ADMINISTRATIVE ISSUES IN THE PRACTICE OF DENTISTRY IN THE MR/MH INSTITUTIONAL SETTING

Purpose of this Module

This module is designed to address some of the major administrative issues that confront a dentist in an institutional setting for developmentally disabled or mentally ill patients. There will be variation in these issues from state to state and institution to institution.

Learning Objectives

After reviewing the written material, the participant shall be able to:

1. List the nine steps involved in quality assurance monitoring.
2. Give examples of dental quality assurance topics that maybe used in MI/MH institutions to monitor patient care.
3. List the set of principles developed by Dr. Deming involving continuous quality improvement.
4. Discuss differences between quality assurance and quality improvement.
5. List the five elements composing a process.
6. Discuss reasons why dental policies should be computerized on a word processor.
7. List a number of topics to be considered for dental policies under health/safety and patient treatment.
8. Describe the preliminary process one would go through when considering a student rotation.
9. Cite some of the positive aspects of affiliation with student rotations.
10. State items to be considered during an orientation with a student at your institution.
11. Describe the primary purpose of most regulatory agencies.
12. List types of documentation that may be required by surveyors reviewing a dental department.
13. Discuss the response staff should have to a surveyor who cites an area of non-compliance.
14. Give a broad definition of Incompetent Adult.
15. Describe the difference between a General Guardian, Guardian of the Person, Guardian of the Estate, Limited Guardian, Interim Guardian, Ad Litem Guardian and Successor Guardian.
16. Contrast Durable Power of Attorney with Health Care Power of Attorney.
17. Differentiate implied versus express consent.
18. State at least three elements of informed consent.
19. Contrast the professional community standard with the reasonable patient standard.
20. Describe at least two dental issues where an institutional dentist might consult with a patient's interdisciplinary team.

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QUALITY ASSURANCE AND QUALITY IMPROVEMENT ISSUES

The healthcare professions have experienced a trend of increasing overview in recent years. Accrediting agencies such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and governmental agencies such as Health Care Financing Administration (HCFA for Medicare/Medicaid patients) have played a significant role in this regard. Part of this overview has been in the form of requirements for Quality Assurance (QA), and more recently Quality Improvement (QI) activities, within healthcare institutions. This has been especially true in psychiatric institutions, which are usually considered "hospitals."

In addition to requirements from outside agencies, QA/QI, because they are self-examinations, provide a system of "self-policing." This approach is preferable to imposed outside monitoring and controls. The trend is clear: QA/QI activities can be expected to increase for both MI and MR facilities. Present trends indicate that QI is rapidly coming to the forefront and may eventually replace QA in many areas. Since the QA concept is likely to continue for some time, both QA and QI philosophical approaches will be discussed here. Institutional dental service administrators are encouraged to pursue additional resources of QA/QI information from within their institutions, as well as from organizations such as the American Dental Association. A bibliography is included to provide further information for the reader.

Quality Assurance

QA establishes an internal structure to identify, define, and rectify inadequacies in the delivery of care. The sequence of problem identification, intervention, and reassessment occurs as an endless loop. It is an inspection, looking for deviations below the norm, and seeking to bring those deviations into line in order to insure at least minimal standards of quality care.

From a "nuts and bolts" standpoint, QA is really nothing more than the periodic assessment (monitoring) of the performance of some aspect of dental care, measured against a pre-determined acceptable level (threshold). If the results do not fall outside of the acceptable range, no action is taken, and monitoring continues. Over time, if compliance continues at a satisfactory level, the time between assessments may be extended, or the monitored topic may even be discontinued in favor of some new aspect of care. If results are out of acceptable range, an investigation is conducted regarding reasons, and solutions (plans) are formulated and implemented. Periodic monitoring is continued to assess the success of the changes made. Time between assessments may be shortened in order to more closely monitor results.

The steps involved in QA monitoring are as follows:

1. Topic selection (aspect of care)
2. Criteria and standards development
3. Data source(s) identification
4. Sample selection (method of selection and size of sample)
5. Data collection
6. Data analysis and report preparation
7. Presentation of report/findings to staff and remedial action (solution) development
8. Solution implementation (intervention)
9. Reassessment (go back to #5)

Since QA activities frequently involve record review, the patients' records must be comprehensive, uniform, and complete. A good initial step in QA is an evaluation of the record keeping process.

The following illustration is provided as an example of QA within a dental service:

***Aspect of Care*:** Proper use of mechanical/physical restraints.

***Indicators*:** Adequate documentation is present showing that all institutional policies (and any other requirements) regarding restraint of patients have been met.

***Data Source/Sample Selection*:** Medical and dental records (charts). Specific criteria should be developed for what is expected in the medical/dental record, so that QA assessments will be accurate and reproducible. Open-ended (too general) criteria should be avoided since interpretation by evaluators can lead to inconsistent and unreliable evaluation results. Well thought out evaluation checksheets that have been trial tested are very valuable in this regard. A decision should be made on the size of the sample to be taken for the audits; i.e. how many charts should be reviewed. The sample should be random and of sufficient size to insure that reliable statistical conclusions can be drawn.

***Practitioner Specific*:** This particular aspect of care is ideally suited for individual dentist evaluations. Reports should show each dentist's performance in coded format rather than by name. Not all QA assessments should or need be practitioner specific, but some practitioner monitoring is an integral part of a good QA program.

***Audit Frequency*:** Every three months. The initial audit frequency is usually set to be fairly frequent, such as every 1 to 3 months. If results establish over time that criteria are being consistently met, it is appropriate to extend the time between audits. Time, effort, and availability of staff required to conduct the audit are also factors in the setting of audit frequency.

***Audit Period*:** Last three months. In this example the monitor looks at data from the last three months. Each audit should look at recent performance. Fresh new data is evaluated so that an accurate picture of current performance is obtained. The setting of the audit period is, of necessity, tied in with the setting of the audit frequency.

***Thresholds*:** Minimal levels of compliance with criteria (thresholds) should be set. Thresholds are somewhat arbitrary, but should reflect how important the criteria are that are being measured. In other words, what are the implications to patients when these criteria are not met?

***Reports*:** Audit reports should be available to all staff involved in the aspect of care monitored. In this example, individual practitioners should receive results of their individual performance as part of the feedback system. Reviewing overall findings at monthly staff meetings, along with documentation in staff meeting minutes regarding problems and recommendations, provides a good feedback mechanism and record of QA activities.

It is important that each dental service come up with appropriate QA monitors that its staff deem meaningful. If the QA activity is viewed as "just another requirement to be met" and nothing more, the activity will end up being of little value. Generally speaking, it is recommended that high risk and high volume procedures be monitored. Some examples of dental QA topics that may prove useful in institutions are listed below:

- R Dental record/chart content (practitioner specific)
- R Use of mechanical/physical restraints (practitioner specific)
- R Radiograph quality (dental assistants)
- R Pre-op sedation for dental treatment (practitioner specific)
- R Effective patient entry into dental service record system
- R Effectiveness of patient scheduling system
- R Timely initial dental examination
- R Timely initiation and completion of identified treatment plan
- R Properly written prophylactic antibiotic SBE orders (practitioner specific)
- R Effectiveness of recall system
- R General anesthesia case protocol compliance

Quality Improvement

Quality Improvement, also known as Continuous Quality Improvement (CQI) and Total Quality Management (TQM), is a relative newcomer to healthcare systems. Since QI is so new, there is still a lot of confusion about what it is and how it differs from traditional QA.

The original philosophy of QI was developed by W. Edwards Deming and Joseph E. Juran, and was used by the Japanese to build very successful manufacturing businesses. QI within industry has demonstrated that quality and efficiency can be substantially improved by applying these principles. Dr. Deming developed a set of principles called the 14 points, which are as follows:

1. Create Constancy of Purpose.
2. Adopt the New Philosophy.
3. Cease Dependence on Inspection.

4. Cease Awarding Business on the Basis of Price Alone.
5. Improve Continuously and Forever.
6. Institute Training and Retraining on the Job.
7. Adopt and Institute Leadership.
8. Drive Out Fear.
9. Break Down Barriers Between Staff.
10. Eliminate Slogans, Exhortations, and Targets for the Work Force.
11. Eliminate Numerical Quotas for Workers and Numerical Goals for Managers.
12. Remove Barriers that Rob People of Pride in Workmanship.
13. Institute a Vigorous Program of Education and Self-Improvement.
14. Put Everybody in the Organization to Work on the Transformation.

Dr. Deming estimated that approximately 85% of the errors introduced in a process are the result of problems with the system rather than the fault of individuals.

QA is generally people/compliance oriented and compartmentalized (i.e. by department), seeking to identify those areas and persons who may be performing at a below-standard level. QI tends to address problems with process within departments and between departments, rather than with people. QI systems are never satisfied with the "status quo," instead believing that improvements can always be made.

The implementation of QI requires organizational changes. Instead of the typical U.S. "top down" management style with its very compartmentally organized structure, QI gives front-line workers new responsibilities and power. Basically, under QI, front-line workers are considered to have unique knowledge about the product manufacturing process which should be recognized and incorporated into management decisions. This is in sharp contrast to the traditional approach where front-line workers merely "carry out" the instructions passed down from above. To make the transition from compliance-oriented QA to QI requires a bridge - employees must be "empowered." Listed below are the nine aspects of empowerment. Employees must be given:

1. A mission and vision.
2. Authority and permission to use it.
3. Control over resources.
4. Access to information.
5. Access to education and training.
6. An environment of trust and respect.
7. Avenues of influence.
8. Meaningful incentives.
9. Clear boundaries

QI stresses a much more integrated and interactive system of communication between all levels and departments of the organization, utilizing the team approach and a strong reliance on accurate statistical monitoring. By speaking with data and managing with facts, the guesswork is taken out of decision-making.

Customer satisfaction and customer-provider relationships are viewed as integral parts of the process. Under the heading of "customer" are included *external* and *internal* customers. External customers are the traditionally thought of customers, i.e., the patients in the healthcare system, for example. However, QI just as strongly emphasizes "internal" customers. For example, physicians can be thought of as customers of the medical and radiology labs. *Any person or department within an institution who utilizes the output (product) of another person or department within an institution is considered an internal customer.* The supplier does not wait for complaints from customers, but actively seeks customer feedback regarding the suitability of the output (product). QI demands that change be based on the customer's needs, not the values of the supplier/provider. QI frequently utilizes a concept called "benchmarking", which compares products, processes and performance against the best of the competition, the thought being to produce a product and process that betters the competition.

A process is composed of 5 elements:

1) Suppliers provide →
2) Inputs on which →
3) Action is taken to produce →
4) Outputs for →
5) Customers.

Within an organization, *the quality of all internal customers' work is directly affected by the quality of the supplied input*. Processes frequently are made up of many subprocesses.

Some examples of processes encountered in an institutional dental practice are:

!	Process	Fill a prescription
	Supplier	Dentist
	Inputs	Prescription for drug
	Action	Pharmacy fills prescription
	Outputs	Drug
	Customer	Patient/Dentist

!	Process	Schedule patient for dental treatment
	Supplier	Dental Secretary/Receptionist
	Inputs	Telephone call
	Action	Ward coordinates date/time and notes on calendar
	Outputs	Patient arrives at dental clinic for appointment
	Customer	Dental Clinic/Patient
!	Process	Initial Dental Examination
	Supplier	Admissions Office
	Inputs	Written patient admission information
	Action	Dental Clinic schedules patient for examination
	Outputs	Initial dental examination
	Customer	Patient/Dental Clinic

QI within a healthcare setting, like QA, cares about areas of sub-par performance, but it is most interested in the average and how to improve it. It constantly searches for performance breakthroughs everywhere. Whereas QA monitors outcomes and processes to assure a certain level of quality care, QI constantly attempts to eliminate defects by *proactively* determining and eliminating the causes. Under QI, institutions will be asking more why, not who, thereby focusing more on processes rather than people. *QI requires a major commitment from senior management to succeed.* Most experts agree that it takes 5 to 10 years to fully implement a comprehensive QI program.

Examples of dental QI topics could include any of the topics listed earlier for QA, with the proviso that instead of being satisfied with minimal threshold levels, the thrust of the monitors would be continuous improvement of the efficiency or performance of the process. Where QI really shines is on *interdepartmental* and *customer-driven* issues. The following is an example of a dental QI topic from a psychiatric institution:

Problem: Dental clinic personnel feel that they are receiving vague and inappropriate referrals, resulting in poor clinic time management:

Process: Patient referral to dental clinic for evaluation/treatment

Supplier: Ward healthcare worker (Physician/PA/Nurse, etc.) or patient

Inputs: Ward healthcare worker observation or patient statement

Action: Ward healthcare worker makes decision that patient needs appointment.

Outputs: Referral form is sent or phone call is made to dental clinic.

Customer: Dental Clinic/Patient

Note that the Dental Clinic is considered an *internal customer* of the ward healthcare worker referral process because the healthcare worker's output (referral) is input to the Dental Clinic.

The steps needed to deal with this problem would be as follows:

- R Organize an *interdisciplinary team* familiar with all aspects of the process involved.
- R Determine the scope of the problem by gathering reliable data on the number of referrals that are vague or inappropriate; break out the numbers by specific type. Collect the data over a significant enough time period to assure reliability (last 6 months to 1 year, for example).
- R Clarify current knowledge of the process and its variation. Investigate all of the ways that referrals are initiated and reach the dental clinic.
- R Understand causes of the process variation. Investigate all facets of the process that contribute to the problem.
- R Propose/plan changes in the process.
- R Implement the changes.
- R Monitor the changes in the process outcome through continued data gathering and surveying of customer satisfaction. Assess whether the process is improving and ways to further improve it.
- R Maintain thorough documentation of the QI process.

The possibilities for QI are literally endless since problems are viewed as opportunities for improvement.

POLICY MANAGEMENT

When Dental Clinic policies are viewed as an imposition and designed merely to meet external requirements, they typically stay on the shelf in dusty notebooks, outdated and infrequently reviewed. This approach is of little benefit, and potentially hazardous, considering the current litigious climate.

Dental Clinic policies should be *living* documents that represent vital current information - information that staff should be aware of and utilize as they perform their job duties.

Due to the tremendous growth of mandates, regulations, and guidelines, it has become almost mandatory that dental policies be computerized on a word processor. This results in higher quality documents, rapid updates, and reduced time demands on staff for retyping.

In order to lessen the chances of policies going out-of-date, specific established protocols and standards should be referenced rather than listed when possible. For example, regarding antibiotic prophylaxis regimens for subacute bacterial endocarditis prevention, refer to "compliance with current American Heart Association (AHA) guidelines," rather than listing the specific regimens, which may change.

Policies should be:

- unambiguous.
- kept updated to reflect current policy.
- reviewed by staff on a predetermined repeating basis (yearly suggested) with documentation showing date and staff signatures.
- located in a readily accessible area to staff for review at any time.
- contained in a binding with a table of contents to provide rapid access to specific policies.
- in a standardized format for consistency.
- signed and dated.

New policies should:

- be reviewed by all staff when they first take effect.
- show the date of the previous (replaced) policy and the effective date of the new policy.

Old policies should be:

- maintained in a separate notebook or file to provide a reference of past policies (questions sometimes arise regarding what policy was in force at a particular time in the past, etc.).

Important categories that should be considered for dental policies are (some of these areas may be covered under institution-wide policies):

I. Dental Records Content and Organization
II. Personnel Issues
  A. Health/safety
    1. Infection Control (Bloodborne Pathogens Standard, etc.)
    2. Hazard Communication Program
    3. Nitrous Oxide Usage/Hygiene
    4. Radiation Hygiene
    5. Mercury Hygiene
    6. Training/Retraining (CPR, etc.)
    7. Fire and Disaster Plans
    8. Accidents/Injuries on the Job
    9. Patient lifting/transfer safety
  B. Conduct/hours/benefits/rights/etc.
III. Patient Treatment
  A. Scope of Services/Eligibility/Appointment Procedures
  B. Restraint of Patients, Physical/Mechanical
  C. Deaf Interpreters
  D. Consent
  E. Management of Patient Refusals
  F. Referral for Services Not Provided
  G. Identification of Removable Prostheses
  H. Radiograph Retention, Storage, and Maintenance
  I. Confidentiality Regulations and Release of Information
  J. Outpatient Services
  K. Treatment of Oral Self-Injurious Behaviors
  L. General Anesthesia (Patient Selection and Operating Room Procedures, etc.)
IV. Quality Assurance/Quality Improvement
V. Dental Treatment for Employees

STUDENT ROTATIONS

With a dearth of experiences in treating MI/MR patients in most dental school curriculums, MI/MR institutions are in a position to offer valuable experience to dental professionals and auxiliaries in training. Dental assisting, dental hygiene, and dental students can benefit in many ways from experiences gained in working in these environments.

Obviously, students can benefit from the variety of clinical procedures that they would encounter in a MI/MR facility that they might not encounter at school. They are exposed to different dental materials and often a slightly different way of providing treatment for a special care patient population. Many MI facilities offer excellent training in treatment of dental emergencies and oral surgery due to the large number of admissions. MR centers offer training in restraints, sedation, behavior management, general anesthesia,

oral hygiene programs, etc.. Also, students learn about medical charts, pharmacology, history and physical examinations, laboratory tests and their results, consents for treatment, and how all these factors affect the dental treatment they will provide to MI/MR patients. Additionally, students are often able to receive credit for clinical procedures done in institutions, for example dentures and extractions.

Initially, staff must entertain the question as to whether they desire students in their clinic. If staff view this as an additional burden and of no benefit then it would be to everyone's best interest not to begin a student rotation. Unquestionably, a student rotation would require additional efforts by dental staff members, but there are many positive aspects for the institution and staff.

On a positive note, student participation can be stimulating to staff in many ways. Each student has quite a different personality and their presence and participation break up the routines of day to day work. They often ask stimulating questions regarding treatment planning and methods of treatment. Student rotations can help prevent or disrupt staff burnout. Most surveyors (HCFA, ICF-MR, JCAHO) perceive student affiliations in a very positive light. Students also bring information on new materials, equipment, and techniques currently being taught at their dental school. Dental staff participating in supervision of students are often appointed as adjunct or part time faculty by the students' school. This can provide additional continuing education opportunities for the dental staff at a reduced rate.

After determining the dental staff's willingness to participate, the dental director should contact the director of the dental assisting/dental hygiene/dental student program. There are a myriad of details to be discussed regarding the number of students, length of rotation, responsibilities of both institutions, etc. As a general rule, no additional institutional monies are necessary for this arrangement, although the MI/MR institution may provide housing and/or meals for visiting students. Students doing an extended externship do occasionally receive a small stipend to cover expenses. With all of the OSHA requirements, students should be required to have the hepatitis B vaccine and a TB test prior to participating in direct patient care.

It is recommended that a written contract be signed by both parties before any students begin their rotation. The college or university is usually experienced in drafting such documents for students participating in off-campus activities.

Depending on the duties to be performed and the length of time that the student(s) will be at an MI/MR facility, staff should prepare an orientation. Topics to be considered during an orientation might be any of the following: funding arrangements, housing arrangements, familiarization to staff and clinic layout, review of dental and medical charts, approved chart abbreviations, review of confidentiality and consent policies, review of infection control policies, orientation to facility and dental clinic policies, level of supervision (checksteps) during treatment of patients, the management of special care patients, medications, review of medical conditions and treatment planning differences for MI/MR populations, etc. Use of various S.A.I.D. modules can provide an excellent background resource for students. At the end of the rotation, it is beneficial to perform an evaluation to see what has been most beneficial to the students and what should be modified and/or deleted for future rotations.

Each institution has different strengths and experiences to offer the dental assistant/dental hygiene/dental students. The rotation can be structured to take advantage of the institution's strength. For example, if dental treatment is provided in the OR under general anesthesia, this would be excellent training for a student; or, if an institution has an excellent oral hygiene program for staff, students could be exposed to the many aspects of such a program and its development. Minimally, the students will be exposed to treating special care patients. Hopefully, this would translate into less fear of this group and a greater likelihood that these professionals would treat special care patients in their practices after graduation. For a small minority of students, it confirms their fears and uncomfortableness in treating this segment of our population.

It is important that students not be viewed as an inexpensive method for providing dental services. These students are still in the process of obtaining their dental education and will require a certain level of supervision. They can not and should not be expected to perform as rapidly as a graduate and they generally should not be assigned the most difficult patients to treat. As they become accustomed to the treatment of special care patients, the variety of treatment and patient management situations can be modified depending on the strengths and wishes of the student. As an instructor, one can generally get a good

feel for the level of performance of the student in a few days. Feedback from staff involved in the direct care of patients with the student can be very valuable.

Finally, many state personnel departments view the supervision of students in a positive fashion and may classify these supervisory dental staff at a higher salary level. This aspect should always be viewed as a secondary benefit. Dental directors should be very receptive to the opinions of the entire dental staff when discussing student rotations. The majority of staff should be in agreement regarding the willingness to participate in student rotations.

ACCREDITATION SURVEYS

Most healthcare facilities, whether for developmentally disabled or psychiatric patients, come under the purview of one or more accrediting agencies.

Some of the regulatory agencies are "voluntary", such as the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), in which the facility requests a survey and pays for the service. Other agencies are involved in mandatory reviews, such as Health Care Financing Administration (HCFA) or Intermediate Care Facilities for the Mentally Retarded (ICF-MR), and are tied to federal and/or state funding under Medicare/Medicaid programs. There are additional accrediting agencies that are not mentioned in this module, such as AC/DD. However, general purposes and survey preparation would be similar.

> "The primary purpose of most regulatory agencies is to insure that standards for patient care are defined and adequately supported by policy, procedure, and organizational structure. In addition, the regulatory agency evaluates the effectiveness of the organization in implementing and monitoring the standards for providing safe, quality patient care." (Smelzer, 1991)

For a dental staff, the best strategy to prepare for any type of review is attention to basic standards of care. One should know and adhere to state or regional dental practice laws. Additionally, close attention should be paid to policies and procedures developed by the American Dental Association (ADA), Centers for Disease Control (CDC), Occupational Safety and Health Administration (OSHA), and other similar organizations. These would include policies related to infection control, universal precautions, hazardous waste, etc. Before one begins to look at the specific standards required of the accreditation agency, these basic issues must be addressed and should be reflected in the written policies and procedures of the dental clinic.

Another step in the preparation for a survey would be to obtain a current copy of standards for the accrediting body (example, 1994 Accreditation Manual for Hospitals- JCAHO). The standards should be reviewed thoroughly for any and all standards that apply to the dental department. Sometimes these standards are grouped together (see copy of ICF-MR standards in appendix) and in other cases standards will be spread over many sections of the standards manual, such as qualified staff, treatment, infection control, equipment/ physical plant, etc.

There is also no substitute for experience when it comes to surveys. Dental staff could contact peers at a similar facility in their state or region to discuss their experience with past surveys. Each facility will usually have a resident expert on regulatory agencies and their standards. If this person does not contact the dental staff, the dental staff should proactively set up a meeting to discuss standards and past experiences with surveyors. Information gained can be used to focus one's efforts to prepare for a survey, particularly if time is of the essence.

It is important to begin preparation for surveys many weeks or months in advance. This will allow adequate time to develop missing policies and procedures, to track down documentation for equipment calibration and/or maintenance, to review documentation on infection control, etc. Actually once these issues are reviewed they should be maintained on a set schedule (e.g. x-ray calibration on an annual basis) for quality patient care and to satisfy requirements for future audits. Sometimes the surveyors will ask to see certain information and documentation that the item in question has been monitored for the last 12 months.

The following suggestions reflect years of experience with many regulatory agencies and do not attempt to address compliance with any one agency or its' standards. In preparing for an audit, consider the following;

- The dental department should have a policy and procedure manual specifically related to dental issues of patient care, staff training, infection control, etc. (see policy section of this module). This manual should be reviewed by staff on a regular basis (annually recommended). The information and policies should be current and specific

to the needs of your facility and its' patients. Just prior to the survey, it is a good idea to review the basics of certain important policies with staff. It is also beneficial to review the different manuals in the clinic to be aware of what is contained in each (example: fire and safety in disaster manual, material and safety data sheets in hazardous materials policy manual).

! Documentation in some areas of equipment maintenance, staff training, and infection control are required for review by surveyors. Some examples are as follows; weekly results from spore testing of autoclaves, annual calibration of radiographic equipment, monthly results of staff x-ray badge monitoring, documentation of staff hepatitis B immunization records, annual staff training in universal precautions/exposure control plan for bloodborne pathogens, annual certification in CPR, monthly review of medications, IV solutions, etc. to check expiration date, and monthly review of sterilized instruments and equipment for date of expiration. In areas where documentation is required on a set schedule, a form for staff to complete is helpful. Also these items can be listed on a calendar to insure routine compliance.

! A facility can do internal audits of its own or set up mock surveys. Areas of internal survey could be handled by the infection control nurse, health and safety officer, or quality improvement coordinator. A mock survey could be conducted by a dental staff member at your facility, dental staff from a similar state/regional facility, or even utilizing dental consultants from a nearby dental school. It would be preferable to have a mock survey conducted by someone with some experience with regulatory standards and audits.

! In addition to a policy and procedure manual, it is a good idea for a dental department to have a separate quality assurance/quality improvement notebook (see QA/QI section of this module). This manual would include facility and departmental QA/QI plans, minutes of monthly dental staff meetings with review of all QA/QI activities and audits, and copies of the audit results, chart reviews, etc. It is recommended to thin this manual periodically to maintain results from the last 1-2 years. Surveyors may question you about old audits if these results are present in the manual, when actually the documentation referred to a period of a prior audit.

! In the area of infection control, a manual or instructions should detail what steps should be followed in the handling, cleaning, disinfecting, and sterilizing of instruments and equipment. Any solutions for infection control should have a label with name of solution and expiration date noted.

! Staff should systematically clean and review contents of drawers and cabinets. Out of date or non-functioning equipment and supplies should be removed for disposal or storage. All containers should be labelled as to contents.

! Posters or signs required for radiology, OSHA, infectious waste, sharps, etc. should be properly displayed for staff and patients.

! Staff should know what to do in case of a fire. Fire extinguishers should be present and in working condition. Exits should be marked properly.

! Any licensed staff should have current license posted in the clinic or readily available for review.

! Proper emergency equipment should be readily available, in date, and in proper working condition. Staff should be familiar with the use of all emergency equipment.

! Staff should be very careful about eating and drinking in areas that may contain infectious materials. For example, placing a coffee pot in a lab area in close proximity with a polishing lathe or dentures to be repaired is not recommended. Also placing food or storing dental materials in close proximity to any specimens or contaminated items (such as in a refrigerator) is not recommended. These areas are best discussed with the facility infection control nurse.

! Student involvement at a facility is generally viewed as positive by surveyors. If the dental clinic participates in the education of dental assisting, dental hygiene, and/or dental students, this should be pointed out (see section on student rotations this module).

! Additional exposure of preventive information through bulletin boards and/or posters is a good idea. Information tailored to residents and staff could be placed in hallways, in bathrooms, or near nursing stations. Posters often have to be covered in contact paper or placed strategically to protect them from being destroyed. They also can be rotated throughout the facility.

! It is important for staff to wear name tags and x-ray monitoring badges.

! Surveyors can be very biased or subjective in their reviews. If they cite something as a problem

or non-compliant with the standards, you could discuss this with the surveyor. However it is best not to argue with the surveyors. If they inspect enough areas, they can always find some items of non-compliance.

GUARDIANSHIP ISSUES

Procedures for appointing guardians for persons who are mentally incompetent vary from state to state. The procedures are usually subject to state statutes as defined by the state's General Assembly or decisional law. In most instances a guardian cannot be designated without a formal judicial declaration of patient incompetency. Limiting the rights of an individual by appointing a guardian should not be undertaken unless it is clear that a guardian will give the individual a fuller capacity for exercising his rights. All related factors in each individual's situation should be considered when exploring the need for guardianship. If the individual is able to understand his or her rights then the individual should be involved in the decisional process.

A "*minor*" is a child less than the age of majority (18 years old). The parent or legal adoptive parent is the *"natural guardian*." An individual over 18 who has never been adjudicated incompetent by a court is *legally competent* in most states. Frequently, developmentally disabled and psychiatric adult patients have compromised abilities to make decisions yet have never been adjudicated incompetent. Many states do not permit natural guardians to make decisions for these compromised adults who have not been formally declared incompetent; some do however, e.g. Georgia.

Criteria for determining competency or incompetency are not exact. Unfortunately there are no single definitions of competency or incompetency that are used throughout the country. Typically, competency is a legal term representing an "all or none" concept. However, many institutionalized patients are not either "fully capable" of participating in decision making or "not capable at all," especially MH patients.

A broad definition of "*incompetent adult*" would be a person who lacks sufficient capacity to make or communicate decisions concerning his person, family or property because of mental illness, mental retardation, physical illness or disability, chronic use of drugs or alcohol, or other cause. It must be shown that the person's incompetence results from one or more of these causes *and* the person is unable to make or communicate important decisions. Many mentally retarded individuals are capable of attending to their affairs. However, some persons with mental retardation or other limitations lack the capacity to make decisions about acquiring the necessities of life, including food, shelter, clothing and medical care.

Each state has different legal processes for obtaining a court appointed guardian. Generally, the process involves filing a petition with the court. Family members, social workers, or other interested parties may file the petition. A multidisciplinary team at the institution where the patient resides may be assembled to determine the patient's need for a guardian, and to start the legal process. Usually, a hearing is set, where the guardian is appointed by the Clerk of Superior Court of the person's home county or county of residence. Generally speaking, a guardian appointed in one state may not meet the criteria for guardians in another state. States that accept nonresident guardians usually require a "processor agent" or "resident agent" to accept service of process for the guardian.

Court appointed guardians may be individuals, corporations (e.g. a bank), or disinterested public agents (e.g. Department of Social Services or County Mental Health Associations). Public agents are usually appointed only after exhaustive efforts have been made to find individuals or corporations to be guardians. The choice of guardian should be determined by the best interests of the incapacitated person (the ward). The legal guardian is <u>not</u> financially responsible for the ward, but is expected to take part in planning for living arrangements and seeing that the ward is cared for. *Guardians of the estate* are appointed solely for the purpose of managing the property, estate, or business affairs

of an incompetent person. Guardians of the estate have no jurisdiction over medical decisions and are usually not needed unless the ward has more than $1000 or property willed to them. Decisions relating to the care, custody, and control of the incompetent person are managed by a *guardian of the person*. A *general guardian* has control over both the estate and the person. The least restrictive alternative is the *limited guardian* which allows power in the narrowest possible circumstances, such as in medical decisions. An *interim guardian* may be appointed when an emergency exists which constitutes an imminent danger to an incompetent person's physical

well-being. Interim Guardians are guardians of the person whose powers extend only so far as necessary to meet the emergency. A *guardian ad litem* is a person (usually a lawyer) appointed by the court to represent the person against whom a guardianship lawsuit has been filed. A *successor guardian* is appointed by the Clerk of Court upon the death, resignation, or removal of a guardian. A guardian may be removed by the Clerk if the ward's estate is mismanaged, the ward is neglected, the guardian is adjudicated incompetent or the Clerk finds the guardian unsuitable.

An alternative to the formal guardianship appointment procedures is the *Durable Power of Attorney*. A competent person referred to as the "*principal*" may give power of attorney to another person referred to as the "*attorney-in-fact*." The "attorney-in-fact" does not have to be a licensed attorney. If a person has a durable power of attorney (durable meaning the power of attorney remains in force even if the person becomes incompetent), this does not automatically mean that the power of attorney covers health care decisions. Powers of attorney usually only involve financial matters and cannot be used for consent for medical/dental procedures unless the document specifically authorizes the "attorney-in-fact" to provide consent to medical/dental care. A *Medical Durable Power of Attorney* or *Health Care Power of Attorney* specifically covers medical treatment decisions. Powers of attorney are found more frequently in institutions for the psychiatric and/or geriatric patient than for the developmentally disabled patient since the patient must be competent when it is granted.

INFORMED CONSENT

Prior to the initiation of any procedure that puts patients at risk, appropriate informed consent should be obtained. Consent is required in all settings (institutional, hospital, or private office). However, the consent required for routine procedures may differ from the consent required for more invasive procedures. The doctrine of informed consent challenges the practitioner belief that health care professionals know what is adequate information for the patient. For the institutional practitioner, the doctrine of informed consent is further complicated by such issues as questionable competency and surrogate decision-makers.

Legal Issues

Informed consent standards vary from state to state. Generally the standards that apply to the physicians in the state will apply to the dentists in the state. Problems with informed consent in dentistry have mainly involved: 1) treatment without consent; 2) treatment beyond what is authorized; and 3) lack of information such as risks. Failure to obtain informed consent could be both a criminal offense (assault and battery) and a personal tort (a malpractice charge). Negligence charges may be brought when there has been inadequate disclosure of risks, such as an incomplete or vague explanation of the intended treatment. The patient must prove that if there had been sufficient information, a different decision regarding treatment may have been made. The focus in negligence is on breach of some standard of care. The patient must show an injury occurred as a result of the nondisclosure. There is no informed consent case if risks are not disclosed but no injury resulted. Assault and battery charges involve completely unauthorized treatment where the patient must prove that there was no consent. The case could also be made for willful nondisclosure, if consent is not obtained, and could justify an award of punitive damages.

Implied vs. Express Consent

Consent may be either implied, or express. Express consent is expressed in words, either written or spoken, which show unambiguous intent. Implied consent arises from the signs, actions, or conduct of an individual that raise the presumption that consent has been given. For example, when a legally competent adult seeks routine dental care, consent is implied. Consent is also implied when a parent takes a child to a dental office for routine dental care. Routine dental procedures (restorations, prophylaxis, etc.) are those procedures the average, reasonable person would expect. However, the average reasonable person would not expect procedures such as sedation, general anesthesia, nitrous oxide or restraints. Problems occur when express consent is given to general dental treatment and the practitioner assumes implied consent is given for additional special procedures. Procedures with which many people are unfamiliar with, and which carry the potential for misuse, misinterpretation, or adverse reactions, should have express consent. The prudent practitioner is advised to seek legal advice and follow institutional policies regarding consent.

Documentation

Documentation of the consent process is essential. Requirements will vary from institution to institution. For the institutionalized patient, consent for routine dental treatment should be obtained upon admission and updated annually or according to institutional policy. In some psychiatric hospitals consent for routine dental treatment may be valid for the length of hospitalization for the patient. It is advisable to use a specific consent form that explains routine dental procedures and their risks. Blanket consent forms signed at the time of admission giving broad consent for all medical/dental procedures should not be used. It is recommended that consent for special dental procedures be written and be time limited. However, for routine dental care, written consent is not required, and verbal or telephone consent if properly documented maybe adequate, depending on the facility. If consent is withdrawn, refused or modified, it should be documented. Consent obtained from nonverbal patients should be written if at all possible. If this can not be done, a legally certified interpreter should be used to obtain consent for the patient. A smile or nod may be a nonverbal patient's means of communication and can be evidence of consent if properly witnessed and documented.

Elements of Consent

Individual states have the authority to define informed consent by statutory or decision law. The practitioner must become familiar with and follow the standards in his/her jurisdiction. Several basic elements that are found in most states' informed consent requirements are presented here. One element of informed consent is the ***mental capacity*** or *competency* of the individual to make reasonable decisions. Children less than 18 years of age are considered incapable of making decisions in their best interest and consent must be obtained from their parent or legal guardian. Legally competent individuals may consent to treatment if they fully comprehend the information needed to make an informed choice. The dentist must consider the following elements when assessing a patient's competence to consent to treatment. The patient must: (1) possess the ability to understand the proposed procedure and its significant risks and benefits; (2) have the ability to retain an understanding of the proposed procedure and describe the treatment and significant risks and benefits; (3) demonstrate the ability to choose between alternative treatments including refusal of treatment; and (4) choose a treatment based on rational reasons. Unfortunately, there is not a standard definition of incapacity in all states throughout the country.

"Compromised" adults may require less technical information and more time to think over the information. They may be competent to provide consent in some situations but not for medical decisions. For these individuals, some states allow a guardian to be appointed for consent for medical procedures. Other states allow the dentist to petition the court for permission to perform necessary treatment. Still other states allow medical decisions to be made by a number of people who have the individual's best interest in mind even though a legal guardian has not been appointed. In any event, the practitioner cannot assume the decision-making power for the patient in the absence of a legal guardian. Reasonable efforts should be made to give information and seek input from the patient regardless of who is the decision maker. If an individual has been adjudicated incompetent, the practitioner must obtain consent from the legal guardian.

Many institutionalized patients who are "incompetent" have not been declared legally incompetent due to uninterested or nonexistent families, or inadequate staffing and support to expedite guardianship proceedings.

It should never be assumed that the administration of the institution has the legal authority to provide consent for individuals who reside in the institution. These "incompetent" individuals who are not mentally able to comprehend treatment information can not provide valid legal consent. Often the result is no dental care. The private practitioner who treats disabled rest or nursing home patients, or developmentally disabled patients who reside in group homes or with their parents, must follow the same requirements. The determination of who gives consent is a complicated issue that varies from state to state.

Another element that must exist for consent to be valid is that it must be *informed*. The individual giving consent (either the patient or the guardian) must have enough information to make an intelligent decision regarding whether to proceed with the procedure. Informed consent should include an explanation of the nature, risks, and benefits of the procedure. However, this does not mean that the practitioner must disclose all possible risks for every dental procedure. Additionally, information should be provided

on the alternative procedures, including no treatment, the type of anesthesia, and the length of time the consent is valid. The person giving consent should have adequate time to make a decision and ask questions.

Legally valid consent must be given *voluntarily*, or without coercion. The person giving consent has the right to choose not to proceed with the procedure. The health care professional may not coerce, or force, the person into consenting to the procedure, even if the decision to forgo the procedure seems unreasonable to the health care professional. The patient must retain autonomy, or the ability to govern one's self, at all times. The dentist may state his or her own treatment preferences and openly give the patient arguments favoring the proposed treatment. However, if the practitioner detects any hesitation in the person giving consent, it may be best not to perform the procedure. Additionally, just because the patient is not resisting treatment does not mean that he/she is consenting to treatment.

Professional Community *vs* Reasonable Patient Standard

As previously stated one element of legally valid consent is that the consent be informed. The question arises as to what specific information a practitioner is required to provide. Two standards of disclosure have evolved in the American courts: the *professional community* and the *reasonable patient* standards. In the past, most states adhered to the professional community standard. This standard required a practitioner to make disclosures that the majority of local practitioners would deem reasonable under the same or similar circumstances. Professionals would be held liable for nondisclosure only if the standard of professional practice was violated.

With the increased focus on the informational needs of the average, reasonable patient rather than on professional standards, a new reasonable patient or materiality standard has developed. This new standard requires disclosure of all aspects of treatment that the average patient would consider significant. The reasonable patient standard reflects the societal demand of personal choice in health care matters for patients. It requires express consent for any procedure which may be considered objectionable to the average patient. What constitutes appropriate practice as perceived by the patient becomes extremely important to the practitioner. With the professional community standard, nondisclosure for some procedures would be reviewed as professionally reasonable and consent would be implied as a part of the general consent to treatment. However, with the reasonable patient standard, implied consent would only apply to aspects of treatment that the average person would anticipate and approve, regardless of their acceptance in the professional community. If a dentist fails to disclose information a reasonable person would consider material to his decision to accept treatment, malpractice has been committed. Many practitioners lack knowledge as to which informed consent standard exists in their state. The best course of action for the prudent practitioner is to practice in a manner that will satisfy the most rigorous informed consent standard. In addition, express consent should be obtained for any procedure that the average person might find objectionable.

Emergency Situations

In most states, in a true medical emergency where any delay would endanger the life or health of the individual, consent is "implied" and treatment may be pursued without "express" consent. However, a dental problem is not usually considered a true medical emergency. If a developmentally disabled or psychiatric patient develops a severe facial abscess with abnormal swelling and infection that compromises the patient's general health, there may be a need to pursue treatment immediately. If so, dental treatment can usually be initiated without consent. Only those procedures necessary to preserve the life or health of the patient should be undertaken without consent. The patient may have refused dental treatment in the past, yet an emergency condition reverses the patient's decision to forgo a procedure and allows the dentist to initiate the procedure without the patient's consent. However, any type of comprehensive dental treatment should only be provided with informed consent.

INTERDISCIPLINARY TEAM PROCESS

The interdisciplinary team is a well established concept in most institutions today. It originated in programming as a process for identifying the needs of the resident; establishing priorities for meeting those needs; determining programs for meeting priority

objectives; reviewing the resident's progress toward the objectives; and modifying the objectives.

The model requires an individual plan of care to be developed from an interdisciplinary evaluation of the resident. The team must include direct-care persons such as technicians responsible for the resident's day-to-day care. The team must also include all those persons whose participation is relevant to meeting the needs of the resident being considered. Examples would include the resident's physician, psychiatrist, dentist, nurse, dietitian, speech therapist, physical therapist, occupational therapist, psychologist, rehabilitation specialist, social worker, behavioral program specialist, and unit manager. The composition of the team should always be determined by the needs of the individual resident. Each participant of the team utilizing whatever skills, competencies, insights, and perspectives his particular training and experience provide, focuses on identifying the needs of the resident, and on devising ways to meet those needs. A totally unified and integrated plan is devised by the team, rather than only by any one member of it. On a face-to-face basis, participants share and discuss all information and recommendations.

The interdisciplinary process is not a single conference but an ongoing, year-long series of events and activities in which all staff working with a particular resident are involved. Communication between team members must take place on a regular basis, daily if needed. The annual meeting is a structured opportunity for each person involved in the process to communicate, to review the previous year's progress and to make plans and set goals for the next year. Prior to the conference disciplines conduct and submit their annual evaluations. All information concerning the resident is gathered and examined at the annual conference. Major decisions are made at the conference and are documented in a written plan. A staff dentist's presence is not needed at all annual staffings. A written report or summary is sufficient in many cases.

The interdisciplinary process usually requires evaluations from disciplines at specific times during the resident's course of living at the institution: upon admission, on request, annually, and upon transfer. Examples of disciplines required to submit evaluations are medical, dental, nursing, dietary, speech and hearing, physical therapy, occupational therapy, psychology, recreational therapy, social work services, educational services, and vocational services.

At most institutions a dental evaluation is required within 30 days of admission. The new admission evaluation might include charting of treatment needs, charting of existing teeth and restorations, soft tissue and oral hygiene assessments, and radiographs where applicable. The requirements for specifics, such as periodontal probings, TMJ evaluations, and radiographs, will vary with the institution and the individual patient.

The annual dental evaluation might include information on the number of dental visits since the last annual evaluation; the type and number of dental procedures; the average behavior; requirements for sedation and/or restraints; the average oral hygiene; toothbrushing recommendations; prognosis for retaining teeth; future treatment plans; and suggested recall.

The amount of consultation with team members regarding medical/dental treatment and procedures will vary from institution to institution and patient to patient. Some institutions require team input for all procedures while others only require team input for special procedures such as extractions, surgical procedures, general anesthesia, prostheses, sedatives, etc. The dentist is responsible for dental care of the patient and thus has final authority for care. The team should always be consulted when it can contribute to the process, but should in no circumstance have the authority to delegate responsibility to the dentist. For example, in matters of routine dental care, the team should not be able to override the dentist's ultimate responsibility for dental care. Behavioral management issues such as whether to treat a resistive patient with sedation and restraints vs. general anesthesia are somewhat different. Consultation with the treatment team would be beneficial. Also, issues involving use of patients' funds for dental treatment (i.e. dentures, crowns, etc.) could be referred to the treatment team. This spreads the decision making responsibilities to a number of professionals.

Many institutionalized patients have multiple medical and behavioral problems. In addition, many receive a variety of medications. Thus, it becomes extremely important for professionals in all disciplines to be familiar with the overall medical and behavioral conditions of the patient. Team members can also provide invaluable information on the patient's competency status; family attitudes, availability, and contact; and the patient's progress in other areas.

Documentation of consultations with other interdisciplinary team members in the progress note of the dental record is essential. It is advisable to include the team members' names and disciplines. The docu-

mentation may be placed in a separate area of the chart or in a different color ink for ready retrieval of nonclinical patient data.

STAFF TRAINING

The importance of ongoing staff training can not be overstated. The administration of an institution is obligated to provide adequate training to staff. Policies, guidelines, and regulations of the dental clinic, institution, state and federal agencies are dynamic and therefore constantly changing. Any changes in policies, procedures, materials, equipment, etc. must be communicated to all involved staff. This training may be accomplished in several ways.

One method is through staff meetings. Staff meetings should be scheduled and announced to ensure all staff come to the meetings ready to learn and participate. This is a good place to review new policies in the dental clinic and at the institution, new equipment and materials, Material Safety Data Sheets (MSDS), etc. The minutes of every staff meeting should be recorded and later signed by each staff member. Where appropriate, training should be documented and filed with Staff Development or Quality Improvement.

Due to budget constraints many institutions have little financial support for continuing education courses offered outside the institution. One avenue of staff training is through the institution's Staff Development Department. Training on CPR, Patient Intervention Techniques, Infection Control, OSHA, Confidentiality, Resident Rights, Grant Writing, etc. is offered through Staff Development at most institutions. Staff can often earn continuing education credits by taking advantage of this "in-house" training. Training records should be kept on all courses attended at the institution and outside the institution. Many institutions also have libraries where staff can review professional publications, videos, etc.

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