

CHAPTER 4. INSTRUCTIONS COMMON TO BOTH INPATIENT AND OUTPATIENT DENTAL PROGRAMS

SECTION I. GENERAL

4.01 LOCAL DENTAL POLICIES AND PROCEDURES

Promulgation of local dental policies and procedures will take two forms. One form relates to matters that are internal to the dental service itself and will usually be referred to as the Dental Service Operations Manual. The other relates to matters that impact upon the operations of other individuals or services within the facility or require their cooperation. These will usually be published as facility memoranda over the signature of the facility Director.

a. **Dental Service Operations Manual.** The Chief, Dental Service, will be responsible for developing and maintaining currentness of an operations manual that details internal dental service policies and procedures essential to clinic function and delivery of dental care. The manual should serve to augment and implement VA and DM&S directives while maintaining consistency with their letter and intent. The following subjects are examples of those that may be covered:

- Oral examinations and diagnostic procedures.
- Clinic dress code.
- Professional department.
- Supervision of dental residents.
- Collection of statistical data.
- Quality assurance procedures.
- Management of dental clinic records.
- Clinic infection control procedures.
- Housekeeping duties and responsibilities.
- Environmental hygiene (radiation, mercury, etc.).

b. **Facility Memoranda (or similarly named local directives).** The Chief, Dental Service, will be responsible for development, coordination, assuring publication, and maintaining currency of center memoranda that apply to the dental service but impact upon the activities or require the cooperation of other services. Examples are as follows:

- Eligibility and priorities for dental care.
- Admission and discharge of dental patients.
- Procedures relating to dental emergency "drop-ins."
- Dental appointments for inpatients.
- Treatment of employee dental emergencies.
- On-ward preventive dentistry sessions.
- \*Authorized use of dental clinic facilities.

\*An example of format and style for a facility memorandum on this subject is provided as appendix 4A. Although local policy may require some variation in format, a local directive covering this subject is mandatory.

### **c. Responsibilities of Dental Service Staff**

(1) Dental service personnel will be expected to be familiar with the provisions of all local policies and procedures, and to conduct their activities in accordance with those provisions. Similarly, they should be able to accurately explain them, as necessary, to patients, other VA employees, and the general public.

(2) The Chief of Dental Service must assure that any changes in local policies and procedures are promptly published and that all dental personnel are kept abreast of such changes. In addition to staff meeting discussions, a system of in-clinic circulation of the policy/procedure documents (with initialing by each individual attesting to their review and understanding) is considered a necessity.

#### **4.02 OFFICER OF THE DAY--DENTAL**

At all health care facilities where two or more dentists are assigned, a rotation roster of "Officer of the Day--Dental" will be maintained. The dental officer of the day will be subject to call for emergency dental care of VA beneficiaries and will keep the facility advised as to where to be contacted during the officer's tour of duty. At facilities with only one dentist, emergency dental coverage will be arranged for by the Chief, Dental Service, in cooperation with the Chief of Staff. The Director will promulgate instructions for the implementation of emergency dental coverage at VA outpatient clinics.

#### **4.03 SUPERVISION OF DENTAL RESIDENTS AND OTHER DENTAL TRAINEES**

a. Dental residents must be provided appropriate supervision during any and all clinical tours of duty in a VA medical facility. This supervision may be provided by the Program Director or a designated, appropriately credentialed physician or dentist member of the medical staff. The degree of such supervision is dependent upon demonstrated knowledge, skill, and judgment of the trainees as well as their level of professional attainment. A well-structured training program should permit and encourage increasing levels of clinical responsibility as defined in program objectives. In addition, all programs should endeavor to instill a sense of compassion for patients as human beings who must be treated with dignity and respect.

b. Supervision must include preceptor review of all treatment plans involving comprehensive care and for all procedures that are complex, involve increased patient risk, or with which the resident has limited experience. Such supervision should include a pre-treatment review of the dental/oral diagnosis, intended dental treatment, and relevant elements of the physical evaluation and medical history. Pre-treatment reviews should be documented in the medical records with comments and/or cosignature by the preceptor when appropriate.

c. Pre-treatment preceptor review is not required for short, uncomplicated procedures when the resident has demonstrated adequate professional knowledge,

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skill, and maturity of judgment in the VA milieu or, as applicable, in an affiliated hospital rotation. Designation of these residents will be on an individual basis by the Program Director and Service Chief (for dental specialty residents) or by the Program Director, Service Chief, and assigned preceptors (for dental general practice residents. Such designation will be based on careful monitoring and may be granted or withdrawn at any time during the residents' program. Implementation must

be accompanied by formal documentation in the resident's evaluation records.

d. During scheduled treatment, the degree of supervision and the physical proximity of the preceptor vary with the demonstrated knowledge, skill and judgment of the resident, the complexity of the procedure, and the condition of the patient. Based on these factors, treatment procedures may be accomplished under one of the following conditions:

(1) The preceptor present within the operatory or the clinic.

(2) The preceptor available within the medical complex, to include an affiliated institution, if geographically adjacent to the VA facility.

(3) Preceptor available on an "on-call" basis;---applicable to situations involving routine, low-risk procedures that a resident may wish to continue after normal clinic closing time.

e. Dental residents on an off-service rotation will be assigned to an appropriate member of the medical staff for supervision, and are subject to the supervisory directives applicable to that service. Dental residents providing dental or oral surgical treatment in the hospital surgical suite will usually be supervised in accordance with paragraph d by an appropriately credentialed member of the dental service staff. Supervisory directives of the surgical service will take precedence, however, if they are more restrictive or detailed.

f. Assignment of a dental resident to independent on-call status during evening, weekend, or holiday hours is permitted if, as in paragraph c, the resident has demonstrated clinical proficiency and judgment deemed sufficient to evaluate dental emergencies and, as indicated by the situation, to provide treatment or to request assistance; and either an appropriately credentialed attending staff member or, if applicable, a more experienced senior resident is assigned on-call as backup for consultation and/or assistance.

g. Undergraduate dental students, dental hygiene students, and dental assistant students (or any other trainees having direct patient contact during a dental clinic rotation in a VA medical facility) must be under the direct supervision of assigned faculty or appropriately designated members of the VA dental service staff. Complexity of assignments and proximity or participation of the instructor are dependent upon the objectives of the program, level of student attainment, demonstrated knowledge and skill, and condition of the patient. Students do not have the authority and they will not be assigned responsibility for providing independent patient care.

h. In a situation where serious or permanent harm could result to a patient or when the life of a patient is in immediate danger, dental service trainees, assisted by other personnel as available, shall be permitted to do everything possible to save the life of a patient or to save a patient from

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serious harm. Appropriate professional staff should be summoned for assistance without delay.

**4.04 DENTAL APPOINTMENTS AND RECORDS**

A system of scheduling dental appointments, consistent with the centralized scheduling program of the facility, will be established and maintained.

a. Unless a local automated system has been developed as an adequate substitute, VA Form 10-2679, Dental Appointment and Record Book, or a similar bound book, will be maintained by each dentist, hygienist and EFDA (expanded function dental auxiliary) to provide a daily record of appointments and services. Annotations will also be made concerning attendance at professional and/or administrative meetings and conferences and all other non-chairside duties.

b. The medico-dental terminology of the latest edition of the American Medical Association's "Current Medical Information and Terminology" and "Physicians' Current Procedural Terminology" and/or other approved references will be used in recording the oral diagnoses and treatment recommendations and procedures. The following abbreviations will be used in recording tooth surfaces:

| Simple       | Compound (Examples)                          |
|--------------|--|
| M (Mesial)   | MO (Mesio-occlusal)                          |
| I (Incisal)  | DO (Disto-occlusal)                          |
| F (Facial)   | MOD (Mesio-occluso-distal)                   |
| D (Distal)   | FO (Facio-occlusal) and similar combinations |
| O (Occlusal) |  |
| L (Lingual)  |  |

c. Periapical films will be mounted to orient the oral structures as they would be viewed from outside the mouth, facing the patient. This is in conformance with the system recommended for standardization by the American Dental Association.

d. The VA utilizes the numbering system for permanent teeth which starts with the maxillary right third molar as tooth No. 1 and proceeds sequentially to the maxillary left third molar as tooth No. 16. The mandibular left third molar is tooth No. 17 and the numbering proceeds sequentially, ending with the mandibular right third molar which is tooth No. 32.

e. Deciduous teeth are identified by capital letters starting with the maxillary right second molar, tooth A, and ending with the mandibular right second molar which is tooth T. The method of proceeding from A to T is similar to that for permanent teeth as outlined in subparagraph d above.

#### **4.05 PROCEDURES PERTINENT TO ORAL SURGERY**

a. **Utilization of Operating Rooms for Oral Surgery Requiring General Anesthesia.** Normally the management of all oral conditions requiring the use of general anesthesia will take place only in hospital operating rooms. Allowances for extending this practice to a dental clinical area may be made where residency programs require trainees to obtain experience in general analgesia and/or sedation for ambulatory dental patients, or when the dental

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service is staffed by qualified personnel with appropriate clinical privileges. The implementation of such a program requires the approval of the Chief of Staff, Chief of Surgery, and the Chief of Anesthesiology.

b. **Fractures of the Zygomaticomaxillary Complex and/or Mandible.** Patients with fractures of the zygomaticomaxillary complex and/or mandible will be admitted to beds allocated to

the surgical service unless there are beds specifically allocated to the dental service. If there is another condition of priority concern, arrangements will be made to admit the patient to another service. Ordinarily, the dental service will be responsible for the treatment of fractures of the zygomaticomaxillary complex and/or mandible. In unusual or complicated cases, such as extensive fractures involving the middle third of the face, the orbits, the cranium, etc., consultation will be requested with the appropriate services. Thus, the care of the patient becomes a team effort assuring the best possible care for the veteran-beneficiary. In fact, consideration should always be given to bringing together the expertise of various professional disciplines where the application of these talents would serve to enhance treatment effectiveness, function restoration and esthetics. In facilities with approved training programs in oral surgery, the Chief, Dental Service, and the Chief of Staff, in cooperation with the Deans Committee, will be responsible for assuring that oral surgery residents are provided with adequate experience to meet the training requirements of the American Board of Oral and Maxillofacial Surgery and the Commission on Accreditation of the American Dental Association.

c. **Written Informed Consent.** It will be necessary, for the performance of all surgical procedures, that the patient be fully informed concerning the procedure(s) and sign consent prior to the initiation of treatment, as required by the applicable specifications contained in paragraph 4.06b through i.

#### **4.06 INFORMED CONSENT FOR PERFORMANCE OF DENTAL OPERATIONS AND OTHER PROCEDURES**

a. **Informed Consent--Verbal.** Except as specified under subparagraph b(1) it will not be necessary to obtain signature consent from an adult patient nor document SF 522, Medical Record-Request for Administration of Anesthesia and for Performance of Operations and Other Procedures, for low risk dental procedures which are commonly practiced by the dental profession and normally understood by dental patients (such as the administration of local anesthesia, preparation of teeth, restorations, oral prophylaxis, fabrication of prostheses, etc.). Prior to initiation of care, the dental care provider will explain to the patient (in language the patient can understand) the need for and the nature of the procedures to be performed, the attendant risks and discomforts, if any, and the extent of care for which the VA will be obligated. A notation documenting the explanation should be placed in the patient's medical record at the time it is given. No further consent(s) is required during the course of care unless there is a significant change in the treatment plan.

b. **Informed Consent--Written**

(1) All dental procedures involving higher risk or about which the average dental patient would not be familiar will require that the patient be fully informed concerning the nature, purpose and benefits of the procedure(s), possibility of complications and problems to be anticipated if no treatment is provided and the extent of dental care for which the VA will be obligated. This information must be attested to by the patient and the dentist on SF 522, Medical

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Record-Request for Administration of Anesthesia and for Performance of Operations and Other Procedures, prior to the initiation of dental treatment involving:

- (a) All surgical procedures.
- (b) All biopsies.

(c) Any dental procedure which would be considered to present unusual risk due to the health status of the patient or the risk factor of the procedure itself.

(d) Any dental procedure which is not commonly practiced by the dental profession whereby the average patient would not be expected to have knowledge of the procedure.

(e) Administration of relative anesthesia, general analgesia or intravenous sedation.

(2) If the treatment anticipated will involve multiple visits or procedures in following an authorized treatment plan, the treatment plan may be summarized, under item 1, part B of SF 522 and explained to the patient. Therefore, it will not be necessary, under this option, to obtain additional or subsequent signatures from the patient as long as the episode of care proceeds according to the following:

(a) There is no significant deviation from the treatment plan as originally outlined.

(b) The original treatment plan is not exceeded.

(c) The elapsed time for accomplishment of the episode of care does not become excessive in relation to the treatment involved and normal healing periods.

(d) No new or unusual problems or complications have arisen which will require alteration of the original treatment plan.

(3) If any of the conditions described under subparagraph above are breached during the course of dental treatment, the circumstances will be amended by the completion of a new SF 522.

(4) Written consent for multiple procedures constitutes only the permission to proceed with dental treatment on a continuing basis and must not be construed to be an obligation for the completion of care by either party (the patient or the VA). The patient is free to terminate treatment at any time, regardless of the treatment plan outlined on SF 522. Likewise, the VA must not be obligated for the completion of dental care on the basis of SF 522 alone. The commitment to complete treatment relates to factors other than the consent to proceed with treatment (i.e., legal eligibility, professional determination of priority of care, length of inpatient stay, occurrence of other intervening medical or dental problems which would contraindicate completion of the treatment plan, etc.).

c. Signatures Required by SF 522, Part C, Signatures, requires the following:

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(1) Item 1, Signature of Counseling Physician/Dentist, should be the signature of the dentist who will perform the procedure. If the individual obtaining the written consent is not to be the treating dentist, the patient will be advised of the identity of the treating dentist. In the event that treatment will be provided by two or more dentists, then the procedures listed in the treatment plan in part B will be numbered. When the dentists who will treat the patient are listed, the numbers corresponding to the treatment each dentist is to provide will be indicated beside the dentist's name.

(2) Items 2 and 3, Signature of Witness, excluding members of operating team, are worded so as to prevent the witness from being an assistant surgeon or surgical consultant who might also be directly involved in performing the operation. In the case of a dentist/dental assistant team, the dental assistant (who will not be performing the operation, per se) may sign SF 522 as a witness.

(3) Item 2, Signature of Patient, and Item 3, Signature of Sponsor/Legal Guardian, are self-explanatory.

d. **Extraction of Teeth--Conditions for Waiver.** When extractions are indicated as emergency dental treatment and when prostheses to replace the tooth or teeth lost by the treatment procedure are not contemplated or intended, the patient will be required to sign a statement of understanding, stamped on the reverse of SF 522, which will read: "I understand and agree that the extraction of tooth number(s) \_\_\_\_\_ is being performed for my benefit and relief, and that such treatment does not obligate the VA to provide replacement for the lost tooth or teeth.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

e. **Extraction of Teeth--Conditions Not Requiring Waiver.** When extractions are indicated as part of the definitive treatment and it is assured that the tooth or teeth lost by the treatment procedure will be replaced by the VA, it will only be necessary to have the patient sign the front of SF 522. If there is any question as to whether the commitment to replace the missing teeth will be carried out or not, the requirements of subparagraphs b, c and d will be followed.

f. **Consent From Patient's Guardian or Next of Kin.** Consent of the patient's guardian or next of kin will be secured on an SF 522 when:

(1) The patient is unconscious or a minor (other than a minor member of the Armed Forces receiving treatment on official authorization).

(2) The patient has been adjudged legally incompetent or is deemed mentally incompetent such as to be incapable of comprehending the significance of such action or of exercising appropriate judgment.

g. **Consent From Director, or Chief of Staff.** When the patient is not competent to give consent, a physician Director, Chief of Staff or a physician acting for either will sign and date the SF 522 as the person authorized to consent for the patient when there is no known guardian or next of kin and oral surgery is necessary for the preservation of the patient's health or life. This procedure will also be used when time does not permit an effort to

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obtain consent from the patient's guardian or next of kin. The guardian or next of kin will be notified as soon as practicable and given reasons for furnishing the treatment without awaiting consent.

h. **Refusal To Consent.** Refusal by the patient or by the legal guardian to give consent for a recommended oral surgery, diagnostic or therapeutic procedure will be recorded in the patient's medical record.

i. **Disposition of SF 522.** SF 522, when signed and dated by the patient or by the person authorized to consent, will be filed in the patient's medical record. (Par. 4.06 is based on 38 U.S.C. 4131.)

#### **4.07 DIAGNOSIS AND TREATMENT OF ORAL MALIGNANCIES**

Effective treatment of oral malignancy often depends on early detection. When the clinical oral examination reveals a suspicious lesion, sound diagnostic, consultative, and/or operative procedures will be employed by the dentist commensurate with his/her experience and clinical privileges. Early diagnosis of oral malignancy can only be established by histopathological examination of representative tissue. All suspicious lesions which have not responded to therapy or resolved within a 2-week period should be biopsied. A tissue registry will be maintained by each dental service, documenting all tissue removed for histopathological examination. This registry will include the patient's name, hospital registry number or Social Security number, date of removal of the tissue, an accurate description of the site of the lesion, the histopathologic diagnosis, and the laboratory accession number (taken from SF 515, Tissue Examination), and the disposition of the patient. If the lesion is determined to be malignant, the patient will be referred to the Tumor Board or appropriate service chief for evaluation and treatment. The dentist is also obligated to examine the perioral and facial skin for abnormalities and a consultation request will be made to the surgical service for further evaluation and treatment if extra-oral malignancy is suspected.

#### **4.08 DENTAL CARE FOR PHYSICALLY HANDICAPPED PATIENTS**

Blind, paraplegic and/or patients who have sustained complete loss of both hands or use thereof will be given priority consideration for dental care when hospitalized. Those veterans who receive aid and attendance should be carefully evaluated for their dental needs related to their medical health status and provided with necessary dental care while hospitalized. Veteran-beneficiaries who are service connected for blindness, paraplegia, quadriplegia and/or complete loss of both hands, or use thereof, may be furnished outpatient dental care on an adjunct basis.

#### **4.09 DEPLETION OF DENTITION: REPLACEMENT OF MISSING TEETH BY PARTIAL OR COMPLETE PROSTHESES**

a. **Depleted Dentition and Replacement of Missing Teeth.** When a patient's dentition has been depleted as a result of VA treatment, it is not required that missing teeth be replaced with prostheses unless:

(1) There is a medical condition requiring improved masticatory function, or

(2) The veteran has eligibility for prostheses under Classes I-VI eligibility, or

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(3) The veteran is a long-term (100 days or more) inpatient, being hospitalized for that period, or being carried as a patient in a VA NHCU (Nursing Home Care Unit) or Domiciliary.

b. **Maintenance or Replacement of Prostheses Provided by the VA.** Under conditions where the VA has previously provided satisfactory oral prostheses, there is no continuing obligation to maintain such dental prostheses or to replace them if they become unserviceable or lost, unless

the veteran has a service-connected medical condition which would require replacement or repair on the basis of professionally determined adjunct care, the veteran is a long-term inpatient, or has statutory eligibility to outpatient dental care. However, any denture lost while a veteran is an inpatient in a VA medical care facility may be replaced if the loss is verified by appropriate ward personnel and replacement is authorized by the Chief, Dental Service.

#### **4.10 DENTAL TREATMENT IN A DEPARTMENT OF THE ARMY, NAVY, AIR FORCE OR U.S. PUBLIC HEALTH SERVICE HOSPITAL**

a. **Prescription of Treatment.** When a VA beneficiary is receiving prescribed treatment in a Department of the Army, Navy, Air Force or U.S. Public Health Service Hospital, dental treatment, if indicated in the treatment for the condition necessitating hospitalization, should be furnished by that facility.

b. **Completion of Prescribed Treatment After Patient's Discharge.** When a VA beneficiary is discharged from a Department of the Army, Navy, Air Force, or U.S. Public Health Service Hospital with uncompleted dental treatment prescribed for a service-connected disability, the question of the necessity for furnishing further outpatient dental care for the treatment of the basic service-connected condition will be given consideration by the VA outpatient clinic of jurisdiction. Such cases will be handled without regard to what dental treatment may or may not have been prescribed for the basic service-connected condition while in such hospital, but the consideration will be based entirely on the treatment for which outpatient eligibility can be established. Exception will be made in cases where a sufficient number of teeth have been extracted to deplete mastication. In this instance, the provisions of paragraph 4.08 will be observed and the beneficiary referred to a VA facility for proper resolution. If the patient meets the eligibility requirements for class III dental treatment, the Chief, Dental Service, of the outpatient clinic of jurisdiction may authorize the treatment on an outpatient basis to a VA health care facility or to a fee dentist. (See M-1, part I, chapter 19.)

#### **4.11 DENTAL TREATMENT IN NON-FEDERAL HOSPITALS**

When a VA beneficiary is hospitalized in a non-federal contract hospital and it has been medically determined that dental care is required in the treatment of the condition for which the patient is hospitalized, the appropriate hospital official will communicate this need to the VA fee jurisdictional facility concerned with a statement as to their facility's capability for providing such treatment. If the VA facility Director considers the need for the dental treatment justified, the dentist will proceed as follows:

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a. If the hospital cannot provide the treatment, arrangements will be made to transfer the patient to a VA inpatient facility, provided further hospitalization is necessary.

b. If the hospital has facilities for providing treatment, the VA facility Director will make authorization for such care.

c. If the hospital furnishes part of the treatment to the extent that depletion of dentition results and the patient has eligibility for replacement, the patient may be referred to a VA facility for completion of treatment under OPT procedures as outlined in paragraph 1.10. If the patient meets the eligibility requirements for class III dental treatment, the Chief, Dental Service, of the facility of jurisdiction may refer the treatment to a VA health care facility or authorize fee-basis care according to the procedures outlined in paragraph 1.10b(2). (See also M-1, part I, ch. 19.)

#### **4.12 STERILIZATION**

a. The prevalence and transmissibility of bacterial and viral infections make it essential that VA Dental Services continually review their techniques for the sterilization of all dental instruments and supplies. Specific directions applicable to sterilization procedures will be included in the Dental Service Operations Manual at each VA facility.

b. Autoclaving, dry heat or ethylene oxide, when properly employed, will effectively accomplish sterilization of instruments and supplies. It is advised, however, that the use of ethylene oxide sterilization be confined to the SPD (Supply, Processing and Distribution) unit unless the dental service is especially equipped to deal with its environmental hazards. In all instances where instruments and supplies have been wrapped and sterilized, the applicable expiration date must be noted on each wrapping. When sterilized items become outdated, they must be resterilized prior to use.

c. It will be the responsibility of the Infection Control Committee at each VA facility to review, periodically, the techniques employed by the dental service for sterilization of instruments and supplies to assure that only effective procedures are being used.

#### **4.13 MERCURY CONTAMINATION AND HYGIENE PRACTICES**

a. There are serious concerns regarding the possibility of mercury intoxication of dental personnel. For this reason, each Chief of Dental Service, with the assistance of the Facility Safety Officer, will write and implement specific procedures for the safe handling of mercury and amalgam by the dental staff. Since appropriate precautions and proper equipment for the handling of amalgam are predominant factors in reducing the risks involved, it is essential that only sealed, pre-measured capsules of mercury and alloy be used by the dental service. Scrap amalgam will be collected, stored under fluid (water, glycerin), and periodically turned over to the Supply Service for disposition in accordance with VA Manual MP-2, subchapter H, section 108-43.414-51. Further recommendations on mercury hygiene are available from the Council on Dental Materials and Devices of the American Dental Association.

b. Environmentally safe levels of mercury vapor are determined by the OSHA (Occupational Health and Safety Administration) of the U.S. Department of Labor. VA medical regions have safety and fire protection engineers as well as Industrial Hygienists assigned that are available to assist facilities in the conduct of programs to test for mercury vapor levels and reduce the hazards thereof. Each Chief of Dental Service will ensure that testing for mercury vapor levels throughout the dental clinic is performed annually. A mercury vapor testing device must also be available to each dental service at times other than the annual test in order to monitor the mercury hygiene practices of new employees or trainees, and to check vapor levels following a mercury spill or other such accident.

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c. Medical surveillance for mercury intoxication must be available as an element of a facility's industrial hygiene program. In the interests of safeguarding the health and safety of employees, annual medical screening of dental service personnel may be authorized as noted in MP-5, part I, chapter 792.

#### 4.14 RADIATION PROTECTION REQUIREMENTS

In the interest of protecting patients and employees from any harmful effects of unnecessary exposure to radiation, the following requirements will be implemented.

a. **Restricted Use.** Patient exposure to x-radiation will be guided by the following precautions and options:

(1) No radiographs will be taken unless it is professionally determined by a dentist or physician to be necessary.

(2) Indications for radiographs are usually limited to the following situations:

(a) A decision has been made to treat the patient and diagnostic radiographs are required.

(b) The radiographs are necessary to confirm clinical findings.

(3) No new radiographs will be requested (except in an emergency) without review of existing dental radiographs to determine if they will satisfactorily augment a thorough clinical evaluation. If duplicate radiographs are desired for any reason, they may be obtained by exposure of twin-pack films or by duplication of the original film. In no case will the patient be subjected to additional radiation for the purpose of creating a duplicate film.

(4) Transillumination is encouraged as an alternative to updating radiographs (particularly in the anterior areas) on a routine basis. If this method is used, clinical notations will be made concerning findings which deviate from earlier radiographs (such as incipient caries).

(5) The use of portable xray units will be avoided to the maximum extent practicable. The utilization of fixed xray units with built-in shielding features is the method of choice.

b. **Safety Requirements in the Use of X-Ray Equipment.** When operating dental xray equipment, unnecessary radiation exposure will be controlled by compliance with the following:

(1) Leaded aprons will be used routinely for shielding patients' gonadal areas. These aprons will be checked for defects, at least annually, and a record maintained.

(2) The operation of dental xray equipment will be restricted to individuals who have demonstrated proficiency in producing radiographs of diagnostic quality with the minimum exposure required. The need for re-exposure, due to evidence of continuing faulty technique, will be strictly

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avoided. Dental assistants hired after January 1, 1987, if they are to perform radiologic duties, must have successfully completed the Dental Radiation Health and Safety Examination administered by the Dental Assisting National Board.

(3) Proper collimation must be used to restrict the xray beam as closely as practicable to the clinical area of interest and as compatible with the dimensions of the xray film being utilized as good technique will allow.

(4) Long cone paralleling technique should be used to minimize the tissue area exposed to radiation. Position-indicating devices should be used with the paralleling technique in order to restrict the xray beam as nearly to the film size as possible.

(5) The shortest possible exposure time, while producing adequate diagnostic information, will be utilized.

(6) Dental xray equipment will be checked for radiation leakage and recalibrated, at least annually, and a record maintained.

(7) All individuals using xray generating apparatus and those closely positioned to it must wear film badges for monitoring individual radiation exposure.

(8) The exposure switch of each fixed xray unit will be arranged so that the operator must remain behind a shielded area in order to operate it. This will require one of the following modifications of a typical manufactured unit:

(a) The hand-held switch which activates the timer control must be fixed to the control panel so the operator cannot be free to move outside the shielded area during exposure.

(b) A floor-mounted or wall-mounted foot switch may be wired to the timer control as a substitute to the hand-held switch. This must be fixed in such a position as to require the operator to be located behind the shielded area during exposure.

(9) Only electronic timers, controlling the accuracy of exposure, will be utilized in the operation of dental xray units.

c. **Training in Radiation Health and Safety.** All dental auxiliaries whose job description calls for operation of radiology equipment are required to receive some measure of continuing education annually to reinforce their awareness of radiation health and safety, and, as necessary, to review operational techniques in that regard. The format and amount of time devoted to such education is optional and should be directed toward the experience and performance level of individual employees. The Chief, Dental Service, is encouraged to involve the Facility Safety Official in assessing individual needs and reviewing the program.

(The provisions of Sec. I are based on 38 U.S.C. 212 and 621.)

## **SECTION II. CUSTODY AND DISPOSITION OF EXPENDABLE DENTAL MATERIALS**

### **4.15 RESPONSIBILITY FOR CUSTODY AND DISPOSITION OF ARTIFICIAL TEETH AND PRECIOUS METALS**

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The Chief, Dental Service, or Chief, Central Dental Laboratory, will have custody of all dental gold, platinum, chrome-cobalt, artificial teeth, bridge facings, and other expendable supplies in the dental clinic or Central Dental Laboratory, as applicable, and will be held responsible for their safekeeping. However, the Chief, Dental Service, or Chief, Central Dental Laboratory, may assign a responsible member of the staff to administer the system of controls for the issue and reissue of these items.

#### 4.16 ACCOUNTING FOR PRECIOUS METALS

a. **Basic Requirements.** All precious metals must be accounted for. Use of VA Forms 10-2936, Precious Metals Record Card, and 10-2609, Precious Metals Issue Slip, is optional. In any case, however, a ledger will be maintained to record:

(1) The date precious metals were received from supply service.

(2) The combined gross troy weight of all gold received excluding fabricated bars.

(3) The number of fabricated gold bars received.

(4) The weight of platinum received.

(5) The date, name of patient and description of each appliance fabricated.

(6) The date, name of patient and description of unserviceable gold appliances received.

(7) The gross weight of all scrap gold turned over to the Chief, Supply Service.

b. **Procedures.** The employee having custody of precious metals will issue the amount and type needed by the dentist or technician and record the date, amount and type of appliance in the ledger. On completion of the appliance, all unused precious metal will be returned to the custodian for reissue (including uncontaminated gold of known quality received from patients). Buttons, crowns, etc., which are unserviceable for reissue, will be collected as scrap gold and melted into one ingot for subsequent turn-in to the Chief, Supply Service, as required by MP-2, subchapter H, section 108-43.313.51.

c. **Inventory Verification.** The Director will designate a responsible official, other than a Dental Service employee, to verify receipts and balances of precious metals annually.

#### 4.17 DISPOSITION OF UNSERVICEABLE PROSTHESES

A patient desiring to retain an unserviceable prosthesis containing gold, whether or not it was provided by the VA, may be allowed to do so. A notation that this appliance has been returned to the patient will be recorded in the ledger and signed by the patient. If the patient prefers not to accept the prosthesis, the appliance will be disposed of it accordance with paragraph 4.16 b above.

#### 4.18 DENTAL PROSTHESES: LOST AND FOUND

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a. **Dental Prostheses Found on Station.** Dental prostheses recovered on VA property will be delivered to the Chief, Dental Service, for identification and appropriate disposition. There will be coordination between the Lost and Found activity of MAS and the Dental Service. If the dentures are not claimed within 90 days, they may be disposed of as unserviceable. Any dentures containing gold will have the gold recovered and disposed of as scrap gold, in accordance with paragraph 416 b.

b. **Dental Prostheses Lost by Patients.** Claims of lost prostheses by patients will not be honored for replacements unless the loss is substantiated through documentation by responsible VA officials who can attest as to their loss or destruction.

(The provisions of sec. II are based on 38 U.S.C. 4115.)

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APPENDIX 4A A Sample Memorandum regarding "Authorized Use of Dental Clinic Facilities is not available on WANG. A copy may be Xeroxed in the VHA Library.