GEORGIA DEPARTMENT OF CORRECTIONS **Standard Operating Procedures**		
Policy Name: Entering Dental Data in the Physical Health Record		
Policy Number: 507.05.08	**Effective Date:** 1/23/2020	**Page Number:** 1 of 4
Authority: Commissioner	**Originating Division:** Health Services Division (Dental Health)	**Access Listing:** Level I: All Access

I. Introduction and Summary:

Standardized dental data entry will be used in the Physical Health Record to document dental conditions and procedures to enhance communication among providers. This procedure is applicable to all facilities that house Georgia Department of Corrections (GDC) offenders to include county and private prisons.

II. Authority:

A. GDC SOP(s): 507.02.01 Health Records Management, Format and Contents, 507.05.04 Specialized Dental Services and Consultations at ASMP, 507.05.06 Dental Screening, Examination and Profiling, 507.05.07 Dental Treatment Priorities, and 507.05.12 Auditing the Dental Unit;

B. NCCHC Adult Standard: PE-06;

C. NCCHC Juvenile Standards: Y-37; and

D. ACA Standards: 4-4360, 4-4353, 4-4365, 4-4346, 4-ACRS-4C-22, 4-ACRS-4C-23, 4-ACRS-7D-08, and 4-ALDF-4D-26.

III. Definitions: None.

IV. Statement of Policy and Applicable Procedures:

A. Dental Screening, Examination, Treatment Plan, and Forensic Record: (Form PI-1152)

1. All entries in the section "Missing Teeth/Extractions/Restorations/Forensic" will initially be done in pencil at the intake facility;
2. They will be redone in ink if a treatment plan is completed at the resident facility;
3. All entries in the section "Existing Pathology/Treatment Plan" will be done in pencil and erased as work is completed or pathology eliminated;
4. Completed work will be charted in ink in the section Missing Teeth/Extraction/Restorations/Forensic;

5. Supernumerary teeth may be diagrammed in place or written about under "Special Comments;"

6. All temporary crowns, bridges and restorations, if they are to be charted, will be entered in the "Existing Pathology/Treatment Plan" section;

7. Orthodontic treatment that is in progress will be entered under the section "Special Comments;"

8. When a comprehensive examination and treatment plan are completed, the date, facility, and dentist will be entered under the Comprehensive Examination section; and

9. The lined Treatment Plan section may be used to aid case planning.

B. Progress Record:

1. All Progress Record entries will be standardized to the extent possible to aid in the continuity of treatment between facilities;

2. Practitioners should use the sequence as listed below:

   a. Date;

   b. Time;

   c. Facility;

   d. Medical history review;

   e. SOAP Format; and

      i. S = Subjective complaint;

      ii. O = Objective observation;

      iii. A = Assessment, including radiographs taken, clinical findings, and diagnosis; and

iv. P = Plan or treatment rendered.

f. Signature of person making the entry.

3. Each time an offender is seen for dental care, a review of the offender's medical history should be documented prior to initiating treatment; and

4. An entry will be made on the Progress Record, dated, and signed by the dentist for every treatment contact with an offender.

C. Placement of Dental Forms in the Health Record:

1. All dental forms will be placed in the Dental Section of the Health Record;

2. The bottom-up order of the dental forms in the dental Section of the Health Record will be as follows:

   a. Dental radiographs will be mounted and placed in a 6x9 envelope and attached to the record;

   b. Consent form P-67-0002-01, if applicable;

   c. All consultation forms in order by date with the oldest on the bottom;

   d. Refusal of Treatment forms;

   e. Progress Record; and

   f. Dental Examination, Treatment Plan, and Forensic Record.

3. If more than one copy of a particular form exists (e.g., Progress Record that is full and another one is started), the oldest dated form will go under the one currently in use.

D. Orders:

1. All orders will be entered in the "orders" section of the Physical Health Record;

2. The progress notes should also reflect those orders; and

3. Consultation requests will be submitted using PI 2007-A, as outlined in SOP 507.02.01 Health Record Management.

Note: All forms shall be utilized per the SOP until such time the SOP is revised or becomes obsolete.

V. **Attachments:** None.

VI. **Record Retention of Forms Relevant to this Policy:** None.