CODA Accreditation Self-Study

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STANDARD 6 - PATIENT CARE SERVICES

6-1 The program must have policies and mechanisms in place that inform patients, verbally and in writing, about their comprehensive treatment needs. Patients accepted for dental hygiene care must be advised of the scope of dental hygiene care available at the dental hygiene facilities.

Intent:
All dental hygiene patients should receive appropriate care that assures their right as a patient is protected. Patients should be advised of their treatment needs and the scope of care available at the training facility and appropriately referred for procedures that cannot be provided by the program. This Standard applies to all program sites where clinical education is provided.

Narrative Response and Documentation:

1. **Describe procedures used to accept patients for treatment in the program's clinic.**

For new patients to the clinic a screening form is completed to partially assess their needs and to gather pertinent information. Potential patients call the front office to inquire about scheduling an appointment. The screening form includes medical, dental, and demographic information. The form asks for the name, phone number, and birth date of the individual. Information is collected about the individual's most recent dental cleaning and when they had radiographs last taken and if they will be bringing them to the appointment. The individual will be asked questions if they are taking certain medications or have specific medical conditions that may require a medical consult or an alteration to treatment. In the case that a medical consult is needed, a medical consult form is filled out with the necessary information and faxed to the individual's medical provider for them to complete and then faxed back to the front office. The medical consult form will determine if alterations to the patient's treatment is needed to be treated in the clinic. Patients also receive an introduction letter and a copy of the patient's bill of rights upon acceptance as a patient. Patients who are specifically found to be within the scope of practice of dental hygiene and are safe to treat are accepted as patients.

2. **Describe the scope of dental hygiene care available at the program's facility. As an exhibit, include the current clinical services form(s).**

Within our scope of dental hygiene care, our student hygienists treat, prevent, and intercept disease to all patients. The program follows the standards of dental hygiene care. Student hygienists complete a periodontal examination and provide a treatment plan that is appropriate for the patient's oral health needs. This not only involves the removal of plaque and calculus, but educating the patient on: oral hygiene instructions, smoking cessation, nutritional counseling, completing an oral cancer screening, acquiring radiographs when necessary, providing antimicrobial therapy when necessary, and sustaining accurate patient records.

a. Exhibit 1: Clinic Fee Schedule form

3. Explain the mechanism by which patients are advised of their treatment needs and referred for procedures that cannot be provided by the program.

Following the completion of the assessment, the student clinician forms a treatment plan for the patient based on their needs. The treatment plan is then explained to the patient in terms of parts of their exam such as the dental chart and periodontal assessment. It is explained if they need radiographs, whether they need a prophylaxis or scaling and root planing, and if they need fluoride varnish. Referrals are provided for patients if they have specific dental conditions that cannot be treated by the program. Upon presentation of the referral, the patient must sign the referral to acknowledge that they have been informed of the need and reason for referral. These conditions include caries, fractured restorations, periodontal pockets greater than 7mm, pathology, malocclusion, mobility, abscesses, inadequate attached gingiva, or furcations above a class I. The referral process involves the condition needing further treatment being identified. A referral form is filled out by the student clinician detailing the condition, the date of the appointment, and what radiographs were taken, if any. The form also states the patient's name and address.

4. Describe how the dental hygiene treatment plans are presented and approved by faculty.

When a patient is seen in the clinic, a student will complete a comprehensive assessment on the patient. The student will then create a full treatment plan that will be presented to the faculty. If the patient is a class one calculus patient, then the faculty will authorize the checked treatment plan prior to the beginning of treatment. If the patient requires multiple appointments, then the student will create a treatment plan for the current appointment as well as all of the future treatment appointments. At the final checkout of each appointment, the faculty member should recheck the treatment plan for the day that was completed and further adjust the treatment plan for any future appointments if needed. The faculty member will swipe the treatment plan after it is completed; this indicates the treatment plan has been approved and shows in the clinical system for documentation purposes.

5. **Explain the program's recall policies and procedures.**

Students who are still in the program are to reappoint their patients according to the proposed recall schedule for that patient, which is found in the treatment plan. The recall interval is set according to the oral health needs of the patient. In cases where the patient has periodontal disease, a more frequent periodontal maintenance recall schedule is indicated. Typically intervals include 3 months, 4 months, and 6 months. If the student who has already seen the patient is unable to accommodate the recall patient, they advise the Office Manager, so that the patient can be scheduled to be seen by another student. Within the Axium system, the Office Manager can print a complete list of all patients assigned to any one provider, so that patients are not inadvertently neglected for recall services. It is the student's responsibility to schedule recall patients.

6. **As an exhibit, include a blank initial patient screening form.**
    a. Exhibit 2: Initial patient screening form

7. **As an exhibit, include a blank client consent form, physician's consultation form and dental referral form.**
    a. Exhibit 3: Client consent form, physician's consultation form, dental referral form

6-2 The program must have a formal written patient care quality assurance plan that allows for a continuous systematic review of patient care standards. The quality assurance plan must be applied at least annually and include:
a) standards of care that are patient-centered, focused on comprehensive care, and written in a format that facilitates assessment with measurable criteria;
b) an ongoing audit of a representative sample of patient records to assess the appropriateness, necessity and quality of the care provided;
c) mechanisms to determine the cause of treatment deficiencies;
d) patient review policies, procedure, outcomes and corrective measures.

Intent:
The program should have a system in place for continuous review of established standards of patient care. Findings should be used to modify outcomes and assessed in an on-going manner. This Standard applies to all program sites where clinical education is provided.

Narrative Response and Documentation:

1. **Describe the program's formal written patient care quality assurance plan.**

The quality assurance plan is a system designed to support and ensure the standards of care in the School of Dental Hygiene are being met. This program is information based, and has been created to evaluate and manage potential obstacles and disputes within the realm of patient care. Its overall purpose is to prevent harm and foster a safe educational environment for both students and patients. This is accomplished through close monitoring and inspection, including monthly patient chart audits. Each month, patient charts are audited for quality assurance of patient care in regards to routine periodontal charting, adequate radiography, proper documentation, medical clearance and medical history information, and more. Any instance of shortcoming is immediately addressed and rectified.

2. **Describe the process to review a representative sample of patient records.**

A representative sample of patient records are reviewed through patient record, or chart, audits. Chart audits assess proper record keeping of patient services as well as ensuring the safety of patients as well as the quality of care provided in the program. There are 3 types of chart audits performed: patient chart audits performed by faculty members, radiographic audits, and student reports. Chart audits completed by faculty members are performed monthly each semester. Radiographic audits are done 4 times a semester. Student reports are a form of chart audit performed once a month. All forms of chart audits check for inaccuracies such as services not completed, in-progress, or completed, services not paid by the patient, and radiographs exposed.

3. **As an exhibit, include the patient record audit form.**
    a. Exhibit 4: Patient record audit form

4. **Describe how patient treatment deficiencies are identified and corrected.**

Each patient that receives treatment in the clinic must complete a pre-screening and a post-screening to ensure adequate treatment. At the end of each patient's dental appointment, a faculty member will review the treatment plan and services rendered, then will ensure that all are correctly documented. Monthly faculty audits are completed on patient charts also. If a faculty member finds any revisions or changes that need to be made, then the faculty member involved in the patient's treatment will be notified. That faculty will then meet with the student that performed treatment on the patient and they will review and correct the treatment plan. The faculty will help the student to correct any treatment planning issues which may mean the patient has to be reappointed to complete

care. Anytime there is a treatment deficiency, the patient will be called, informed of the treatment deficiency, and will be requested to return to the clinic to have the treatment completed. All refusals will be recorded in the patient's record. If a treatment deficiency is found on a high calculus patient, then the student and faculty member that were involved with that appointment must work together to ensure that all calculus is removed from that quadrant. If a faculty member has been found to be deficient in proper instrumentation, then a senior faculty member will review and practice using instruments for calculus removal with the faculty member. Once all problems have been addressed in a chart audit then the chart will be reviewed by the clinic director who will verify that all deficiencies have been corrected. If patterns of treatment deficiencies are consistently being found in the clinic department, then these deficiencies will be addressed during the next clinic faculty meeting. All clinical faculty participate in monthly calibration sessions to ensure that all faculty members are in concordance with each other concerning clinical procedures and policies.

5. **Identify the policies and procedures used to track completed patients and ensure active patients are completed.**

Students are able to access their active patient list within the scheduler. The Office Manager can print out the full patient list for each provider, so that no patients are left without treatment. Reports can be run showing each student's completed patients and incomplete patients. Ethically and legally, students are to complete treatment of patients and plan their recall appointments appropriately. Not doing so is considered patient abandonment and is not allowed. When patients no show appointments or cancel appointments, students must track this in the clinical record and attempt to reappoint with patients as soon as possible. For repeat no shows, or for patients not answering student phone calls, the Clinical Director must be informed. With review and approval by the Office Manager, an inactivation letter is sent to the patient, which is also scanned and uploaded into the patient's electronic health record under "letters to patient." Any efforts made by the student to reach out to patients (phone calls, messages, letters, conversations, and canceled/failed appointments) are documented in the electronic medical record for tracking purposes.

6. **Identify any changes made to clinic policies and/or procedures based on quality assurance program outcomes. As an <u>exhibit</u>, include the quality assurance reports.**

At the end of each semester, several reports are created. The created reports are as follows: radiographic quality assurance report, incident report form, chart audit review report, sterilization log report, patient satisfaction survey results report, weekly and monthly patient billing account audit, and student list of planned and in progress

treatments. These are reported to the faculty and students to view to evaluate for any pattern of deficiency. The deficiency is then assessed and corrected.

a. Exhibit 5: Quality assurance reports

7. Discuss how the program assesses patients' perceptions of quality of care. Describe the mechanisms to handle patient complaints. As an <u>exhibit</u>, include the patient satisfaction survey instruments and data results.

At the Dental Hygiene Clinic at Old Dominion University, patients have the right to be treated with respect and professionalism. They can expect courteous and confidential treatment, as well as treatment that meets the standard of care in the profession, including appropriate infection control. Patients have the right to inspect their patient record and any radiographs taken, and to have advanced knowledge of fees and services. Additionally, they have the right to an explanation of recommended treatment, alternate treatment options, and the risks associated with no treatment. Patients are encouraged to participate in the planning of their treatment through informed consent and can refuse recommended treatment through informed refusal. They have the right to continuity of care or referral for continued care. Patients participating in experimental research have the right to written informed consent and the right to refuse participation. Lastly, they can provide feedback, comments, or complaints about treatment using the confidential Patient Satisfaction Survey.

Old Dominion hygiene staff and faculty are available to handle any complaints. However, if the matter is not resolved to the patient's satisfaction, they can submit a confidential patient satisfaction survey which is posted on the dental hygiene website. The appropriate department will address the issue based on the nature of the complaint.

a. Exhibit 6: Patient satisfaction survey instruments and data results

6-3 The use of quantitative criteria for student advancement and graduation must not compromise the delivery of comprehensive dental hygiene patient care.

Intent:
The need for students to satisfactorily complete specific clinical requirements prior to advancement and graduation should not adversely affect the health and care of patients.

<u>Narrative Response and Documentation:</u>

1. **Describe policies and procedures relative to patient assignment strategies.**

Students are assigned clinical requirements each semester. These include comprehensive services for cross-cultural student-patient care, the medically complex patient, patients who are partially and fully edentulous, periodontal disease, and radiographs, as well as teaching cases. Failure to meet these requirements can lead to remediation and/or impede student progress through the program. Students are assigned patients passed down to them by students from a previous graduating class. Students must schedule patients for care. Students are able to make requests to the Office Manager for patient assignments (age, calculus classification, etc.) to help pair patients needing care with students needing to complete those services for clinical requirements. These patients are obtained from recall information from previous visits. Students are to update the Requirements Google Document to indicate the number of services they have completed, are in process of completing, or have planned for each clinical requirement. Senior students in need of high calculus patients are scheduled for those patients who were previously a class 4 or higher and are returning after over 3 years. New patients are added to a wait list by having their information obtained on a "New Patient Info for Wait List" form at the front desk of the clinic. When a student has a "please fill" spot in the schedule, these clinical sessions can be filled with waiting patients. It is up to the student to request appointment time slots to be filled or blocked. Students' recall patients can be scheduled according to the assigned student's open slots for new patient days or "please fill" slots. Alternatively, the patient appointment request can be sent to the provider via email. For patients not in process who are not available when the assigned student is in clinic, the patient can be scheduled with another student. Patients in process must continue with care under the same student. Students may market for patients according to guidelines set within the clinic manual.

2. **Discuss all efforts made to ensure students can complete clinical patient requirements.**

Multiple efforts are made to ensure that all students are able to complete all necessary patient requirements. Each semester, students will be assigned varying amounts of patients in different categories of periodontal health stages, age ranges, and special needs. These requirements have been calibrated and are comparable with similar hygiene programs across the country. Students are responsible for scheduling their own patients, however they have ample access to the facility's database of patients for potential contacts. Students obtain a list of patients from a recent graduate that become their patients. Additionally, the clinic receptionist assists in scheduling patients to students in

an unbiased systematic method. Requirements are completed effectively as patients are actively being recruited by both students and faculty alike. If a student is unable to meet requirements, they may face remediation, allotted additional clinic time, or allowed specific instances of adjustment at the director's discretion. These situations are specific to the conditions of the circumstances. All efforts will be made to ensure ethical patient care is completed in its entirety.

6-4 The program must develop and distribute a written statement of patients' rights to all patients, appropriate students, faculty, and staff.

Intent:
The primacy of care for the patient should be well established in the management of the program and clinical facility assuring that the rights of the patient are protected. A written statement of patient rights should include:

a) considerate, respectful and confidential treatment;
b) continuity and completion of treatment;
c) access to complete and current information about his/her condition;
d) advance knowledge of the cost of treatment;
e) informed consent;
f) explanation of recommended treatment, treatment alternatives, the option to refuse treatment, the risk of no treatment, and expected outcomes of various treatments;
g) treatment that meets the standard of care in the profession.

Narrative Response and Documentation:

1. **As an exhibit, provide a copy of the written statement of patients' rights. Describe how the statement is distributed to students, faculty, staff and patients.**

The dental hygiene care provided by this institution is based on research evidence, ensuring that patients receive quality care. Patients are offered the most appropriate care available, without discrimination based on race, sex, sexual preference, national origin, color, religion, age, or disability. Before initiating care, patients receive a comprehensive dental hygiene care plan, which includes a hard and soft tissue exam and a head and neck exam. All providers involved in patient care are certified in basic life support, and faculty members involved in patient care are duly credentialed and licensed. Patients are informed of their rights and responsibilities, as well as care options, risks, costs, and benefits before initiating care. Patients have the right to refuse treatment and are informed of the risks associated with not receiving treatment. They are treated with respect and dignity in a safe environment. Patients are treated in a timely manner, and the chief

complaint of the patient is addressed in the care plan. The treatment progresses in a logical and orderly fashion, consistent with oral disease control. Additionally, patient records are established and maintained, including documentation of all demographic data, medical, dental, and pharmacologic history, examination findings, consultations, radiographic and diagnostic data, treatment procedures, and referrals. The patient records are maintained in a manner that provides for access while maintaining confidentiality of Personal Health Information (PHI) and Personal Identifiable Information (PII). Preventive health services are of utmost importance, and they include an evaluation of oral health risks and appropriate interventions. Follow-up visits consistent with oral and peri-oral conditions are scheduled. Patients receive instruction on both the prevention of oral disease and the maintenance of oral health, and an oral health maintenance program is offered. These preventive health services ensure that patients maintain good oral health and prevent the development of oral diseases. The clinic waiting room displays the written statement of patient rights for all patients, students, and staff to see. Prior to performing any treatment, faculty and students must read and comprehend all elements of this statement.

a. Exhibit 7: Written statement of patients' rights

6-5 The program's policies must ensure that the confidentiality of information pertaining to the health status of each individual patient is strictly maintained.

Intent:
The program should have a system in place to ensure patient confidentiality. All individuals who have access to patient information will ensure patient confidentiality.

Narrative Response and Documentation:

1. Describe how patient confidentiality is maintained.

The Old Dominion School of Dental Hygiene is committed to maintaining patients' personal health information (PHI) and personal identifiable information (PII) as confidential. In order to protect the confidentiality of patients, we complete the following: provide training to faculty, students, and staff. Our computer systems have encryption, VPN, data security software, and we have policies in place for risk analysis. Not only will patients' PHI and PII be kept confidential, but our hygienists will respect the patients' information and demonstrate autonomy. Employees are required to sign a HIPAA Confidentiality Agreement.

Examples of Selected Exhibits:

Exhibit 1: Clinic Fee Schedule form
Exhibit 2: Initial patient screening form
Exhibit 3: Client consent form, physician's consultation form, dental referral form
Exhibit 4: Patient record audit form
Exhibit 5: Quality assurance form
Exhibit 6: Patient satisfaction survey instruments and data results
Exhibit 7: Written statement of patients' rights