ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 113.60	Page 1 of 1
	Effective Date: December 30, 2021	
	Distribution: A	
	Supersedes: N/A	
Approved by: Lisa Helton		
Subject: DENTAL SERVICES ADMINISTRATION		

POLICY CHANGE NOTICE 21-33

INSTRUCTIONS:

Please add to Section VI. (B) and re-number accordingly:

"1. Intake Dental Questionnaire, CR-4203: This form shall be completed by facility dental staff during the period of intake classification before the intake dental examination and filed in Section VI. of the health record."

Please change Section VI. (C)(3) to read as follows:

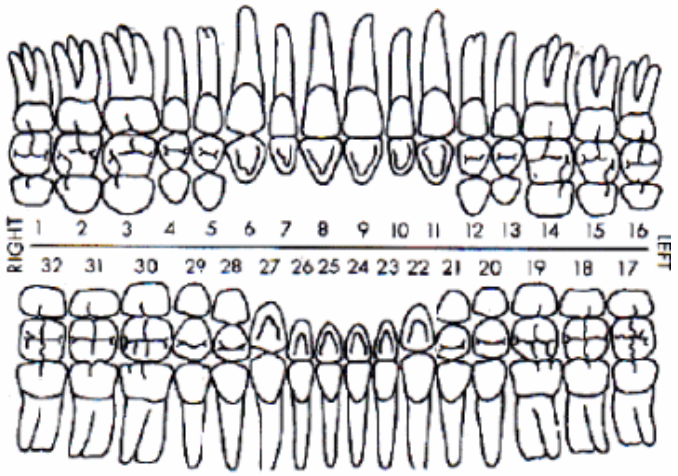
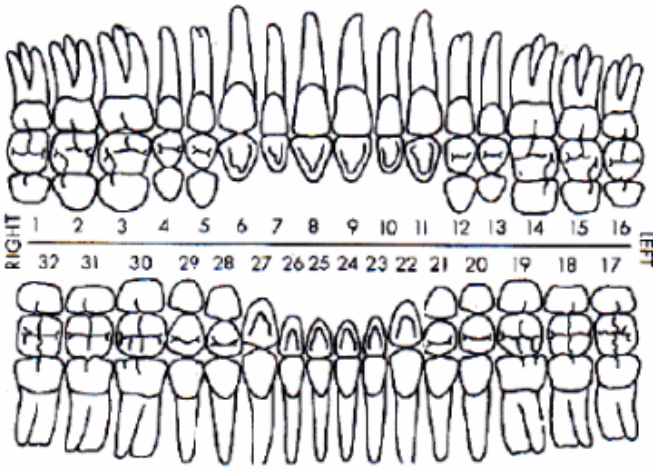
"3. Dental Sick Call: Dental complaints shall be presented during the regularly scheduled sick call visit and will be conducted by a nurse. After the inmate is examined, the nurse shall document the complaint and objective assessment on the TDOC Nursing Protocol Progress Note (NPPN), Dental Pain, CR-4240. The nurse will refer such complaints to the institutional dentist on the Institutional Health Services Referral, CR-3431, as appropriate. (See Policy #113.11) The dentist will triage the complaints and provide treatment following recognized clinical priorities, making a special effort to care for dental emergencies (Category I) during the established dental sick call period. Initial dental sick call visits are generally chargeable co-payment visits. (See Policy #113.15)"

Please change Section VII. to read as follows:

"VII. ACA STANDARDS: 5-ACI-6A-19, 5-ACI-6A-25, and 5-ACI-6B-02."

Please strike-through the CR-1889 on page six of this policy. Add the attached pages 8, 9, and 10 and re-number policy pages accordingly.

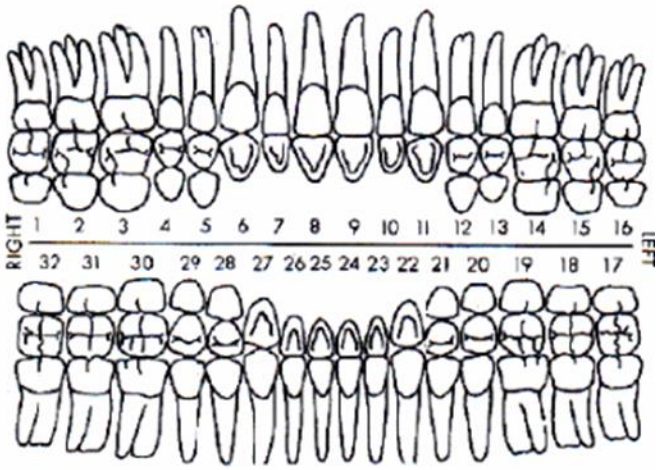
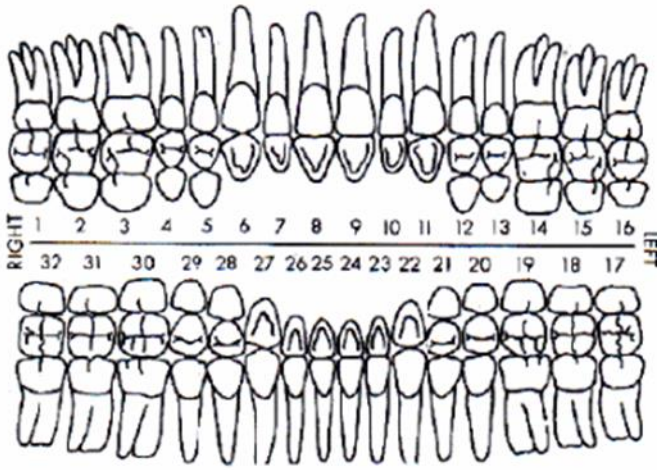
TENNESSEE DEPARTMENT OF CORRECTION
DENTAL RECORD

SECTION 1: **DENTAL EXAMINATION**	**RESTORATION AND TREATMENTS**
	
Date of Initial Examination:	**Comments**
Oral Pathology:	Treatment Category:
Gingivitis, Vincent's Angina, Stomatitis	OHI
Periodontoclasia	
Incipient, Moderate, Severe	
Other Findings	
Calculus: Light, Moderate, Severe	Allergies:
Radiographs:	
Periapical, BTW, Panorex	
Oral Cancer Exam	
Prosthetic:	
Denture, RPD, CD, Upper, Lower	

Initial Treatment Plan:

Examination Completed by: _____ Title: _____

Inmate Name:	TDOC ID:	DOB:
Institution:	Date:	

SECTION 2: ATTENDANCE RECORD	
1. RESTORATIONS AND TREATMENTS (completed during hospitalization)	*SUBSEQUENT DISEASE AND ABNORMATILITES*
	

ALLERGIES:

DATE/ TIME/ LOCATION	TX. CAT.	SERVICES PROVIDED	PROVIDER

Inmate Name:	TDOC ID:	DOB:
Institution:	Date:	

TENNESSEE DEPARTMENT OF CORRECTION

NURSING PROTOCOL PROGESS NOTE – DENTAL PAIN

_____
INSTITUTION

Name: _____TDOC ID: _____

Date/Time:_____ Allergies: _____

**See MAR for current medications*: Compliant? ☐ Y ☐ N Recent change? ☐ Y ☐ N If Yes, describe: _____

Subjective: Chief Complaint-

Onset: _____ Duration:_____

Recent Dental Work: ☐ Y ☐ N Facial Trauma: ☐ Y ☐ N Drug Ingestion: ☐ Y ☐ N

Activity prior to onset: _____ Prior history of same ☐ Y ☐ N

If yes, what was the treatment and when? _____

History of: ☐ Drug Abuse ☐ Heart Disease ☐Diabetes

Aggravating Factors: ☐ None ☐ Temp ☐ Jaw Movement ☐ Chewing

Pain Scale (0-10): _____☐ Sharp ☐ Dull ☐ Constant ☐ Stabbing ☐ Intermittent

Location of Pain: _____

Associated Symptoms: ☐ None ☐ Nausea ☐ Vomiting ☐ Fever/Chills ☐ Facial/Neck Swelling

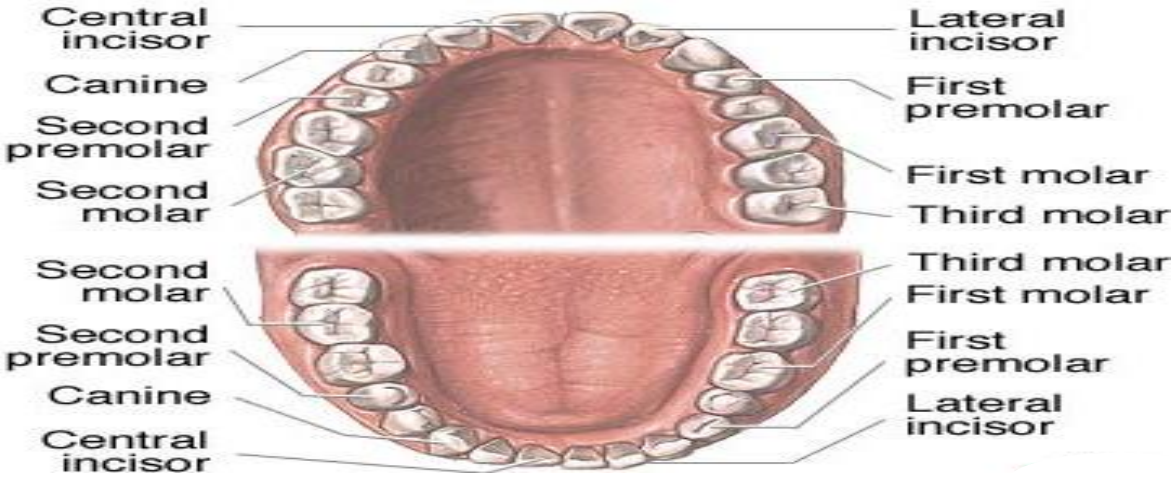
☐ Difficulty Swallowing ☐ Bad Breath ☐ Other:_____

Objective:

Vital Signs: T: P: R: BP: / O2 Sat: _____ Weight: _____

Gen Appearance: ☐ Alert, Oriented & No Distress ☐ Alert & Distressed ☐ Alert-Not Oriented

**Place "X" on affected tooth*



Skin: ☐ Norm ☐ Dry ☐Warm ☐Moist/Clammy ☐ Pale ☐Cyanotic ☐Jaundice

Head Trauma: ☐ None ☐ Y-Describe_____ ☐ Facial Asymmetry

Neck and Jaw: ☐ Norm ☐ Swollen ☐ Tender on Palpation ☐ Pain reproduced with movement

Gums: ☐ Norm ☐ Red ☐ Swollen ☐ Lesions ☐ Bleeding ☐ Bad Breath ☐Visible Lesions ☐Tooth Abnormality

Additional Examination: _____

_____

Use blank CR-1884 for addl. Documentation

Assessment: Alteration in Comfort due to Dental Pain

Plan: Provide treatment per Nursing Protocol

Duplicate as Needed

TENNESSEE DEPARTMENT OF CORRECTION

NURSING PROTOCOL PROGESS NOTE – DENTAL PAIN

☐ **Emergent** **Life Threatening or Patient in Extreme Distress – Activate EMS**	☐ **Urgent** **Notify Provider Directly if:**	☐ **Routine** **Refer to Provider if:**
☐ Active Bleeding **ON** Anticoagulant **Interventions:** ☐Oxygen@ 2-15Liters via NC or NRB to maintain O2 saturation =>95% ☐Place in most comfortable position ☐Elevate legs, if SBP<90 ☐Monitor vital signs q5mins until EMS arrive ☐Start IV with Normal Saline 0.9% 500 ml/hr. for Systolic BP < 90, otherwise KVO, or per Provider's order **Site:** _____ **# of attempts:** ____ **Gauge:** _____ **Time:** _____ **Pt. tolerated: ☐Well ☐Fair ☐Poor** **Time provider notified**_____ **Time provider responded**_____ **☐ Orders received ☐ No**	**SBP** <90 or >170**; DBP**>100**; T>**100.4; **RR** <10 or >24; **HR** <60 or >100**; O2Sat** <=94% ☐Active Bleeding **NOT** on Anticoagulant ☐Drooling ☐Difficulty with Swelling ☐Avulsed Tooth ☐Abscessed Tooth ☐Fractured/Displaced Jaw ☐Fractured Maxilla/Eye Socket ☐Pain 7/10 ☐ Patient Education Provided ☐ Patient instructed to resubmit sick call if problem worsens, does not improve, or new symptoms develop. ***Complete Sexual History Screening on all patients.*** **Time provider notified** _____ **Time provider responded**_____ **☐ Orders received ☐ No**	☐ **Protocol Treatment ineffective x 2 within 7 days** ☐ **Protocol does not adequately meet the patient's objective clinical needs** **Interventions:** ☐ Acetaminophen 325 mg tabs, 2 tabs 3 x daily PRN x 4 days **OR** ☐ Ibuprofen 200 mg tabs, 2 tabs 3x daily PRN x 4 days ☐ Patient Education Provided ☐ Patient instructed to resubmit sick call if problem worsens, does not improve, or new symptoms develop. ***Sexual History Screening:*** Have you ever had any STDs? ☐Yes ☐No What do you do to protect yourself from STDs and HIV? _____ What concerns about STDs do you have? _____ Review/provision of the appropriate level of risk-reduction/abstinence handout and counseling for each patient.

Emergency Transport

☐Time EMS Notified: _____

☐ Emergency Room transfer documentation completed

☐ Emergency Room notified; **Report Given to**: _____

Depart Date/ Time: _____ Type of Transport: _____

_____	_____	_____
LPN Signature	Printed Name	Date

OR (*Routine*) Both *(Urgent/ Emergent)*

_____	_____	_____
RN Signature	Printed Name	Date

Duplicate as Needed

TENNESSEE DEPARTMENT OF CORRECTION

INTAKE DENTAL QUESTIONNAIRE

INQUIRE:

1. Are you in good health? ……Y ☐ N ☐
   Has there been any change in your general health within the past year? ……Y ☐ N ☐
2. Are you under the care of a physician? ……Y ☐ N ☐
   If yes, what is the condition being treated?_____
3. Have you had any serious illnesses or operations? ……Y ☐ N ☐
   If yes, what was the problem? _____
4. Do you or have you had any of the following diseases or problems?

Rheumatic Fever	Y ☐ N ☐	Fainting Spells/Seizures/Epilepsy	Y ☐ N ☐
Heart Murmur	Y ☐ N ☐	Diabetes	Y ☐ N ☐
Heart Disease	Y ☐ N ☐	Jaundice/Hepatitis	Y ☐ N ☐
High Blood Pressure	Y ☐ N ☐	Liver Disease	Y ☐ N ☐
Low Blood Pressure	Y ☐ N ☐	Inflammatory Rheumatism	Y ☐ N ☐
Stroke	Y ☐ N ☐	Stomach Ulcers	Y ☐ N ☐
Chest Pain	Y ☐ N ☐	Kidney Trouble	Y ☐ N ☐
Shortness of Breath	Y ☐ N ☐	Tuberculosis (INH Treatment)	Y☐ N ☐
Swollen Ankles	Y ☐ N ☐	STI-Syphilis/Gonorrhea	Y ☐ N ☐
Artificial Heart Valves	Y ☐ N ☐	HIV+/AIDS	Y ☐ N ☐
Prosthetic Joints	Y ☐ N ☐	IV Drug Use	Y ☐ N ☐
Seasonal Allergies	Y ☐ N ☐	Sickle Cell Anemia	Y ☐ N ☐
Asthma	Y ☐ N ☐	Hemophilia	Y ☐ N ☐
Hives/Skin Rash	Y ☐ N ☐	Anemia	Y ☐ N ☐
Thyroid Problems	Y ☐ N ☐	Other (list): _____	
Cancer/Tumors/Cysts	Y ☐ N ☐		

5. Have you had any abnormal bleeding associated with previous tooth extraction, dental surgery, or trauma?……Y ☐ N ☐
6. Have you had any prior serious trouble with dental treatment? …… Y ☐ N ☐
7. Have you ever had treatment for cancer of your head or neck, including surgery, radiation treatment, or chemotherapy?……Y ☐ N ☐
8. Do you bruise easily? ……Y ☐ N ☐
9. Have you ever required a blood transfusion? ……Y ☐ N ☐
   If yes, approximate date: _____ Explain the circumstances: _____
10. List all medications you are presently taking or have taken in the last two weeks (include any over-the-counter medication): _____
_____
11. Are you allergic to or have you ever reacted to:

Local Anesthetics/Novocaine	Y ☐ N ☐	Iodine/Seafood	Y ☐ N ☐
Penicillin/Antibiotics	Y ☐ N ☐	Nickel Metals	Y ☐ N ☐
Sulfa Drugs	Y ☐ N ☐	Latex	Y ☐ N ☐
Aspirin, Tylenol or Motrin	Y ☐ N ☐	Other (list): _____	

12. Do you have any disease, condition or problem not listed above that you think I should know about? ……Y ☐ N ☐
13. Are you pregnant? ……Y ☐ N ☐ N/A ☐
    If yes, how many months? _____
14. Do you have any problems associated with your menstrual period? ……Y ☐ N ☐ N/A ☐

Comments: _____

I certify that the foregoing information supplied by me is true and complete to the best of my knowledge.

_____

Date Signature of Patient Signature of Dental Staff Reviewing History

Inmate Name:	TDOC ID:	DOB:
Institution:	Date:	