1.0 PURPOSE

To provide oral care to inmates under the direction and supervision of a dentist licensed in the State.

2.0 SCOPE

This policy and procedure applies to all correctional facilities and their assigned personnel.

3.0 REFERENCES, DEFINITIONS, AND FORMS

.1 References

a. Hawaii Revised Statutes (HRS), § 26-14.6, Department of Public Safety.

b. HRS, § 353C-2, Director of Public Safety, Powers and Duties.

c. Department of Public Safety (PSD), Policies and Procedures (P & P), COR.10.1A.06, Continuous Quality Improvement Program.

d. PSD, P & P, COR.10.1A.14, Inmates Requesting Private Medical Care Provider.

e. PSD, P & P, COR.10.1E.03, The Transfer Screening.

f. National Commission on Correctional Health Care Standards for Prisons and Jails, (2018).

g. American Dental Association.

.2 Definitions

a. Universal Dental Recording System: A means of identifying teeth by number.

b. Prosthetics: Artificial devices to replace missing body parts; in this case, dentures, bridges, etc.

.3 Forms

a. DOC 0406, Consultation Record (attached).

b. DOC 0409, Dental Treatment Record (attached).

c. DOC 0411, Dental Health Questionnaire (attached).

d. DOC 0417, Refusal to Consent to Medical/Surgical/Dental Treatment/Medication (attached).

d. DOC 0424, Dental Examination (attached).

d. DOC 0427, Consent to Operation, Post-Operative Care, Medical Treatment, Anesthesia or Other Procedure (attached).

e. DOC 0449, Medical Needs Memo (attached).

f. DOC 0475, Dental Problem Sheet (attached).

4.0 POLICY

.1 Dental examinations and treatments for inmates shall be performed by, and under the direction and supervision of a dentist licensed to practice in the State of Hawaii.

.2 Dental care of inmates shall be timely and includes immediate treatment for urgent or painful conditions. The inmate's serious urgent and emergent dental needs shall be met.

5.0 PROCEDURES

.1 Dental screening of newly admitted inmates shall occur within fourteen (14) days of admission into the Department of Public Safety (PSD) jail facilities and within seven (7) days of admission to prison facilities.

.2 Inmates transferring between one PSD facility to another who have received a dental screen while at the sending facility do not require a new screening at the receiving facility if the documentation in the dental record indicated the service was received within the 14 to 7 days requirement respectively.

.3 The dental screening shall include visual observation of the teeth and gums, noting any gross abnormalities which requiring immediate referral to a dentist. Health staff having received documented training by a dentist can perform dental screens. The screening shall be recorded in the patient's dental record.

.4 Instructions in oral hygiene and preventive oral education are given to patients, within fourteen (14) days of admission, by a dentist, dental hygienist, or health staff with documented training by a dentist.

.5 A dentist shall perform a dental examination on all inmates within thirty (30) days of admission to a PSD prison facility and within one (1) year of admission to a PSD jail facility. Inmates who transfer from one PSD facility to another who received a dental exam while at the sending facility do not require a new examination at the receiving facility if the documentation in the dental record transfers with the inmate.

Inmates who are re-admitted and who received a dental examination and treatments within the past year do not require a new examination unless so determined by the supervising dentist.

.6 Dental examinations shall include the patient's dental history, extraoral head and neck examination, charting of teeth and examination of hard and soft tissue of the oral cavity with a mouth mirror, explorer and adequate illumination. The examination results shall be recorded on Form DOC 0424, Dental Examination utilizing the Universal Dental Recording System.

.7 Oral treatment shall be prioritized for emergencies, acute injuries to the teeth, acute injuries to the oro-facial complex, infection control, pain management, proper mastication and maintaining the patients' health status.

.8 Bitewing x-rays and additional radiographs may be taken at the time of the patient's first treatment appointment and thereafter as clinically indicated.

.9 Each inmate shall have access to the preventive benefits of fluorides in a form determined by the dentist to be appropriate for the needs of the individual.

.10 Extractions shall be performed in a manner consistent with community standards of care and adhering to the American Dental Association's clinical guidelines. Extractions are limited to the following:

a. Non-restorable teeth

b. Periodontally compromised teeth

c. Severe, acute or chronic infection

Informed patient consent for extractions is required on DOC 0427, Consent to Operation, Post-Operative Care, Medical Treatment, Anesthesia or Other Procedure.

.11 Inmates can seek private dental care at their own expense in accordance with PSD, P & P, COR.10.1A.14, Inmates Requesting Private Medical Care Provider. For security reasons, dental staff should encourage the private provider to come to the facility to provide the services. Approval for private provider care must be approved by the Correctional Health Care Administrator or designee.

.12 Medical reviews of any inmates to be transferred to another correctional facility shall include consideration of any pending dental work. Should an inmate's pending transfer involve a facility at which an institutional dentist is not readily available, and the inmate has major uncompleted dental work pending, the inmate shall not be transferred until dental services have been completed.

.13 All dental records shall be confidential. These records shall be maintained for all patients and shall include as indicated:

a. DOC 0406 Consultation Record

b. DOC 0409 Dental Treatment Record

c. DOC 0411 Dental Health Questionnaire

d. DOC 0417 Refusal to consent to Medical/Surgical/Dental Treatment/Medication

e. DOC 0424 Dental Examinations

f. DOC 0427 Consent to Operation, Post-Operative Care, Medical Treatment, Anesthesia, or Other Procedure

g. DOC 0449 Medical Needs Memo

h. Perio Chart

i. DOC 0475 Dental Problem Sheet

j. Access to digital X-rays.

.14 When an inmate transfers to another facility, the dental record shall be transferred according to PSD, P & P, COR.10.1E.03, The Transfer Screening.

.15 Dental records shall be notated in S-O-A-P or problem-oriented format. All notes shall include the client's complaint, the examination, the diagnostic impression/assessment, and the treatment plan.

.16 Form DOC 0406 Consultation Record shall accompany the inmate to an outside dental referral. DOC 0406 will also be used when a dental consultant comes to the facility. The Consultation Record and the consultant's report shall be filed in the Consultation Index of the medical record. A copy of the consultation record and consultant's report shall be filed in the dental record.

.17 All dental staff shall adhere to standard precautions as an infection control practice. Infection control practices as defined by the American Dental Association and the Centers for Disease control and Prevention and OSHA shall be followed. These include but are not limited to the use of personal protective devices, sterilization of reusable instruments, the protection and disinfection of operatory equipment, and properly disposing of hazardous waste and sharps.

No inmate shall be denied dental treatment because of an infectious condition.

.18 Reviews of dental services will be included in the PSD health services quality assurance program as described in PSD, P & P, COR.10.1A.06, Continuous Quality Improvement Program.

APPROVAL RECOMMENDED:

Caroline Mee MD — November 06, 2018
Medical Director — Date

APPROVAL RECOMMENDED:

November 06, 2018
Health Care Division Administrator — Date

APPROVAL RECOMMENDED:

November 06, 2018
Deputy Director for Corrections — Date

APPROVED:

November 06, 2018
DIRECTOR — Date

STATE OF HAWAII DEPARTMENT OF PUBLIC SAFETY

Facility _____ **CONSULTATION RECORD**

Last	First	DOB	SID

Request To: Appt. Date Time

Reason for Consultation*: _____

Requesting Provider Date

CONSULTANT'S REPORT (HISTORY, FINDINGS, DIAGNOSIS, RECOMMENDATIONS)

Consultant's Signature Title/Specialty Date

45 Code of Federal Regulations 164.512 (k)(5): A covered entity may disclose to a correctional institution or a law enforcement official having lawful custody of an inmate or individual protected health information about such inmate or individual, if the correctional institution or such law enforcement official represents that such protected health information is necessary for: a) the provision of health care to such individuals; b) the health and safety of such individual or other inmates; c) the health and safety of the officers or employees of or others at the correctional institution; d) the health and safety of such individuals and officers or other persons responsible for the transportation of inmates or their transfer from one institution, facility, or setting to another ; e) law enforcement on the premises of the correctional institution; and f) the administration and maintenance of the safety, security, and good order of the correctional institution. For the purposes of this provision, and individual is no longer an inmate when released on parole, probation, supervised release, or otherwise is no longer in lawful custody.

***PSD Staff: Complete Form Doc 0497 if a significant change in health status has occurred.**

Original: Medical Record
Yellow: Consultant's Copy

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

DENTAL TREATMENT RECORD

DATE	TIME	TOOTH #	TREATMENT RECEIVED

CONFIDENTIAL

Facility: _____ DENTAL HEALTH QUESTIONNAIRE Date: _____

NAME: _____ SID: _____ DOB: _____
(LAST) (FIRST)

In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1.	Has there been any change in your general health within the past year	YES	NO
2.	My last dental/physical examination was on _____.		
3.	Are you under the care of a physician?	YES	NO
	If so, what is the condition(s) being treated? _____		
4.	Have you had any serious illness or operation?	YES	NO
	If so, what was the illness or operation? _____		
5.	Have you been hospitalized or had a serious illness within the past 5 years?	YES	NO
	If so, what was the illness? _____		
6.	Do you have or have you had any of the following diseases or problems?		
	a. Rheumatic fever or rheumatic heart disease	YES	NO
	b. Heart problems (heart trouble, heart attack, coronary insufficiency, coronary occlusion, arteriosclerosis, stroke)	YES	NO
	c. High blood pressure	YES	NO
	d. Allergy	YES	NO
	e. Sinus trouble	YES	NO
	f. Asthma or hay fever	YES	NO
	g. Fainting spells or seizures	YES	NO
	h. Diabetes	YES	NO
	i. Hepatitis, jaundice or liver disease	YES	NO
	j. Arthritis	YES	NO
	k. Inflammatory rheumatism (painful swollen joints)	YES	NO
	l. Stomach ulcers	YES	NO
	m. Kidney trouble	YES	NO
	n. Tuberculosis	YES	NO
	o. Low blood pressure	YES	NO
	p. Venereal disease	YES	NO
	q. AIDS, HIV+, HIV-	YES	NO
	r. Other	YES	NO
7.	Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?	YES	NO
	a. Do you bruise easily?	YES	NO
	b. Have you ever required a blood transfusion?	YES	NO
	If so, explain the circumstances: _____		
8.	Do you have any blood disorder such as anemia?	YES	NO
9.	Have you had surgery or X-ray treatment for a tumor, growth or other condition of your head or neck?	YES	NO
10.	Are you taking any drug or medicine?	YES	NO
	If so, what _____		
11.	Are you allergic or have you reacted adversely to any medicines?	YES	NO
12.	Have you had any serious trouble associated with any previous dental treatment?	YES	NO
	If so, explain _____		
13.	Do you have any disease, condition, or problem not listed above that you think I should know about?	YES	NO

_____ _____
Patient Signature Date

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

REFUSAL TO CONSENT TO MEDICAL/SURGICAL/DENTAL TREATMENT/MEDICATION

NAME: _____ SID: _____ DOB: _____

FACILITY: _____ DATE: _____ TIME: _____

I, the undersigned patient, refuse the following treatment and/or medication: _____

_____

(Describe Treatment and/or Medication)

The risk of refusing treatment or medication has been explained to me and I accept the risk involved. I release the State, the Department, the facility administration and personnel, the Health Care Division administration and medical personnel from any responsibility or liability for any unfavorable reaction, outcome, or any untoward results due to this refusal on my part to accept treatment or medication.

_____ _____

(Signature of Patient) (Date)

I, the undersigned, have explained to the above named patient the risk involved in refusing treatment or medication recommended for the patient's continued good health and I witness the patient's refusal of the recommended treatment or medication

_____ _____ _____

(Print Name) (Signature & Title) (Date)

A referral has been made to a provider: YES NO

I have reviewed this case and if necessary have further counseled this patient on the risk of refusing treatment or medication.

_____ _____ _____

(Print Name of Provider) (Signature & Title) (Date)

** If the patient refuses treatment and/or medication and refuses to sign this consent, please have refusal witnessed by another correctional employee.*

I have witnessed the above named patient refuse the recommended treatment or medication and I have also witnessed the patient's refusal to sign this consent form.

_____ _____ _____

(Print Name & Title) (Signature & Title) (Date)

SID _____ FACILITY _____

STATE OF HAWAII
DEPARTMENT OF CORRECTIONS

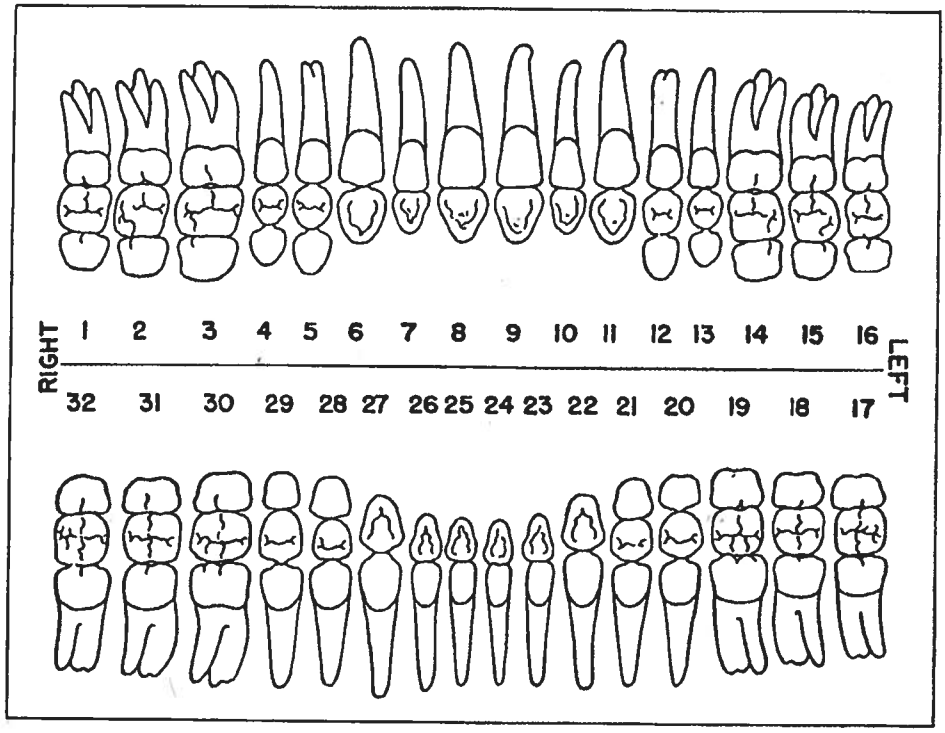
DENTAL EXAMINATION

NAME _____ D.O.B. _____ SSN _____

Date Admitted _____ Exam Date _____

Medical Alert _____

_____



Classifications:

Plaque _____

_____

Stain _____

_____

Calculus deposits _____

Slight____ Mod____ Severe____

Gingiva _____

_____

Recession _____

_____

Periodontal Condition _____

_____

_____

Prosthetics: FUD FLD PUD PLD

_____

B. EXTRAORAL INSPECTION	Normal	Abnormal
Face		
Head		
Neck		
Lymph Nodes		
TMJ		
C. ORAL INSPECTION		
Lips		
Vestibule		
Mucosa		
Pharynx		
Tonsils		
Gingiva		
Palate		
Tongue		
Floor of the Mouth		

COMMENTS: _____

_____

_____

_____

_____

_____

_____

_____

CONFIDENTIAL

CONSENT TO OPERATION, POST OPERATIVE CARE, MEDICAL TREATMENT, ANESTHESIA, OR OTHER PROCEDURE

Patient: «FirstName» «FirstName»
SID: «SID» DOB: «DOB»
Facility: _____ Date:

You have the right and obligation to make decisions concerning your health care. The physician must provide you with the information and advice concerning the proposed procedure so that you can make an informed decision.

(1) Explain the nature of the condition(s) in professional and ordinary language.
PROFESSIONAL: _____

ORDINARY LANGUAGE: _____

AT _____

(2) Describe procedures(s) to be performed in professional and ordinary language, if appropriate.
PROFESSIONAL: _____

ORDINARY LANGUAGE: _____

AT _____

(3) I recognize that, during the course of the operation, post operative care, medical treatment, anesthesia, or other procedure, unforeseen conditions may necessitate my above-named physician and his or her assistants, to perform such surgical or other procedures as are necessary to preserve my life and bodily functions.

(4) I have been informed that there are many significant risks, such as severe loss of blood, infection, cardiac arrest and other consequences that can lead to death or permanent or partial disability, which can result from any procedure.

(5) No promise or guarantee has been made to me as to result or care.

Any section below which does not apply to the proposed treatment may be crossed out. All sections crossed out must be initialed by both the physician and the patient.

(6) I consent to the administration of (general, spinal, regional, local) anesthesia by my attending physician, by an anesthesiologist, a nurse anesthetist, or other qualified party under the direction of a physician as may be deemed necessary. I understand that all anesthetics involve risks that may result in complications and possible serious damage to such vital organs as the brain, heart, lungs, liver and kidney.

These complications may result in paralysis, cardiac arrest and related consequences or death from both known and unknown causes.

(7) I consent to the use of transfusion of blood and blood products as deemed necessary. I have been informed of the risks which are transmission of disease, allergic reactions, and other unusual reactions.

(8) Any tissue or part surgically removed may be disposed of by the hospital or physician in accordance with accustomed practice.

(9) Any additional comments may be inserted here:
_____
_____

(10) I have had the opportunity to ask questions about this form.

FULL DISCLOSURE

[ ] I AGREE TO AUTHORIZE THE PROCEDURE DESCRIBED ABOVE AND I AGREE THAT MY PHYSICIAN HAS INFORMED ME OF THE:

a) DIAGNOSIS OR PROBABLE DIAGNOSIS.
b) NATURE OF THE TREATMENT OR PROCEDURE RECOMMENDED.
c) RISKS OR COMPLICATIONS INVOLVED IN SUCH TREATMENT OR PROCEDURES.
d) ALTERNATIVE FORMS OF TREATMENT, INCLUDING NON-TREATMENT, AVAILABLE.
e) ANTICIPATED RESULTS OF THE TREATMENT.

_____ _____
Patient/Other Legally Responsible Person Sign, If Applicable Date

_____ _____
Physician Date

DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

MEDICAL NEEDS MEMO

Facility:_____ Date: August 30, 2018

TO:_____ FROM: «UserName»

Inmate: «FirstName» «LastName» SID#: «SID» Housed in:_____

Duration:_____ Days; _____; Weeks; _____Months;_____Indefinitely

* Health Status Classification Report required if there is a *significant* change in health status

Original : UTM/ACO Work Supervisor
Copy: Inmate, Facility ADA Coordinator

DOC : 0449 (05/05)

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

DENTAL PROBLEM LIST

NAME:_____ SID#:_____

FACILITY:_____

#	PROBLEM	DATE OBSERVED	DATE COMPLETED	NOTES

DOC 0475 (3/12)