an inmate/patient history.
  - Obtaining objective data, including vital signs.
  - Performing a physical assessment.
  - Prioritizing inmate/patient care.
  - Notifying the MOD of the inmate/patient's condition.
2. If in the opinion of the medical staff, the situation requires the attention of a dentist, the MOD, via the medical clinic's RN, shall be responsible for contacting the DOC or CD at the earliest opportunity, to arrange for definitive treatment.
3. Upon contact the DOC or CD might provide or order treatment or might order the inmate/patient's transfer to another treating facility. The DOC or CD might alternately issue orders for care and follow-up for non-emergency conditions.
4. The RN shall review and sign a CDCR Form 237 F for each inmate/patient with a dental emergency. If an inmate/patient is unable or refuses to complete the CDCR Form 237 F, the RN shall complete the form on behalf of the inmate/patient, documenting the complaint and the reason the inmate/patient did not personally complete the form. The RN, or designee, shall file the CDCR Form 237 F, upon completion, in the dental section of the inmate/patient's UHR.
5. The dentist, DOC, or CD contacted outside dental clinic operating hours, regarding a dental emergency, shall record each dental emergency on the CDCR Form 237 C *Dental Progress Notes* or the CDCR Form C-1 *Supplement to Dental Progress Notes* in the Subjective, Objective, Assessment, Plan, Education (SOAPE) format. Each entry shall include at a minimum the information outlined in sections III.B.8 and III.B.9 of this policy. The dentist, or designee, shall file all of the required documentation, upon completion, in the dental section of the inmate/patient's UHR.

6. The dentist, DOC, or CD contacted outside dental clinic operating hours, regarding a dental emergency, shall ensure that any needed follow-up care is scheduled relating to the dental emergency for which the dentist, DOC, or CD was contacted.
7. The dentist or DOC contacted outside dental clinic operating hours, regarding a dental emergency, shall notify the CD, or designee, on the next working day of the dental emergency contact. This notification shall include, but not be limited to the following:
  - Inmate/patient's name
  - Inmate/patient's chief complaint
  - Diagnosis or provisional diagnosis
  - Treatment or action provided or ordered
  - Any scheduled follow-up care

**E. After Hours Emergency Transfers:**

1. When in the opinion of the treating dentist, DOC, or CD it becomes necessary to transfer an inmate/patient to a General Acute Care Hospital (GACH), or other facility for emergency dental services, the RN shall make a written request on a CDCR Form 7252 *Request for Authorization of Temporary Removal for Medical Treatment* and notify the Watch Commander. The RN shall document on the CDCR Form 7252 the following:
  - Inmate/patient's name and CDCR number.
  - Name of receiving GACH or dental facility.
  - Description of the condition necessitating transfer.
  - The dental evaluation or treatment recommended by the DOC.
  - Name of the DOC.
2. The CDCR Form 7252 *Request for authorization of Temporary Removal for Medical Treatment* shall be submitted prior to the transfer, and shall be approved so as to create no undue delays. In a life or death situation, it shall not be necessary to await completion and return of the form. The inmate/patient shall be transferred immediately.
3. The treating dentist, DOC, or CD shall:
  - Contact the receiving physician or dentist at the receiving GACH or facility and obtain his or her acceptance of the inmate/patient.
  - Document in the inmate/patient's UHR, a brief history of the illness or injury, treatment received, reason and permission for the transfer, as well as the name of the accepting physician or dentist.
  - Write an order or provide verbal orders to the emergency medical services physician for the transfer of the inmate/patient.

- Document on the transfer form a brief history of the illness or injury, treatment received and reason for transfer. The RN in the absence of the treating dentist, DOC, or CD shall complete the transfer form.
  - Determine whether an ambulance is necessary, and if so, direct the RN, or designee, to contact the contract ambulance service. If an ambulance is unnecessary, the Watch Commander shall provide a state vehicle for transportation.
4. The Transfer Form shall accompany the inmate/patient to the GACH.
  5. The RN, or designee, shall notify the GACH or facility of the impending transfer.

### *References*

Director's Rule: Title 15, CCR, Section 3351;

Title 17, CCR, Chapter 5, Subchapter 4, Group 1, Article 1 and Section 30106; Title 22, CCR, Sections 79673, 79675, 79677, 79679

## IV. GENERAL GUIDELINES REGARDING DENTAL EMERGENCIES FOR REGISTERED NURSES

### 1. Standard Operating Procedures for ALL Dental Emergencies

**Performed by:** Registered Nurse (RN) trained in dental assessment

The RN shall:

- Maintain airway.
- Obtain vital signs.
- Obtain as much information regarding the inmate/patient's medical and psychiatric history as possible. Check present medications, drug allergies and tetanus status.
- Determine the nature and degree of any pain complaint.
- If bleeding, determine whether it is pulsating (arterial) or merely oozing (non-arterial). Apply gauze packs to any uncontrolled bleeding site.
- Keep inmate/patient NPO.
- Consult physician if inmate/patient is severely hypertensive.
- Telephone the DOC immediately.
- Carry out any written or verbal orders given by the DOC.

For **fracture**: if it is external (bone protruding through skin), contact oral and maxillofacial surgeon immediately or consult with Medical Officer of the Day (MOD) or DOC regarding transport to contract hospital.

For **fracture**, place ice pack on area for 20 minutes, then off for 20 minutes, and continue to alternate.

For **fracture**, keep the inmate/patient lying quietly on the gurney until DOC has determined the disposition.

For **fracture**, instruct inmate to keep jaw immobile.

For **avulsed tooth**, immerse tooth in a container of milk; other mediums in order of choice include saline, or sterile water.

For oral infection, post-extraction bleeding, and acute dental pain, keep the inmate/patient sitting in a chair or supine with head elevated until the DOC has determined the disposition.

For aspirated or swallowed tooth, keep the inmate/patient sitting upright or standing until DOC has determined the disposition.

For aspirated or swallowed tooth, contact emergency medical services physician for assistance.

For aspirated or swallowed tooth, try to keep inmate/patient calm.

For post-extraction, caution inmate/patient not to spit or lie down flat.

For post-extraction bleeding, instruct inmate/patient to bite firmly on one or two pieces of sterile 4 x 4 gauze at the extraction site with maximum pressure for a minimum of 30 minutes. Replace the gauze pack if it becomes saturated with blood.

For post-extraction bleeding, take and record vital signs every 15 minutes until stable.

**Documentation:** The nurse shall document in the UHR the history, general physical status, vital signs; the time dentist and/or physician was notified; all findings of tests performed and results; the assessment and any treatment, procedure or medication administered, and the inmate/patient's tolerance to these items; disposition and any follow-up care.

**Reference:** Title 22, CCR, Sections 79673, 79675, 79677, 79679

## 2. Standard Operating Procedures for Specific Emergencies

### ALVUSED TOOTH

**Performed By:** RN trained in dental assessment

**Procedure:** The RN shall:

- Maintain airway.
- Obtain vital signs.
- Obtain as much information regarding the inmate/patient's medical and psychiatric history as possible. Check present medications, drug allergies and tetanus status.
- Determine the nature and degree of any pain complaint:  
 Pain:  present  absent  localized  diffuse  
 Duration of pain:  seconds  minutes  
 Pain is:  sharp  dull  throbbing  spontaneous  intermittent  continuous
- If bleeding, determine whether it is pulsating (arterial) or merely oozing (non-arterial). Apply gauze pack to any uncontrolled bleeding site.
- Immerse tooth in a container of milk; other mediums in order of choice include saline or sterile water.
- The possibility of successful re-implantation declines rapidly with time. After two hours post-avulsion it is rarely possible to save the tooth.
- Keep inmate/patient Nothing By Mouth (NPO).
- Consult physician if inmate/patient is severely

hypertensive.

- Telephone the Dentist on Call (DOC) immediately.
- Carry out any written or verbal orders given by the DOC.

**Documentation:**

The nurse shall document in the UHR the history, general physical status, and vital signs; the time the dentist and/or physician was notified; all findings of tests performed and results; the assessment and any treatment, procedure or medication administered, and the inmate/patient's tolerance to these items; disposition and any follow-up care.

**Equipment/Supplies:** Milk, saline, sterile water, sterile gauze

**Reference:** Title 22, CCR, Sections 79673, 79675, 79677, 79679

**FRACTURES: MAXILLA, ZYGOMA, ZYGOMATAIC ARCH, MANDIBLE**

**Performed By:** RN trained in dental assessment

**Procedure:** The RN shall:

- Maintain airway.
- Obtain vital signs.
- Obtain as much information regarding the inmate/patient's medical and psychiatric history as possible. Check present medications, drug allergies and tetanus status.
- Determine the nature and degree of any pain complaint.
- If bleeding, determine whether it is pulsating (arterial) or merely oozing (non-arterial). Apply gauze pack to any uncontrolled bleeding site.
- Keep inmate/patient NPO.
- Consult physician if inmate/patient is severely hypertensive.
- Instruct inmate to keep jaw immobile.
- Telephone the DOC immediately.
- If fracture is external (bone protruding through skin), contact oral and maxillofacial surgeon immediately or consult with Medical Officer of the Day (MOD) or DOC regarding transport to contract hospital.
- Place ice pack on area for 20 minutes, then off for 20 minutes, and continue to alternate until the DOC has determined the disposition.
- Keep the inmate/patient lying quietly on the gurney until DOC has determined the disposition.
- If surgical reduction is necessary but can not be provided in a timely manner the inmate/patient may be kept comfortable with pain medication, antibiotics, and a liquid diet until treatment can be initiated. The patient should be followed daily until treatment is initiated.
- Carry out any written or verbal orders given by the DOC.

- Documentation:** The nurse shall document in the UHR, the history, general physical status, vital signs; the time the dentist and/or physician was notified; all findings of tests performed and results; the assessment and any treatment, procedure or medication administered, and the inmate/patient's tolerance to these items; disposition and any follow-up care.
- Equipment/Supplies:** Ice pack, gauze, gurney
- Reference:** Title 22, CCR, Sections 79673, 79675, 79677, 79679

**ORAL INFECTION**

**Performed By:** RN trained in dental assessment

- Procedure:**
- The RN shall:
  - Maintain airway.
  - Obtain vital signs.
  - Obtain as much information regarding the inmate/patient's medical and psychiatric history as possible. Check present medications, drug allergies and tetanus status.
  - Determine the nature and degree of any pain complaint:  
 Pain:  present  absent  localized  diffuse  
 Duration of pain:  seconds  minutes  
 Pain is:  sharp  dull  throbbing  spontaneous  intermittent  continuous
  - If bleeding, determine whether it is pulsating (arterial) or merely oozing (non-arterial). Apply gauze pack to any uncontrolled bleeding site.
  - Keep inmate/patient NPO.
  - Consult physician if inmate/patient is severely hypertensive.
  - Telephone on-call dentist immediately.
  - Keep the inmate/patient sitting in a chair or supine with head elevated until the DOC has determined the disposition.
  - Carry out any written or verbal orders given by the DOC.
  - Prompt initiation of appropriate antibiotic therapy is imperative as well as the application of internal (hourly warm water rinses) and external heat (warm compresses) to the infected area.

- Documentation:** The nurse shall document in the UHR the history, general physical status, vital signs; the time the dentist and/or physician was notified; all findings of tests performed and results; the assessment and any treatment, procedure or medication administered, and the inmate/patient's tolerance to these items; disposition and any follow-up care.
- Equipment/Supplies:** Sterile gauze, warm water, warm compresses.
- Reference:** Title 22, CCR, Sections 79673, 79675, 79677, 79679

**POST-EXTRACTION BLEEDING****Performed By:** RN trained in dental assessment**Procedure:** The RN shall:

- Maintain airway.
- Obtain vital signs.
- Obtain as much information regarding the inmate/patient's medical and psychiatric history as possible. Check present medications, drug allergies and tetanus status.
- Determine the nature and degree of any pain complaint:  
Pain:  present  absent  localized  diffuse  
Duration of pain:  seconds  minutes  
Pain is:  sharp  dull  throbbing   
spontaneous  intermittent  continuous
- Determine the bleeding whether it is pulsating (arterial) or merely oozing (non-arterial). Apply gauze pack to any uncontrolled bleeding site.
- Keep inmate/patient NPO.
- Consult physician if inmate/patient is severely hypertensive.
- Telephone on-call dentist immediately.
- Keep the inmate/patient sitting in a chair or supine with head elevated until the DOC has determined the disposition.
- Caution inmate/patient not to spit or lie down flat.
- Instruct inmate/patient to bite firmly on one or two pieces of sterile 4 x 4 gauze at the extraction site with maximum pressure for a minimum of 30 minutes. Replace the gauze pack if it becomes saturated with blood.
- Take and record vital signs every 15 minutes until stable.
- Carry out any written or verbal orders given by the DOC.

**Documentation:** The nurse shall document in the UHR, the history, general physical status, vital signs; the time the dentist and/or physician was notified; all findings of tests performed and results; the assessment and any treatment, procedure or medication administered, and the inmate/patient's tolerance to these items; disposition and any follow-up care.

**Equipment/** Sterile gauze

**Supplies:**

**Reference:** Title 22, CCR, Sections 79673, 79675, 79677, 79679

**ACUTE DENTAL PAIN****Performed By:** RN trained in dental assessment**Procedure:** The RN shall:

- Maintain airway.
- Obtain vital signs.
- Obtain as much information regarding the inmate/patient's medical and psychiatric history as possible. Check present medications, drug allergies and tetanus status.
- Determine the nature and degree of any pain complaint:
  - Pain:  present  absent  localized  diffuse
  - Duration of pain:  seconds  minutes
  - Pain is:  sharp  dull  throbbing  spontaneous  intermittent  continuous
- Increased by:  sweet  sour  cold  heat  pressure  lying down flat  medication
- Decreased by:  heat  pressure  sweet  sour  cold  medication  lying down flat
- If bleeding, determine whether it is pulsating (arterial) or merely oozing (non-arterial). Apply gauze pack to any uncontrolled bleeding site.
- Keep inmate/patient NPO.
- Consult physician if inmate/patient is severely hypertensive.
- Telephone the DOC immediately.
- Keep the inmate/patient sitting in a chair or supine with head elevated until the DOC has determined the disposition.
- Carry out any written or verbal orders given by the DOC.

Acute dental pain is the common result of tooth injury, traumatic pulpitis, or fracture. Early administration of appropriate antibiotics is imperative if infection is suspected

**Documentation:** The nurse shall document in the UHR, the history, general-physical status, vital signs; the time the dentist and/or physician was notified; all findings of tests performed and results; the assessment and any treatment, procedure or medication administered, and the inmate/patient's tolerance to these items; disposition and any follow-up care.

**Equipment/Supplies:** Sterile gauze

**Reference:** Title 22, CCR, Sections 79673, 79675, 79677, 79679

**ACUTE TMJ/TMD PAIN****Performed By:** RN trained in dental assessment**Procedure:** The RN shall:

- Maintain airway.
- Obtain vital signs.
- Obtain as much information regarding the inmate/patient's medical and psychiatric history as possible. Check present medications, drug allergies and tetanus status.
- Determine the nature and degree of any pain complaint:  
Pain:  present  absent  localized  diffuse  
Duration of pain:  seconds  minutes  
Pain is:  sharp  dull  throbbing   
spontaneous  intermittent  continuous
- If bleeding, determine whether it is pulsating (arterial) or merely oozing (non-arterial).
- Keep inmate/patient NPO if sedation or general anesthesia is anticipated.
- Consult physician if inmate/patient is severely hypertensive.
- Telephone the DOC immediately.
- Carry out any written or verbal orders given by the DOC.

If the condyles are dislocated early reduction is essential.

**Documentation:** The nurse shall document in the UHR, the history, general physical status, vital signs; the time the dentist and/or physician was notified; all findings of tests performed and results; the assessment and any treatment, procedure or medication administered, and the inmate/patient's tolerance to these items; disposition and any follow-up care.**Equipment/  
Supplies:** N/A**Reference:** Title 22, CCR, Sections 79673, 79675, 79677, 79679**ASPIRATING OR SWALLOWING A TOOTH****Performed By:** RN trained in dental assessment**Procedure:** The RN shall:

- Maintain airway.
- Obtain vital signs.
- Obtain as much information regarding the inmate/patient's medical and psychiatric history as possible. Check present medications, drug allergies and tetanus status.
- Determine the nature and degree of any pain complaint:  
Pain:  present  absent  localized  diffuse

Duration of pain:     seconds     minutes

- If bleeding, determine whether it is pulsating (arterial) or merely oozing (non-arterial). Apply gauze pack to any uncontrolled bleeding site.
- Keep inmate/patient NPO.
- Chest and abdominal radiographs are essential to determine the location of the tooth with immediate referral to the appropriate physician or hospital if aspiration has occurred.
- Contact emergency medical services physician for assistance.
- Consult physician if inmate/patient is severely hypertensive.
- Telephone DOC immediately.
- Keep the inmate/patient sitting upright or standing until DOC has determined the disposition.
- Try to keep inmate/patient calm.
- Carry out any written or verbal orders given by the DOC.

**Documentation:**

The nurse shall document in the UHR, the history, general physical status, vital signs; the time the dentist and/or physician was notified, all findings of tests performed and results; the assessment and any treatment, procedure or medication administered, and the inmate/patient's tolerance to these items; disposition and any follow-up care.

**Equipment/  
Supplies:**

Sterile gauze

**Reference:**

Title 22, CCR, Sections 79673, 79675, 79677, 79679

**ACRONYM TABLE**

ACLS	Advanced Cardiac Life Support
CCR	California Code of Regulations
CDCR	California Department of Corrections and Rehabilitation
CTC	Correctional Treatment Center
DOC	Dentist on Call
GACH	General Acute Care Hospital
LVN	Licensed Vocational Nurse
MOD	Medical Officer of the Day
MEC	Medical Executive Committee
MTA	Medical Technician Assistant
NPO	Nothing by Mouth
PCPC	Patient Care Policy Committee
RN	Registered Nurse
TMD	Temporomandibular Joint Disorder
TMJ	Temporomandibular Joint
UHR	Unit Health Records

# Chapter 5.11

## Direct Medical Orders (E)

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### I. POLICY

CDCR DCHCS personnel's issuance of and compliance with all direct medical orders must be consistent with applicable statutes, standards, and administrative policy.

### II. PURPOSE

The purpose of this policy is to ensure that CDCR DCHCS personnel are in compliance with applicable State law in regard to direct medical orders.

### III. PROCEDURE

A. Licensed Health Care Staff who, by virtue of their license, are authorized by law or regulations to issue direct medical orders must:

1. Write and sign all orders they issue, or
2. Verbally communicate such orders to appropriate health care providers, and sign these orders during the next patient visit as specified by the California Board of Medical and Dental Examiners.
3. In the absence of the ordering health care provider, verbal orders may be countersigned by a non-ordering dentist or physician.

B. Modifications to direct medical orders must be authorized by a licensed practitioner.

## CHAPTER 5.12

### Therapeutic Diets (E)

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#### I. POLICY

The CDCR shall provide inmates/patients with supplemental nutritional support when medically necessary.

#### II. PURPOSE

To establish and maintain a system whereby inmates/patients are supplied with nutritional support when medically necessary. Nutritional support shall be defined as:

*Therapeutic Diet:* Special meals prepared under the direction of a Clinical Dietitian for inpatients admitted to a licensed general acute care hospital, skilled nursing facility, correctional treatment center bed, or recognized outpatient renal program.

*Nourishment Bags:* Standardized food items, in addition to the standard meal, provided for inmates/patients who have certain diseases or medical conditions.

*Supplements:* High caloric drinks or high caloric foods bars, provided in addition to or in the place of the standard meal, for inmates/patients with certain diseases or medical conditions.

#### III. PROCEDURE

- A. A physician's order shall be written for all therapeutic diets, nourishment bags, and supplements.
- B. All inmates/patients shall be allowed to make food choices from among items provided in the standard meal. Outpatient therapeutic diets shall only be prescribed at specific institutions that provide special diets for end stage renal disease, liver disease, or heart disease.
- C. Physicians and dentists must advise and/or educate inmates/patients about making food choices from the standard meal that are consistent with the inmate/patient's disease(s) or medical condition(s). Physicians and dentists must also counsel inmates/patients about the ramifications of non-compliance with recommended dietary modifications. Any such counseling must be documented in the Progress Notes portion of the Unit Health Record.
- D. All institutions, except as mandated by court order, shall implement the following policies:
  1. Health Care Managers (HCM) shall require that:
    - a. Physicians prescribe a therapeutic diet if medically indicated. These diets shall follow California Department of Health Services' licensure regulations, and the facility diet manual and menu plan as approved by the Clinical Dietitian.

- b. Consistent with medical necessity, physicians shall prepare a written order (including a stop date) for supplements and nourishment bags for inmates/patients who are pregnant, diabetic, immunocompromised, in end-stage liver disease, in kidney failure, malnourished, or with oropharyngeal conditions resulting in difficulty eating regular diets.
    - c. A physician or his/her designee shall advise inmates/patients, whose disease or medical condition can be stabilized by dietary modification, about making selections from the standard meal.
    - d. Physicians shall adhere to the chart of standardized nourishment bags and supplements, for inmates/patients with special dietary needs who are making food selections from the standard meal.
    - e. Consistent with dental necessity, dentists shall prepare a written order (including a stop date) for dietary supplements for inmates/patients with conditions resulting in difficulty eating regular diets.
2. Institutions Division, through Facility Wardens and Food Managers, shall maintain a system whereby:
  - a. The CDCR Food Plan and standardized departmental menus, and recipes are consistently followed by Food Services, enabling inmates/patients who have been advised about making dietary modifications to select items from the standard meal.
  - b. Substitutions to the master menu shall be made in a manner that is consistent with the nutrition guidelines of the CDCR.
3. Administrative Services Division, through the Departmental Food Administrator, shall maintain a Food Services Program whereby:
  - a. The CDCR Food Plan meets the dietary needs of most inmates/patients by providing a "Heart Healthy," low fat, low salt diet.
  - b. A nutritional analysis of the CDCR Food Plan is performed whenever menu changes are made in order to ensure that the standard meals remain "Heart Healthy."
  - c. Standardized Departmental recipes are maintained, consistent with the CDCR Food Plan.

# CHAPTER 5.13

## Pharmaceuticals (E)

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### I. POLICY

The CDCR Pharmacy Services shall ensure that the pharmaceutical needs of the facility dental clinics are met, and are in accordance with all applicable State and Federal regulations regarding prescribing, dispensing, administering, and procuring pharmaceuticals.

### II. PURPOSE

To establish guidelines and procedures for the purpose of ensuring that the pharmaceutical needs of CDCR facility dental clinics are adequately met.

### III. PROCEDURE

#### A. General Pharmaceutical Procedures

1. Each facility will maintain a current copy of the Pharmacy Operational Procedure Manual.
2. It is the responsibility of the Director of Pharmacy Services to ensure that the manual is reviewed annually and remains current.
3. At a minimum, the manual will contain information on the following:
  - a. Development and subsequent updating of a facility formulary or drug list for pharmaceuticals stocked by the institution. The formulary also shall include information about the availability of and the methods for procuring non-legend medications.
  - b. Protocols whereby medication orders may only be written by licensed Health Care Services staff for treatment modalities within the scope of each practitioner's license, and only by those health care staff credentialed by and having privileges at the local institution.
  - c. Procurement, dispensing, distribution, administration, and disposal of pharmaceuticals.
  - d. Maintenance of records as necessary to ensure adequate control of and accountability for all drugs and which ensure that areas are devoid of medications that are outdated, discontinued, or recalled.
  - e. Maximum-security storage of and accountability for Drug Enforcement Agency (DEA) controlled substances as well as for needles, syringes, and other items that are likely to be subject to abuse.
  - f. Automatic drug stop orders or required periodic review of all orders for DEA controlled substances, psychotropic drugs, or any other drug that should be restricted

because it lends itself to abuse or which is prescribed as a Directly Observed Therapy (DOT) medication.

- g. A method for notifying the prescribing health care provider of the impending expiration of a drug order so that the practitioner can determine whether the drug administration is to be continued or altered.
- h. Administration of drugs only upon the order of a physician, dentist, or other authorized individual with designated privileges.
- i. The prescribing of psychotropic or behavior-modifying medications only when clinically indicated (as one facet of a program of therapy) and not for disciplinary reasons.
- j. Maintaining all medications under the control of appropriate staff members. Inmates shall not prepare, dispense or administer medications except for self-medication programs approved by the prison administrator and the prescribing health care provider, (e.g., "keep-on-person" program).

#### B. Dental Clinic Pharmaceutical Procedures

1. CDCR dental departments shall not store, stock, package, or dispense medications to inmates/patients.
2. Only CDCR dentists, and other licensed health care staff, in accordance with State and Federal regulations, may prescribe and/or administer medications to inmates/patients.
3. Dental assistants and dental laboratory technicians shall not administer prescribed dental medications to inmates/patients.
4. All dental prescriptions shall be written by a dentist on CDCR Form 7221 *Physician's Orders* and shall be documented in the Services Rendered section of CDCR Form 237 B *Health Record – Dental Form* of the Unit Health Record (UHR).
  - a. On CDCR Form 7221 *Physician's Orders*, the dentist shall enter the date, time of order, condition for which the medication was ordered, drug name, strength, number of doses, frequency of dose, and route of administration.
  - b. Each dentist shall use one line at a time and shall not skip lines.
  - c. Only medications from the approved list of drugs contained in the CDCR *Drug Formulary* shall be prescribed for inmates/patients.
  - d. Each dentist shall:
    - 1) Write legibly.
    - 2) Use a name stamp or print their name.
    - 3) Sign their name after writing the order(s).
5. Stat orders may be filled by hand carrying the *Physician's Orders* form to the pharmacy or by giving it to the nurse, or Medical Technical Assistant (MTA) located in each unit for immediate delivery to the pharmacy.

## Chapter 5.14

### Access to Care (E)

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#### I. POLICY

The CDCR DCHCS shall ensure that all inmates/patients are provided access to dental care. The Chief Dentist (CD), Dental Program, DCHCS shall be responsible for developing policies and procedures that ensure all inmates receive equal access to dental care.

#### II. PURPOSE

To ensure that CDCR inmates have timely and equal access to dental care by utilizing a system that provides guidelines enabling inmates to receive dental care based on medical necessity.

#### III. DISCUSSION

For the purpose of this policy, access to care means that an inmate/patient can be seen by a clinician in a timely manner, be given a professional clinical judgment, and receive medically necessary care. The CD, or designee, shall ensure access to dental care for all inmates/patients by identifying and eliminating any unreasonable barriers that obstruct the availability of dental services. Unreasonable barriers to an inmate's access to health services are to be avoided. Examples of unreasonable barriers include the following:

- Punishing inmates for seeking care for their serious health needs.
- Assessing excessive co-payment charges to prevent or deter inmates from seeking care for their serious health needs.
- Deterring or obstructing inmates from seeking or receiving care for their serious health needs.

#### Dental Clinics

All inmates shall be informed via the DCHCS CDCR *Inmate/patient Orientation Handbook to Health Care Services* and the Facility Level Dental Health Orientation/Self-Care Program, (Reference: Chapter 2.13 *Facility Level Dental Health Orientation/Self-Care Program*) of the facility dental services available to them.

The Institution Dental Health and Self-Care Educator (IDHSE), or dental assistant designee, shall review the inmate/patient's Unit Health Record (UHR) upon arrival at a new CDCR facility for urgent (Priority 1) dental needs, (Reference: Chapter 5.9 *Continuity of Care*).

All inmates shall have equal access to dental services by:

- Submitting a CDCR Form 7362 requesting dental care .
- Unscheduled dental visits for emergency and urgent (Priority 1) dental services.
- Referral from other health care providers, ancillary, and custodial staff.

- Educated dental triages to have specific complaints addressed.
- Receiving a dental treatment priority based on clinical findings and radiographs. All inmates/patients shall be eligible to receive dental treatment based on their assigned dental treatment priority. Dental treatment priorities are defined in Chapter 5.4: *Dental Treatment Priorities*.
- Each inmate/patient who requires special dental needs shall have treatment initiated or scheduled regardless of length of incarceration after approval by the Dental Authorization Review Committee.

#### IV. PROCEDURE

##### A. General Requirements

1. Each dental clinic shall maintain a minimum staffing ratio of one dentist and one dental assistant per 515 inmates.
2. Dental services shall be available at least eight hours per day, Monday through Friday, excluding holidays. Clinics shall operate a minimum of eight hours per day and shall remain open until all authorized emergency, scheduled urgent care (Priority 1), and educated inmates/patients have been seen.
3. Inmates/patients are expected to initiate access to dental services utilizing the CDCR Form 7362 *Request for Medical/Dental Services*. The CDCR Form 7362 shall be available to inmates/patients in the housing units, clinics, Reception Center (RC), and from Health Care (HC) staff. The CDCR Form 7362 is a confidential medical document used to assess the priority of the request and to access the appropriate discipline or provider.
4. Each institution shall have at least one locked box on each yard/facility designated for depositing the CDCR Form 7362 by the inmate/patient.
5. If an inmate/patient is unable or refuses to complete a request form, HC staff shall complete the form on behalf of the inmate/patient, documenting the complaint and the reason the inmate/patient did not personally complete the form. In this instance, the HC staff member completing the CDCR Form 7362 must sign and date the form.
6. Special procedures will be implemented to ensure that inmates who have difficulty communicating (e.g., those who are non-English proficient, developmentally disabled, illiterate, mentally ill, or hearing impaired) have equal access to dental services. Translation services (including sign language) shall be available for inmates/patients, as necessary, via bilingual health care staff or by utilizing a certified interpretation service (i.e., AT&T Translation Services) when bilingual health care staff are unavailable. Each institution shall maintain a contract for certified interpretation services, (Reference: Chapter 5.6 *Interpreter Services – Monolingual/Non-English Speaking Inmates*).
7. The CD shall make arrangements with the custody unit supervisor to have inmates/patients with emergent and urgent (Priority 1) requests, as determined by the dentist and/or health care provider, report to the clinic on their own or escorted to the

dental clinic for evaluation. If an inmate/patient is unable to walk, arrangements shall be made to have the inmate/patient transported to the dental clinic or Triage and Treatment Area (TTA) as appropriate. The dentist shall see these inmates/patients upon their arrival at the clinic, and if needed provide treatment. All dental interviews shall be conducted in a confidential manner, subject to security concerns.

8. In cases of dental emergencies, inmates/patients shall receive dental services without submitting a CDCR Form 7362. Inmates/patients may access emergency care by making their needs known to custody or HC staff. Inmates/patients with a life threatening illness or injury shall receive immediate medical attention.
9. Dental assistants shall not make dental assessments exceeding their scope of license, training, or departmental policies.

**B. CDCR Form 7362 Collection, Triage, and Distribution**

1. Mondays through Fridays the following shall occur:
  - a. A HC staff member shall pick up the CDCR Form 7362s daily.
  - b. After returning to the clinic, the Registered Nurse (RN)/Medical Technical Assistant (MTA) shall initial and date the request forms.
  - c. The CDCR Form 7362s shall be separated, distributed by service requested (e.g., medical dental, or mental health), and forwarded to their respective areas for processing.
  - d. A dental staff member shall enter each CDCR Form 7362 requesting dental services in the CDCR Form 7362 Request for Dental Treatment Log (RDTL). The dentist shall review, initial, and date all requests for dental services daily to establish dental priorities of an emergent (Emergency) or urgent (Priority 1) nature. In those instances when there is not a dentist in the clinic, the CD shall be notified to provide direction.
  - e. Inmates/patients with dental emergencies during dental clinic operation hours shall be seen by a dentist on the same day to establish disposition and provide treatment if needed. Inmates/patients with dental emergencies after dental clinic operation hours shall be managed by the medical department. If in the opinion of the medical staff, the situation requires the attention of a dentist, the Medical Officer of the Day (MOD), via the medical clinic's RN, shall be responsible for contacting the on-call dentist at the earliest opportunity, to arrange for treatment. Upon contact the on-call dentist shall arrange to see the inmate/patient as soon as possible.
  - f. All other inmates/patients with dental needs will be seen within the timeframes established by Chapter 5.3 *Recording and Scheduling Dental Patient Visits*.

2. On weekends and holidays the following shall occur:
  - a. The TTA RN shall review each CDCR Form 7362 for medical, dental, and mental health services; shall establish medical priorities on an emergent and non-emergent basis; and shall refer accordingly to the appropriate health care staff.
  - b. If a dentist is not available, then the TTA RN shall contact the physician on call.

### C. Dental Triage Line

1. The dental triage line shall consist of the following:
  - Inmates/patients who have submitted a CDCR Form 7362;
  - Inmates/patients with a dental emergency that walk-in or are called-in by custody staff;
  - Health care and custody staff referrals of inmates/patients with a dental emergency.
2. The dentist shall conduct a "Dental Triage Line" by directing an inmate/patient to the dental department for dental triage. For each inmate/patient requesting dental services, the dentist, or designee, shall at minimum document the following information on the CDCR Form 237 C *Dental Progress Notes* or the CDCR Form 237 C-1 *Supplement to Dental Progress Notes*: the nature and history of complaint, current medical history review, response to the inmate/patient, vital signs, and physical findings. Documentation recorded on the CDCR Form 237 C or C-1 shall be in the Subjective, Objective, Assessment, Plan, Education (SOAPE) format, (Reference: Chapter 6.1 *Health Records Organization and Maintenance*). In addition, for each inmate/patient requesting dental services the dentist shall initial and date the CDCR Form 7362 at the time of the dental triage. When documentation is completed, the dentist, or designee, shall file the CDCR Form 7362 and the CDCR Form 237 C or C-1 in the dental section of the inmate/patient's UHR.
3. For inmates/patients with a dental treatment Priority 1, a dentist shall complete a dental triage within 72 hours, with the exception of holidays, after receipt of the inmate/patient's CDCR Form 7362 in the dental clinic. For all other inmates/patients, a dentist shall complete a dental triage within ten days, with the exception of weekends and holidays, after receipt of the inmate/patient's CDCR Form 7362 in the dental clinic.
4. Dental triages conducted as a result of dental emergency walk-ins or call-ins; or health care or custody staff referrals shall be documented on the CDCR Form 237 *Dental Pain Profile* and the CDCR Form 237 C or C-1. Each inmate/patient presenting to the dental clinic for a dental triage of a dental emergency shall complete a CDCR Form 237 F before the triage is conducted. The dentist shall review and sign the CDCR Form 237 F before completing the dental triage. If an inmate/patient is unable or refuses to complete the CDCR Form 237 F, the dentist shall complete the form on behalf of the inmate/patient, documenting the complaint and the reason the inmate/patient did not personally complete the form. Documentation recorded on the CDCR Form 237 C or C-1 shall be in the Subjective, Objective, Assessment, Plan, Education (SOAPE) format.

When documentation is completed, the dentist, or designee, shall file the CDCR Form 237 F and the 237 C or C-1 in the dental section of the inmate/patient's UHR.

5. If the inmate/patient fails to report for the dental triage the dentist, or designee, shall follow the policy for "Failure to Report for Dental Ducats" as outlined in Chapter 5.2 *Priority Health Care Services Ducat Utilization*.
6. Once a dentist has completed the dental triage, dental treatment shall be provided within the timeframes indicated for the inmate/patient's dental priority (Reference Chapter 5.4 *Dental Treatment Priorities*).
7. The dentist shall complete the *Inmate Co-payment for Health Care Services* section of the CDCR Form 7362, as outlined in Chapter 5.1 *Inmate Co-payment for Health Care Services* for each dental triage conducted on an inmate/patient (Authority: Title 15, CCR, Section 3354.2).

#### D. Dental Appointments

1. The dental assistant, or designee, under the direction of the dentist, shall prepare the dental care ducat lists for dental appointments no later than one day prior to the scheduled visit. Inmates/patients scheduled for dental appointments shall be ducated at designated intervals. Inmates/patients shall receive a ducat prior to their scheduled appointment, and shall arrive at the clinic at the specified time on the ducat. All health care ducats are to be considered priority ducats in order to facilitate access to dental care (Chapter 5.2 *Priority Health Care Services Ducat Utilization*).
2. A list of UHR's necessary for dental appointments shall be generated from the dental clinics. Dental clinic staff shall forward this list to Health Record Services one day prior to the scheduled appointments. The UHR shall be available when the patient is seen except in exceptional circumstances (e.g., out to court and newly arriving inmates/patients).
3. Each inmate/patient requesting dental services shall be seen if he or she is ducated and arrives at the clinic for their scheduled appointment, unless the CD, or designee, cancels the appointment.
4. In the event of the dentist's absence, and other staff dentists are unable to cover his or her appointments in the clinic, such appointments may be canceled only with the approval of the CD, or designee.
5. If an inmate/patient fails to show for a dental appointment, then the dentist, or designee, shall follow the policy for "Failure to Report for Dental Ducats" as outlined in Chapter 5.2 *Priority Health Care Services Ducat Utilization*.

#### E. Female Inmate/patient Dental Visits

1. A female staff member shall attend each dental visit scheduled for a female inmate/patient requiring a dental examination and/or treatment by a male dentist. The female staff member shall be present for the duration of the dental visit.

2. If clinical assistance with the examination is required, the female staff member shall be an appropriate health care staff member.
3. The female staff person shall be identified by name and recorded in the CDCR Form 237C or C-1.

**F. Male Inmate/patient Dental Visits**

1. Another staff member shall be present in the dental clinic when a female dental staff member and a male inmate/patient are present in the dental clinic.

**G. Lockdown**

1. During a facility or prison lockdown, dental staff shall coordinate with the clinic RN/MTA and custody staff to facilitate continuity of care. A lockdown shall not prevent the completion of scheduled dental appointments, and custody personnel shall escort the inmate/patient to the dental clinic, subject to security concerns.
2. In facilities/housing units on lock down status, a system shall be maintained to provide inmates/patients access to health care services. Access to health care services shall be accomplished via daily rounds by HC staff and daily collection of CDCR Form 7362s. The HC staff shall refer all inmates/patients requiring dental treatment to the dental clinic for evaluation and treatment.
3. Inmates/patients in Restricted Housing Units (RHU) (i.e. Administrative Segregation, Security Housing, Psychiatric Services, Protective Housing), shall have access to CDCR Form 7362s. The inmates/patients shall be provided a method for depositing the CDCR Form 7362 in the locked box for daily pick up by HC staff or the CDCR Forms 7362 shall be collected by the RN/MTA/ Licensed Psychiatric Technician (LPT) during the daily rounds in the RHU. The RN/MTA/LPT shall refer all inmates/patients requiring dental treatment to the dental clinic for evaluation and treatment.

# Chapter 5.15

## Dental Care (E)

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### I. POLICY

The CDCR shall provide medically necessary dental care for all inmates in a timely manner, under the direction and supervision of dentists licensed by the Board of Dental Examiners of the State of California. Such care shall be based on medical necessity and supported by outcome data as effective dental care.

### II. PURPOSE

To determine and define the scope of CDCR dental services and to establish procedures and guidelines for the delivery of dental care to inmates incarcerated in CDCR facilities.

### III. DEFINITIONS

**Medically Necessary:** health care services that are determined by the attending dentist, or other licensed health care provider, to be reasonable and necessary to protect life, prevent significant illness or disability, or alleviate severe pain, and that are supported by health outcome data as being effective medical care.

**Outcome Study:** the definition, collection, and analysis of comparable data, based on variations in treatment, concerning patient health assessment for purposes of improving outcomes and identifying cost-effective alternatives.

**Outcome Data:** statistics, such as diagnoses, procedures, discharge status, length of hospital stay, and morbidity and mortality of patients that are collected and evaluated through the use of scientific methodologies and expert clinical judgment for the purposes of producing outcome studies.

**Severe Pain:** a degree of discomfort that significantly disables the patient from reasonable independent function.

**Significant Illness and Disability:** a medical condition that causes, or may cause if left untreated, a severe limitation of function or the ability to perform daily life activities or that may cause premature death.

### IV. PROCEDURE

Dental screenings at Reception Centers, and/or dental examinations and treatment plan formulations at Mainline Institutions shall be performed by a licensed dentist.

Within 60 days of assignment to a Reception Center facility, all inmates shall receive a dental screening as part of their initial health assessment. Inmates/patients shall also receive dental

health education in the form of a pamphlet on oral health self-care. The dental screening results shall be recorded on CDCR Form 237A and the screening dentist shall review the results with the inmate/patient.

Within 90 days of assignment to a Mainline Institution, all inmates shall receive a complete dental examination. The attending dentist shall order and interpret all necessary radiographs for each inmate/patient, and if indicated, shall formulate a dental treatment plan. When a treatment plan is proposed, the attending dentist shall provide the inmate/patient with an explanation of the advantages and disadvantages of the treatment plan.

The results of the dental examination and the inmate/patient's treatment dental priority classification shall be recorded in the dental section of the inmate/patient's Unit Health Record (UHR) on CDCR Form 237-B & C. The dental examination shall include:

- A health history.
- Charting of the existing teeth and restorations.
- Charting of dental decay.
- An examination of the hard and soft tissues of the oral cavity with a mouth mirror, explorer, and adequate illumination, as part of an oral cancer screening.
- Determination of the inmates' dental plaque score.
- A periodontal examination.

All inmates/patients assigned to a Mainline Facility shall receive oral hygiene instruction and dental health education by a dental assistant or other properly trained health care personnel. This instruction shall consist of measures to assist the inmate/patient in caring for his or her own oral health, such as instruction in the proper brushing and flossing of teeth and in proper nutrition for dental health.

Routine rehabilitative care shall be provided as clinically indicated and documented in the dental treatment plan. This type of care shall be provided at Mainline Institutions and shall include:

- Diagnosis and treatment of Periodontal conditions.
- Dental Restorative Services.
- Endodontic Services.
- Prosthodontic Services.

Re-admitted inmates who received a dental examination at a Mainline Institution within the past six months, shall not receive a new examination, except as determined by the Chief Dentist (CD).

Transferred inmates who have already received a complete dental examination at a Mainline Institution shall not be re-examined upon transfer from one CDCR institution to another unless they meet the requirements for annual or bi-annual examinations as set forth in Chapter 2.3 *Periodic Dental Examination – Assigned Facility*.

The CD of each institution, or designee, in consultation with the CD, Division of Correctional Health Care Services (DCHCS), shall be responsible for tracking the scheduling and provision of screenings, examinations, and dental care for inmates/patients.

***Excluded Services***

Excluded dental services refer to attempted curative treatments and do not preclude palliative therapies to alleviate serious debilitating conditions such as pain management and nutritional support.

Dental services or treatment shall not be routinely provided for the following conditions:

1. Conditions that improve on their own such as:
  - Benign oral lesions.
  - Traumatic oral ulcers.
  - Mildly inflamed gingiva manifested by changes in color and gingival form in association with bleeding in response to gentle probing of the gingival tissue, but lacking evidence of bone resorption or clinical attachment loss. Gingivitis secondary to pregnancy or certain medication regimens, for example.
  - Recurrent aphthous ulcer.
2. Conditions that are not readily amenable to treatment, including, but not limited to:
  - Shrinkage and atrophy of the bony ridges of the jaws.
  - Benign root fragments whose removal would cause greater damage or trauma than if retained for observation.
3. Cosmetic procedures, which may include, but are not limited to:
  - Removal of existing body-piercing metal or plastic rings or similar devices within the oral cavity, except for security reasons.
  - Restoration or replacement of teeth for esthetic reasons.
  - Restoration of any natural or artificial teeth with unauthorized biomaterials.
4. Surgery that is not medically necessary, which may include, but is not limited to:
  - Extractions of asymptomatic teeth or root fragments unless required for a dental prosthesis, or for the general health of the patient's mouth.
  - Removal of a benign bony enlargement (torus) unless required for a dental prosthesis.
  - Surgical extraction of asymptomatic un-erupted teeth.
5. Services that have no established outcome on morbidity or improved mortality for health conditions.
6. Root canals on posterior teeth (bicuspid and molars), or multi-rooted canals.
7. Implants.

8. Fixed prosthodontics (dental bridges).
9. Cast or laboratory processed crowns.
10. Orthodontics.

***Exceptions to Excluded Dental Services***

Treatment for conditions that are excluded within these regulations *may* be provided in cases where all of the following criteria are met:

1. The inmate's attending dentist prescribes the treatment.
2. The treatment is medically necessary.
3. The service is approved by the facility's CD, and if applicable the Dental Authorization/Utilization/Quality Review Committee (DA/UQR), whose decision to approve an otherwise excluded service shall be based on:
  - Medical necessity.
  - Approved health care outcome data supporting the effectiveness of the services as medical treatment.
  - Co-existing medical problems.
  - Acuity.
  - Length of inmate's sentence.
  - Availability of service.
  - Cost.
  - Other factors

# CHAPTER 6.1

## Health Records Organization and Maintenance (E)

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### I. POLICY

CDCR dental personal shall document all dental treatment rendered to CDCR inmates/patients, including medications utilized during dental treatment, in the inmate/patient's Unit Health Record (UHR).

### II. PURPOSE

To establish procedures for the correct documentation in the UHR of dental services rendered to inmates/patients and to provide guidelines for the development, utilization, and management of inmate/patient health records.

### III. PROCEDURE

#### A. GENERAL HEALTH RECORD ORGANIZATION AND MAINTENANCE

1. A UHR shall be maintained for each inmate/patient consistent with applicable laws and in accordance with Division of Correctional Health Care Services (DCHCS) Medical Services Standards.
2. The UHR shall contain the following:
  - a. Identification data.
  - b. Problem List (including allergies, special needs, chronic illness clinics, permanent medical passes, non-english speaking status, etc.)
  - c. Receiving, screening, and health assessment forms.
  - d. Prescribed medication and therapeutic orders.
  - e. Reports of laboratory, radiographic, and diagnostic studies.
  - f. Clinic notes.
  - g. Special needs treatment plans, if any.
  - h. Immunization records.
  - i. All findings, diagnoses, treatment, and dispositions.
  - j. Informed consent, treatment refusal, and release of information forms.
  - k. All consultant's reports and procedural results.
  - l. Discharge summaries of inpatient admissions and hospitalizations.
  - m. Place, date, and time of each medical encounter.
  - n. Signature and title of each documenter.

3. All services rendered, either direct hands-on care or indirect care (e.g., radiological interpretations), must be documented in the UHR at the time treatment is provided or when observations are made by the appropriate health care provider. Each entry in the UHR must:
  - a. Be legible
  - b. Be documented in chronological order with no blank lines between entries.
  - c. Contain the date and time of the entry.
  - d. Include the legible signature, title, and credentials of the person making the entry, or the name stamp with authentication by the person making the entry.
4. All documentation in the UHR record must be entered with *black* ink.
5. All verbal or telephone orders shall be co-signed within 72 hours, with the date, time, signature, and credentials of the practitioner.
6. All providers of direct care should utilize a format that includes subjective data, objective findings, assessment, a plan in the recording of patient evaluations, and education (SOAPE). The complete obliteration of any entry and use of correction fluid are prohibited.
7. Any UHR removed from the health records filing system must be replaced with an out-guide or similar chart tracking system. Only approved CDCR forms are authorized for inclusion in the UHR. The practice of using unapproved forms or making modifications to approved forms is greatly discouraged and is not authorized for permanent inclusion in the UHR. To avoid misinterpretations, only the approved list of symbols and abbreviations as outlined in this policy and procedure will be utilized. This does not pertain to the filing of appropriate clinical information.
8. The facility health records supervisor shall assure that each UHR is reviewed for completeness prior to filing. In the event a UHR is incomplete due to the death, resignation, termination, or incapacitation of the attending clinician, it shall be given to the unit health supervisor, or if he/she is the person who is no longer available, then the Health Care Manager (HCM)/Chief Medical Officer (CMO) at the local institution will determine if some other provider on staff can complete the record.

#### B. DENTAL HEALTH RECORD ORGANIZATION AND MAINTENANCE

1. The dental section of the UHR shall contain the following:
  - a. CDCR Form 237B *Mainline Dental Examinations*
  - b. CDCR Form 237B-1 *Supplemental Mainline Examination*
  - c. Periodontal Exam Chart (if applicable)
  - d. Plaque Index Scoring (if applicable)
  - e. CDCR Form 237A *Reception Center Screening*
  - f. CDCR Form 237 C *Dental Progress Notes*
  - g. CDCR Form 237 C-1 *Supplemental Progress Notes*

- h. *Dental Consent For Treatment Forms*
  - i. *CDCR Form 7225 Refusal of Dental Examination/Treatment*
  - j. *Dental Consent For Endodontic Treatment*
  - k. *CDCR Form 193 Inmate Trust Withdrawal Order*
  - l. *CDCR Form 7362 Inmate Co-pay*
  - m. Dental requests for consultation forms
  - n. Dental Chronos, etc.
2. Proper and consistent documentation must be maintained to insure compliance with applicable State and Federal laws and regulations and DCHCS UHR Policy.
  3. In order to maintain consistency and compliance with existing policies, it is important to utilize only approved dental abbreviations.
  4. Only approved methods for charting diseases, abnormalities, missing teeth, existing restorations, and treatment completed while incarcerated shall be utilized.
    - a. In-processing Screening – A sample charting of screening findings and illustrating symbols used along with an explanation of the usage is provided.
    - b. Charting Diseases and Abnormalities – Dental treatment needs that are diagnosed subsequent to the in-processing examination (i.e., re-examination findings) shall be charted in this section.
    - c. Restorations and Treatments – A sample charting of treatments provided during the inmate's incarceration as well as illustrating symbols used along with an explanation of their usage is provided. THESE ENTRIES ARE MADE IN BLACK INK DOCUMENTING TREATMENT JUST COMPLETED DURING THE INMATE – PATIENT VISIT.
  5. Health History.
    - a. The initial health history is to be recorded on the appropriate form, and shall be signed and dated by the inprocessing dentist.
    - b. Health histories shall be signed and dated by each new treating dentist, and revised or updated:
      - 1) At the time of an inmate's annual or biannual dental examination.
      - 2) On the occasion of each new dental examination.
      - 3) As appropriate, based on the inmate's existing medical conditions, during the delivery of an extended series of treatments.
  6. Treatment Plan – Any planned treatment shall be entered in the "Treatment Plan Section" on the front side of CDCR Form 237B. Treatment plans formulated as a result of routine inmate requests shall be entered numerically according to treatment priority and shall be based on the inmate's oral condition and length of incarceration.
  7. S.O.A.P.E. Format: All dental health care providers shall utilize the S.O.A.P.E. format, which includes (S)Subjective data, (O)Objective findings, (A)Assessment, a (P)Plan, and

(E) Education in the recording of patient evaluations. Entries made in an inmate's dental health record as the result of a sick call visit for evaluation of a specific or routine complaint must include, but are not limited to, the following:

- a. Chief complaint or purpose of visit (SUBJECTIVE)
- b. Objective findings (OBJECTIVE)
- c. Diagnosis or medical impression (ASSESSMENT)
- d. Treatment plan (PLAN)
- e. Patient education (EDUCATION)

8. Authenticating Entries

- a. Dentists are authorized to authenticate any entry in the dental health record and are *required* to authenticate direct patient care entries and denial or cancellation of any sick call appointment.
- b. Dental assistants are authorized and required to authenticate entries pertaining to: the provision of preventive procedures, screening (subjective and objective findings) of inmates, receiving and disposition of sick call requests, and other non-direct patient care entries.
- c. Office assistants, office technicians, or dental receptionist/clerk(s) are authorized to transcribe in the dental health record those entries not requiring clinical judgment as determined to be appropriate by the Chief Dentist (CD). They may sign the transcribed entry, but the appropriate dental personnel (dentist, dental assistant) must authenticate the entry. Examples of such transcription include but are not limited to the following:
  - 1) Entries pertaining to the receipt of a sick call request.
  - 2) NO SHOW for failed appointments.
  - 3) Issuance of toothbrush, denture cream, flossers, etc.

9. Services Rendered Section. A narrative description of all outpatient dental services and any information determined to be appropriate by the treating dentist shall be documented in the Services Rendered Section of the UHR. Examples of supplemental information include but are not limited to:

- a. Lab reports.
- b. Recommendations.
- c. Probable prognosis in doubtful or complicated cases.
- d. Failure to keep an appointment.
- e. Failure to follow health care provider's instructions.
- f. Refusal of recommended treatment.
- g. Placement on lay-in status.
- h. Appointments cancelled.

- i. Treatment rendered.
  - j. Amount of anesthetic utilized.
  - k. Medication prescribed.
10. **Priority Classification.** Following each visit, the inmate's overall treatment priority shall be updated and recorded in the UHR. This priority is reflective of the status of the inmate's oral condition after the visit.
11. **CDCR Forms.** Only approved CDCR forms or forms generated by an outside dental/medical consultant (e.g., oral surgeon, periodontist, etc.), are to be included in the UHR.

**Approved CDCR Dental and Medical Forms:**

CDCR 237 A (Rev.1/00) *Dental Screening Reception Center (RC)*. This form shall be completed by the dentist as part of the initial dental screening of incoming inmates at the RC.

CDCR 237B (Rev 1/00). *Dental Examination*. The dentist shall use this form when completing a non-reception center, comprehensive dental examination.

CDCR 237 B-1 *Mainline Exam Supplemental Form*. This form is used to note changes and additions to the Dental Treatment Plan.

CDCR 237 C (Rev 1/00) *Dental Progress Notes*. This form shall be used to document subsequent dental treatments and visits.

CDCR 237 C-1 *Supplemental Dental Progress Notes*. This form provides additional space to document changes and additions to the Dental Progress Notes.

CDCR 7293 (Rev 1/00) *Conditions of Admission/Placement*. This form shall be signed by each inmate admitted to an inpatient setting, or placed in an outpatient-housing unit. It shall be filed in the patient identification section of the inpatient/outpatient UHR.

CDCR 7342 (Rev 1/00), *Informed Consent to Surgical Special Diagnostic, or Therapeutic Procedures*. This form shall be used by dentists as well as physicians, and shall be filed in the Consults/Procedures/Treatment Section of the UHR. This form has been revised to combine the following forms, which have been discontinued: CDCR Form 7203, *Consent for Medical/Dental/Surgical Services*, and CDCR Form 7204, *Consent for Surgical Operation*.

CDCR 7385 (Rev 1/00) *Authorization for Release of Health Care Record*. This form shall be used by all inmates requesting authorization for release of information from their UHR, or from a previous health care provider, and shall be filed in the green face sheet/Medico-legal section of the UHR.

*Dental Health History*. This form is to be completed at the receiving institution when treatment is rendered and shall list any past or present illnesses, medications currently being taken, or allergies to medications, etc. This form is available in English and Spanish.

*Consent for Dental Treatment.* This form is to inform inmate/patient of risk/benefits complications of any dental treatment or procedures, and must be signed by the inmate/patient and treating Dentist prior to beginning any dental treatment or procedure.

*CDCR 239 (Rev 5/91) Prosthetic Prescription.* This form must accompany each dental laboratory case during shipping and processing. The form must be completed and signed by the attending dentist, and must describe the prosthetic work to be performed by the dental laboratory.

*CDCR 7243 Consultant's Record.* This form shall be used when requesting consultation between medical and dental staff.

*CDCR 128-C Medical/Psychiatric/Dental.* This chrono report shall be used for any pertinent notation that the attending practitioner requests be placed in the inmate/patient's central file. It is also used to record an inmate's refusal of treatment or refusal to appear for a priority appointment.

*CDCR 7225 Refusal of Examination and/or Treatment.* This form shall be completed when the inmate refuses to submit to a dental examination and/or dental treatment. This form shall become a part of the UHR and the completion of this form shall be noted in the inmate's central file by completing a CDCR 128-C.

*CDCR 7362 Health Care Services Request for Treatment.* This form shall be used by inmates to request a dental appointment.

*CDCR 237 F Dental Pain Profile.* This form is utilized by nursing personnel to evaluate an inmate's dental symptoms. All CDCR dentists should be familiar with this form.

## CHAPTER 6.2

### Informed Consent (E)

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#### I. POLICY

The CDCR, its agents, and the Division of Correctional Health Care Services, shall adhere to the requirements set forth in *California Code of Regulations* Title 15, Article 8, Section 3353 "Informed Consent Requirements."

#### II. PURPOSE

To set forth procedures to ensure and document that an inmate's right to informed consent is observed.

#### III. PROCEDURE

A. The treating dentist(s), physician(s), or their designees, must obtain the inmate/patient's informed consent as documented on CDCR Form 7342 (Rev 1/00), *Informed Consent to Surgical Special Diagnostic, or Therapeutic Procedures* for any surgical or invasive procedure.

B. In emergent situations, inmates shall be treated under the law of implied consent.

## CHAPTER 6.3

### Privacy of Care (E)

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#### I. POLICY

All CDCR dental departments shall provide dental services that meet contemporary community standards as outlined by the Dental Board of California in the Dental Practice Act of 2002 (California Business and Professions Code Section 1600, *et seq.*). All dental services shall be rendered with consideration for the inmate/patient's dignity and feelings and in a manner designed to ensure privacy of care in patient treatment and to encourage the inmate/patient's subsequent use of dental services.

#### II. PURPOSE

To establish guidelines and procedures dental clinics shall use to ensure privacy of care during inmate/patient dental treatment.

#### III. PROCEDURE

- A. Inmate/patient dental treatment shall be performed in private (i.e., only authorized DCHCS staff shall be present in the treatment area unless security necessitates the presence of a CDCR Custodial Officer). A chaperon shall be present when indicated.
- B. Photographing or videotaping of medical/dental procedures shall only be done with the written consent of the inmate/patient, and with the approval of the DCHCS, and the local administration. A formal Use of Force incident, where continuous video recording is used to document the entire event, shall be excepted from this requirement.

## CHAPTER 6.4

### Medical/Dental Chronos

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#### I. POLICY

Within the CDCR, all inmate health information concerns shall be recorded using CDCR Form 128-C1, Medical/Dental Chrono.

#### II. PURPOSE

To ensure that inmates' health information is recorded and tracked in a systematic and uniform manner.

#### III. PROCEDURE

##### A. The CDCR 128-C1, Medical Chrono:

1. Shall indicate functional capacity and physical restrictions relative to housing units, diagnosis, and work assignments.
2. May also contain health alerts or recommendations for placement in health programs such as: the Clinical Correctional Case Management System (CCCMS), the Enhanced Outpatient Program (EOP), the Mental Health Crisis Beds, the Disability Placement Program, the Chronic Care Program, Outpatient Housing Unit placement, or Skilled Nursing Facility/Correctional Treatment Center/General Acute Care Hospital/CDCR acute care hospital admission.
3. Shall indicate an inmate/patient's Tuberculosis (TB) code and Dental Classification.
4. Shall remain current until a new CDCR Form 128-C1 is generated documenting a new physician's order.

##### B. Each CDCR Form 128-C1, Medical Chrono that indicates a permanent medical condition or disability shall be a permanent chrono and shall not be regenerated upon inmate transfer.

##### C. Medical chronos shall not have health conditions stated in the body of the form, such as Seizure Disorder, Asthma, Diabetes, Chronic Infectious Disease, Allergies, Orthopedic Conditions, Cardiac Disease, Hepatitis, Contagious Diseases, Communicable Diseases, etc.

## Chapter 6.5

### Medical/Dental Lay-Ins (E)

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#### I. POLICY

Inmates/patients within the CDCR who require medically indicated bed rest shall be provided with medical/dental lay-ins by institution licensed health care staff.

#### II. PURPOSE

To establish standards and guidelines for the use of medical/dental lay-ins.

#### III. PROCEDURE

- A. A VGA 171 or CDCR Form 128C chrono shall be written for all medical lay-ins.
- B. Medical/dental lay-ins shall be issued only by Physicians, Dentists, Registered Dental Assistants, Registered Nurses (RN), or Licensed Vocational Nurses (LVN), i.e. licensed health care staff. Medical/dental lay-ins shall be issued only to inmates/patients needing medically indicated bed rest or who temporarily cannot perform their assigned duties, but who do not require inpatient infirmary or hospital care.
- C. Medical lay-ins shall be issued for specific time periods. Lay-ins requiring confinement to quarters for longer than a 24-hour period must be ordered by a physician or a dentist, and the order must include a termination date.
- D. Upon expiration of the lay-in, the inmate/patient shall:
  - return to normal activities
  - be re-evaluated by the physician or dentist for possible reissue of a lay-in
  - be re-evaluated by the physician or dentist for possible transfer to a facility with an infirmary or hospital.
- E. Inmates/patients on medical/dental lay-ins must be confined to their cells or dormitory beds, except to eat, obtain medication, shower, or to access the facility law library.
- F. Health care staff may re-evaluate the lay-in status of any inmate/patient at any time depending on the inmate/patient's behavior and/or activity.

Distribution of the CDCR Form 128C is the following:

- Original to Unit Health Record
- Copy to inmate/patient
- Copy to inmate supervisor/housing officer
- Copy to Central Files

## CHAPTER 6.6

### Dental Holds and Inmate/patient Transport/Transfers (E)

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#### I. POLICY

The CDCR shall utilize a dental hold process when the transfer or transport of an inmate/patient is not dentally appropriate.

#### II. PURPOSE

To establish procedures and criteria for placing dental holds on inmates scheduled for transfer or transport.

#### III. PROCEDURE

A. The treating dentist shall determine if a dental hold should be placed on an inmate/patient.

B. A dental hold shall be placed on an inmate/patient for any of the following reasons:

- The inmate/patient has untreated Priority 1A dental treatment needs.
- Immediate dentures were recently inserted.
- The inmate/patient is awaiting completion of endodontic treatment (i.e., the obturation of canals).
- The inmate/patient is awaiting an outside specialty consultation and/or treatment.
- The inmate/patient is awaiting laboratory or biopsy results.
- The inmate/patient is undergoing treatment for a fracture of the mandible or maxilla, and/or is still in wired fixation.

C. The dental hold shall be removed or lifted only by the attending dentist, outside specialty consultant, or the Chief Dentist (CD).

D. The criteria for placing or removing a dental hold on an inmate/patient shall follow the procedures established in the Health Care Services "Medical Hold" Policy.

E. The treating dentist shall document the dental hold on the CDCR Form 237B *Dental Health Record* and on the Physicians' Orders.

F. The CD shall review the UHR and the Medical Hold policy to ensure compliance with approved policies and procedures.

G. The CD shall notify the Health Care Manager or designee of the placement or removal of a dental hold and shall complete all required documents.

Exhibit

B

# DENTAL PROGRAM IMPLEMENTATION PLAN

	Tasks	Comments	Target Start Date	Target Completion Date	Actual Completion Date
A	Implement relevant portions of Policies and Procedures at each Reception Center (RC) and Mainline Institutions		7/1/06	12/31/11	
A.1	Implementation of relevant portions of Policies and Procedures at the following institutions: Avenal State Prison, Calipatria State Prison, Centinela State Prison, California State Prison- Corcoran, Folsom State Prison, Ironwood State Prison, California State Prison- Los Angeles County, Mule Creek State Prison, Kern Valley State Prison, Pleasant Valley State Prison, California State Prison- Sacramento, Substance Abuse Treatment Facility, and Salinas Valley State Prison. (2006 rollouts)		7/1/06	12/31/08	
A.2	Implementation of relevant portions of Policies and Procedures at the following institutions: California Correctional Center, California Men's Colony, California Medical Facility, Correctional Training Facility, Pelican Bay State Prison, Sierra Conservation Center and California State Prison- Solano (2007 rollouts)		7/1/07	12/31/09	
A.3	Implementation of relevant portions of Policies and Procedures at the following institutions: The mainline facilities of California Rehabilitation Center, California Correctional Institution, Central California Women's Facility, California Institute for Men, California Institute for Women, Deuel Vocational Center, High Desert State Prison, North Kern State Prison, Richard J. Donovan Correctional Facility, San Quentin State Prison, Valley State Women's Prison, and California State Prison- Wasco (2008 rollouts)		7/1/08	12/31/10	

# DENTAL PROGRAM IMPLEMENTATION PLAN

Tasks	Comments	Target Start Date	Target Completion Date	Actual Completion Date
A.4 Implementation of relevant portions of Policies and Procedures at the following institutions: The RC facilities of California Rehabilitation Center, California Correctional Institution, Central California Women's Facility, California Institute for Men, California Institute for Women, Deuel Vocational Center, High Desert State Prison, North Kern State Prison, Richard J. Donovan Correctional Facility, San Quentin State Prison, Valley State Women's Prison, and California State Prison- Wasco (2009 rollouts)		7/1/09	12/31/11	
B.1 Hire a project manager (PM).		1/1/05	7/1/06	
B.2 Retain an Information Technology (IT) expert.		7/15/05	6/1/06	
B.3 Chief Dentists meeting at Health Care Services Division (HCSD) to discuss Dental P&Ps, Stipulated Agreement, and implementation plan.	Meetings with the Chief Dentists to be held at HCSD on a quarterly basis beginning June 2005.		Ongoing	
C Dental workload, salary, and space study		7/16/05	8/30/06	
C.1 Develop scope of services for dental workload, salary, and space study		8/1/05	9/30/05	9/30/05
C.2 Conduct Dental Salary study		8/1/05	6/30/06	
C.3 Conduct Dental Space study		8/1/05	6/30/06	
C.4 Conduct Dental Workload/Staffing study		8/1/05	6/30/06	
D Dental Flossers, Toothbrushes and Fluoridate Tooth Powder	Memo to field to obtain flossers, soft toothbrushes, and fluoridated Tooth Powder	5/1/05	7/1/05	7/15/05
D.1 Audit for compliance			Ongoing	
E Dental Policies and Procedures and Dental Forms				
E.1 Develop HCSD dental P&Ps.				8/2/04
E.2 Revise P&Ps, if applicable.		9/16/06	10/16/06	
E.3 Distribute final P&Ps to the field, Legal Affairs, PLO, Labor Relations, Regional Administrators, Chief Dentists, etc.		3/1/07	3/30/07	

# DENTAL PROGRAM IMPLEMENTATION PLAN

Tasks	Comments	Target Start Date	Target Completion Date	Actual Completion Date
E.4	Conduct readiness assessment of each institutional dental department according to their roll out schedule.	4/1/06	Ongoing as plan is rolled out.	
E.5	Annual revisions of the dental P&Ps.	4/1/08	Ongoing	
E.6	Annual revision based on 2006 rollouts.	4/2/08	8/9/08	
E.7	Revise and track revisions made to P&Ps based upon divisional review.	11/21/08	1/26/09	
E.8.	Annual Review P&Ps for consistency with other policies.		Ongoing	
E.9	Research identify forms, and develop (new or existing), which are required to implement the P&Ps.			4/13/05
E.10	Annual review of dental forms.		Ongoing	
F	Dental Equipment and Space Analysis			
F.1	Dental Equipment			
F.1.1	Survey institutional dental clinics for major and minor equipment replacement needs.	10/04	11/04	11/04
F.1.2	Obtain replacement equipment	11/05	6/07	
F.1.3	Identify new equipment needs required to comply with regulations and mandates.	12/04	12/06	
F.1.4	Establish criteria and parameters for equipment in need of immediate replacement, and equipment in need of replacement within one year or within three years.	10/04	12/31/04	12/31/04
F.1.5	Research relevant documents, American Dental Association, governmental agencies, dental equipment manufacturers for recommended replacement cycles for dental equipment.	12/04	4/29/05	5/1/05
F.1.6	Develop a replacement lifecycle for dental major and minor equipment.	12/04	5/29/05	6/15/05
F.2.1	Survey each of 2006 institutions for necessary physical plant upgrades necessary to implement P&Ps, Stipulated Agreement, and comply with federal and state regulatory agencies requirements. Evaluate space for separate sterilization rooms, digital dental x-	10/17/05	6/30/06	

# DENTAL PROGRAM IMPLEMENTATION PLAN

Tasks	Comments	Target Start Date	Target Completion Date	Actual Completion Date
rays and panoramic machines, dentist office space, clinical space, and OT space.				
F.2.2 Develop and finalize plans for physical plant alterations for 2006 roll out institutions.	Completion dates may be affected by comprehensive Healthcare space survey.	10/06	5/1/07	
F.2.3 Make necessary modifications identified to 2006 institutions.	Completion dates to be determined by results of survey and extent of physical plant changes.			
F.2.4 Survey each of 2007 institutions for necessary physical plant upgrades necessary to implement P&Ps, Stipulated Agreement, and comply with federal and state regulatory agencies requirements. Evaluate space for separate sterilization rooms, digital dental x-rays and panoramic machines, dentist office space, clinical space, and OT space.	It is anticipated that the space analysis survey will take approximately three years to complete.	8/16/06	4/25/07	
F.2.5 Develop and finalize plans for physical plant alterations for 2007 roll-out institutions.	Completion dates and modifications to be determined by space analysis			
F.2.6 Make necessary modifications identified to 2007 institutions.	Completion dates to be determined by results of survey and extent of physical plant changes.			
F.2.7 Survey each of 2008 institutions for necessary physical plant upgrades necessary to implement P&Ps, Stipulated Agreement, and comply with federal and state regulatory agencies requirements. Evaluate space for separate sterilization rooms, digital dental x-rays and panoramic machines, dentist office space, clinical space, and OT space.	It is anticipated that the space analysis survey will take approximately three years to complete.			
F.2.8 Develop and finalize plans for physical plant alterations for 2008 roll out institutions.	Completion dates and modifications to be determined by space analysis			
F.2.9 Make necessary modifications identified to 2008 institutions.	Completion dates to be determined by results of survey and extent of physical plant changes.			
F.2.10 Survey each of 2009 institutions for necessary physical plant upgrades necessary to implement P&Ps, Stipulated Agreement, and comply with federal and state regulatory agencies requirements. Evaluate space for separate sterilization rooms, digital dental x-rays and panoramic machines, dentist office	It is anticipated that the space analysis survey will take approximately three years to complete. However, completion dates may be affected by comprehensive Healthcare space survey.			

Last updated: 4/26/06

# DENTAL PROGRAM IMPLEMENTATION PLAN

Tasks	Comments	Target Start Date	Target Completion Date	Actual Completion Date
space, clinical space, and OT space. Develop and finalize plans for physical plant alterations for 2009 roll out institutions reception centers.	<i>Completion dates and modifications to be determined by space analysis.</i>			
F.2.11 Make necessary modifications identified to 2009 institutions.	<i>Completion dates to be determined by results of survey and extent of physical plant changes.</i>			
G Dental Key Indicators and Audit Tool:				
G.1 Develop an audit tool to track compliance with Dental P&Ps and Stipulated Agreement.	<i>To be developed in conjunction with Court Experts and Plaintiffs' Counsel.</i>			
G.1.1 Identify Subject Matter Experts and Project Manager for project.				
G.2 Finalize key indicators and audit tool for dental P&Ps and Stipulated Agreement requirements for mainline institutions and RCs.				
G.3 Determination of the compliance passing score.				
H Information Technology:				
H.1. Conduct information technology needs assessment for a tracking and monitoring system for the implementation of dental P&P and Stipulated Agreement.		4/1/05	10/30/05	6/30/05
H.2 Develop a Feasibility Study Report to identify an interim and long-term dental tracking, scheduling, and monitoring system.		9/30/05	8/06	
H.3 Select a dental tracking, scheduling, and monitoring system	<i>Completion dates may be affected by budget approval process.</i>	12/05	11/06	
H.4 Computerized Dental Tracking and monitoring system implementation.	<i>Completion dates may be affected by budget approval process.</i>		3/31/07	
I Self-care Prevention Program				
I.1 Develop dental assistant dental self-care educational and training program.				3/31/05
I.1.2 Develop lesson plans for self-care program.		4/4/05	10/1/06	
I.1.3 Train QMAT, HCSD dental unit, and field staff on the self-care program.		12/8/05	Ongoing	

# DENTAL PROGRAM IMPLEMENTATION PLAN

	Tasks	Comments	Target Start Date	Target Completion Date	Actual Completion Date
I.1.4	Implement self-care training for dental assistants statewide.	Training is for only the designated positions	7/3/06	Ongoing	
I.1.5	Develop self-audit tool on self-care program.	Institutions to perform self-auditing of self-care program, with periodic review by HCSD.	6/27/06	Ongoing	
I.1.6	Finalize and approve self-audit tool.		7/1/05	8/1/05	8/1/05
I.1.7	Develop lesson plans on self-audit tool.		8/1/05	10/30/06	
I.1.8	Train staff on self-audit tool.		8/30/05	Ongoing	
I.1.9	Implement self-audit tool.	Self-audit tool to be distributed to Wardens, HCM, and Chief Dentists at all mainline institutions.	7/3/06	Ongoing	
I.1.9.1	Monitor the self-care program via the self-audit tool.	Monitoring to be ongoing.	7/3/06	Ongoing	
I.2	Self-care pamphlet for Reception Centers:				
I.2.1	Finalize and approve reception center oral health instruction pamphlet.			8/1/05	8/1/05
I.2.2	Develop self-audit tool of reception center oral health instruction pamphlet.	Institutions to perform self-auditing of RC oral health instruction pamphlet, with periodic review by HCSD.	6/27/05	7/1/08	
I.2.3	Finalize and approve self-audit tool.		7/1/05	8/1/08	
I.2.4	Develop lesson plans on self-audit tool.		12/18/05	10/1/08	
I.2.5	Train staff on self-audit tool.		3/30/05	2/1/09	
I.2.6	Implement self-audit tool.	Self-audit tool to be distributed to Wardens, HCM, and Chief Dentists at all institutions with reception center facilities.	9/30/06	Ongoing	
I.2.7	Monitor reception center oral health instruction pamphlet via the self-audit tool.	Monitoring to be ongoing.	According to roll out date.		
J	Health Care Services Orientation Handbook				
J.1	Develop dental section in HCSD Orientation Handbook Identify any training needed.		7/1/05	8/30/05	8/30/05
J.2	Distribute the inmate health care orientation handbook to all institutions.		9/1/05	3/31/06	3/31/06
J.3	Develop self-audit tool on Health Care Services Orientation Handbook.	Institutions to perform self-auditing of Health Care Services Orientation Handbook, with periodic review by HCSD.	7/27/05	11/1/05	3/31/06
J.4	Finalize and approve self-audit tool.		12/1/05	1/1/06	3/31/06

# DENTAL PROGRAM IMPLEMENTATION PLAN

	Tasks	Comments	Target Start Date	Target Completion Date	Actual Completion Date
J.5	Develop lesson plans on self-audit tool.		1/10/06	3/31/06	3/31/06
J.6	Train staff on self-audit tool.		8/30/06	Ongoing	
K	Establish Dental Quality Management Assessment Team		7/1/05	Ongoing	
K.1	Train QMAT on dental policies and procedures, implementation plan, and Stipulated Agreement		6/30/06	Ongoing	
L	Training				
	<i>Training for Trainers for Dental Staff:</i>				
L.1	Complete Training for Trainers (T4T) for Chief Dentists and dental assistants on special assignment at Health Care Services Division (HCSD).		4/15/05	4/7/05	4/7/05
L.2	Develop memo to Chief Dentists requesting field staff be identified for T4T training.		6/30/05	11/1/05	11/1/05
L.2.1	Approve and distribute memo to Chief Dentists at the 2006 roll out institutions requesting staff be identified for T4T.	<i>The Chief Dentists would then be required to send a list of volunteered identified staff to HCSD.</i>	7/5/05	12/1/05	12/1/05
L.3	HCSD to receive list of identified staff for T4T at the 2006 roll out institutions from the Chief Dentists.	<i>Identified staff from the institution should contain at least the Chief Dentist, 1 staff dentist, and 2 dental assistants.</i>	10/25/05	12/1/05	12/1/05
L.4	Schedule T4T training for Chief Dentists and selected dental staff at the 2006 roll out institutions.	<i>Classes are offered on a monthly basis. Approximately 84 staff members will require T4T from the 2006 roll out institutions.</i>	1/30/06	7/1/06	
L.5	Chief dentists and identified dental staff from the 2006 roll out institutions to complete T4T.		4/1/06	8/3/06	
L.6	Distribute memo to Chief Dentists at the 2007 roll out institutions requesting staff be identified for T4T.	<i>The Chief Dentists would then be required to send a list of identified staff to HCSD.</i>		7/3/06	
L.7	HCSD to receive list of identified staff for T4T at the 2007 roll out institutions from the Chief Dentists.	<i>Identified staff from the institution should contain at least the Chief Dentist, 1 staff dentist, and 2 dental assistants.</i>	7/3/06	7/17/06	
L.8	Schedule T4T training for Chief Dentists and selected dental staff at the 2007 roll out institutions.	<i>Classes are offered on a monthly basis. Approximately 42 staff members will require T4T from the 2007 roll out institutions. Therefore, an average of</i>	7/17/06	7/2/07	

Last updated: 4/26/06

# DENTAL PROGRAM IMPLEMENTATION PLAN

	Tasks	Comments	Target Start Date	Target Completion Date	Actual Completion Date
L.9	Chief dentists and identified dental staff from the 2007 roll out institutions complete T4T.	approximately 4 staff members need to be scheduled per month starting on 8/1/06.	8/1/06	7/2/07	
L.10	Distribute memo to Chief Dentists at the 2008 roll out institutions requesting staff be identified for T4T.	Approximately 4 staff members at the 2007 roll out institutions need to complete T4T training per month starting on 8/1/06. The Chief Dentists would then be required to send a list of identified staff to HCSD.		7/2/07	
L.11	HCSD to receive list of identified staff for T4T at the 2008 roll out institutions from the Chief Dentists.	Identified staff from the institution should contain at least the Chief Dentist, 1 staff dentist, and 2 dental assistants.	7/2/06	7/16/07	
L.12	Schedule T4T training for Chief Dentists and selected dental staff at the 2008 roll out institutions.	Classes are offered on a monthly basis. Approximately 72 staff members will require T4T from the 2007 roll out institutions. Therefore, an average of approximately 7 staff members need to be scheduled per month starting on 8/1/07.	7/16/07	7/1/08	
L.13	Chief dentists and identified dental staff from the 2008 roll out institutions complete T4T.	Approximately 7 staff members at the 2007 roll out institutions need to complete T4T training per month starting on 8/1/07.	8/1/07	7/1/08	
L.14	Milestone: Training of Chief Dentists and selected dental staff at all CDC institutions is completed.	Previous T4T programs have completed training for the 2009 roll out institutions.		7/1/08	
L.15	Schedule T4T training for dental QMAT unit and HCSD dental unit staff.		1/1/06	11/1/06	
L.16	Completion of T4T training of dental QMAT unit and HCSD dental unit staff.		6/30/06	12/31/06	
L.17	Train RNs and Physicians on protocols for dental emergencies		9/1/06	Ongoing	
L.18	Implement Plan for Dental Emergency Services		9/1/06	1/1/06	1/1/06
M	Local Operating Procedures:				
M.1	Develop Local Operating Procedures (LOP) for each set of roll out institution	To start after the completion of training the field on the dental P&P and associated forms.	1/30/06	Ongoing	
M.2	Develop training based on the LOP.		7/1/06	Ongoing	
M.3	Train appropriate institution staff on the LOP.		9/1/06	Ongoing	
N	Dental QMAT Monitoring:				

# DENTAL PROGRAM IMPLEMENTATION PLAN

Tasks	Comments	Target Start Date	Target Completion Date	Actual Completion Date
N.1	Review implementation/roll out schedule.		Ongoing	
N.2	Review calendar and create site visit schedule.		Ongoing	
O	Recruitment of Dental Program Positions:			
O.1	Advertising /other recruitment activities		Ongoing	
O.2	Fast track hiring of Dentists	9/1/05	7/1/06	
O.3	Fast track hiring of Dental Assistants	9/1/05	7/1/06	
O.4	Recruit Office Technician positions	9/1/05	7/1/06	
O.5	Fast track hiring of Office Technician positions	1/1/06	12/31/06	
O.6	Fast track hiring of QMAT positions	10/1/05	11/1/06	
P	Dental Emergency Services			
P.1	Develop plan for Chief Dentists On-Call	9/1/05	12/15/05	12/15/05
P.2	Train on Dental On-Call plan	12/15/05	1/1/06	12/15/05
P.3	Dentist on call at each CDCR institution		1/1/06	12/27/05

Exhibit

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IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF CALIFORNIA

**CARLOS PEREZ, et al.,**

Plaintiffs,

v.

**JAMES TILTON, et al.,**

Defendants.

CASE NO. C-05-5241

**ORDER APPOINTING  
EXPERTS UNDER RULE 706**

At the request of the parties and for good cause, the Court appoints, with their consent, court experts under Rule 706 of the Federal Rules of Evidence. Compensation for these experts shall be approved by the Court and paid by the California Department of Corrections and Rehabilitation.

Pursuant to Rule 706(a) the Court informs the experts that their duties shall be as follows:

1. At the request of any party or the Court, the experts shall evaluate Defendants' Dental Implementation Plan and their Dental Policies and Procedures, to advise the Court and the parties whether they are sufficient to satisfy Defendants' obligations as set forth in the Stipulation filed concurrently with this Order.

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1           2.    At the request of any party or the Court, the experts shall evaluate Defendants'  
2 compliance with the Dental Implementation Plan and the Dental Policies and Procedures, to  
3 advise the Court and the parties whether Defendants' level of compliance satisfies their  
4 obligations as set forth in the Stipulation.

5           3.    At the request of any party or the Court the experts shall evaluate any modifications  
6 proposed by Defendants to determine whether those modifications in combination with the  
7 Implementation Plan, Dental Policies and Procedures, and the Audit Instrument are sufficient to  
8 satisfy Defendants' obligations set forth in the Stipulation.

9           4.    At the request of any party or the Court, the experts shall evaluate any modifications  
10 proposed by Plaintiffs to determine whether those modifications are necessary to satisfy  
11 Defendants' obligations set forth in the Stipulation.

12          5.    At Defendants' request, the experts shall estimate their projected fees and expenses  
13 related to their expert duties under this Order for a specified period of time. Any such estimation  
14 shall not be binding upon the experts, nor may it be used by Defendants to limit the experts in  
15 executing their duties under this Order.

16          6.    The parties have the right to discuss with the experts their methodology for evaluating  
17 Defendants' compliance with the Implementation Plan and the Dental Policies and Procedures.

18          7.    When Defendants indicate they have conducted an audit using the Audit Tool and  
19 found an institution to be in compliance with its Dental Policies and Procedures, the experts shall  
20 be available to conduct a separate audit, using the same Audit Tool, within 30 days of notice by  
21 Defendants. The experts' written report on their audit shall be transmitted to the parties within 30  
22 days of the experts' audit.

23          8.    In fulfilling their duties, the experts shall address systemic deficiencies in CDCR's  
24 delivery of dental care. The experts shall review the care provided to individual class members  
25 to determine whether systemic deficiencies exist.

26          9.    Any evaluations by the experts shall be transmitted to the parties in a written reports.  
27 Such reports shall contain the experts' conclusions and shall specify the information upon which

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1 any conclusions are based. The experts' reports shall be admissible in any judicial proceeding in  
2 this case.

3 10. At the request of any party or the Court, the experts shall attend any negotiations,  
4 mediation sessions, or court hearings.

5 11. The experts shall be available to meet with the parties in person or by telephone in a  
6 manner that is reasonable and convenient. The experts may communicate with the parties jointly  
7 or separately. Information communicated by the experts separately to one party may not be used  
8 by that party when that party communicates or files a motion with the Court, unless that party  
9 provides the other party with advance notice of the intended disclosure.

10 12. In fulfilling their duties under this order, the experts shall have access to all parts of  
11 any institution, all relevant documents, all individuals (including interviews with staff or  
12 inmates), dental meetings, dental proceedings, and dental programs to the extent that such access  
13 is reasonably needed to fulfill their obligations.

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15 **IT IS SO ORDERED.**

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17 Dated: \_\_\_\_\_

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UNITED STATES DISTRICT JUDGE

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