



*Dental Anesthesiology
Resident Manual*

ACKNOWLEDGMENT

I have confirmed that I have read the Ohio State University College of Dentistry Dental Anesthesiology resident Policies and Procedures, including controlled substances distribution policy, due process policies, complaint information and blood borne pathogens policy.

I understand and accept my obligations as outlined.

Print

Signature

Date

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Program Description

Beginning 2015, in compliance with the 2007 CODA guidelines, The Ohio State University Medical Center offers a 36-month Anesthesiology Residency for dentists designed to fulfill all the requirements of CODA (Commission on Dental Accreditation) and The American Dental Board of Anesthesiology (ADBA).

This program prepares the dentist anesthesiologist to manage pain and anxiety in the most comprehensive manner for all dental/maxillofacial patients. At the conclusion of the program, the resident will be proficient in providing intubated and non-intubated general anesthesia, deep sedation and conscious sedation for diverse dental and maxillofacial surgical procedures performed on healthy and medically compromised patients, and to function in diverse patient care environments from tertiary level facilities through to private practice.

The program begins in late June with two weeks of hospital orientation, formal courses covering comprehensive patient examination, intravenous sedation and an introduction to anesthesiology. The residents then join their medical colleagues for 3 months of closely supervised, and often individual, basic anesthesiology training, including daily formal lectures. This is followed by 3 months of medicine, 2 months of resident level 1 (CAI) general operating room experience, 2 months of basic pediatric anesthesiology and one month on both the acute pain service and ICU.

The second year education includes 4 months of general surgical cases and 2 months of advanced pediatric anesthesia. Four 1 month rotations in focused areas of anesthesiology are provided, after which more complex anesthesiology care and on-call activity is permitted. Finally one month is devoted to OPAC (Out Patient Anesthesia Clinic).

The third year provides 3 months of advanced head and neck care and 9 months of providing anesthesiology services at both the College of Dentistry and Nationwide Children's Hospital Dental Surgery Center. This includes two days per week of anesthesia services for outpatient oral & maxillofacial procedures including LeFort osteotomies, mandibular osteotomies, bone grafting procedures, various plastic procedures, and dento-alveolar surgery. One day per week is spent in the GPR clinic providing general anesthesia for medically, emotionally, and intellectually compromised patients. One day per week is devoted to the delivery of intubated and non-intubated anesthesia for complex pediatric dental restorative procedures. Anesthesiology resident also provide a key component of support for conscious sedation activities in other departments, the maintenance of College anesthetic and emergency equipment, BLS & ACLS certification and recertification, and pre-anesthetic physical examinations for other departments within the College of Dentistry.

Residents participate in multiple didactic experiences and case management conferences including a research project in the field of anesthesiology. The resident is expected to produce a research paper suitable for submission to a scientific journal before completion of their residency. An optional Master's degree can be arranged. Tuition fees are required for the Master's degree, however these can be offset significantly by the OSU employee tuition reimbursement that is available. At this time, completing all MS degree requirements while in the program should cost less than \$4000 over the 36 months. Time will be allotted within the program to complete all required coursework.

Graduates of the program are eligible for membership in the American Society of Dentist Anesthesiologists and the Diplomate examination by the American Dental Board of Anesthesiology.

This is a funded position paying OSU Medical Center resident salaries at the applicable PGY I – III level. Malpractice insurance is waived. Parking passes and health insurance may be purchased through the University.

Overview of Curriculum Management Plan

PROPOSED	1 st Year	1 st Year	2 nd Year	2 nd Year	3 rd Year	3 rd Year
July	UH Introductory	UH Introductory	ICU 1	UH2	Dent Anes /R	UH James
August	UH Introductory	UH Introductory	UH 2 / Research	UH 2 / Research	Dent Anes /R	UH James
September	UH 1 / Project Ident	UH 1 / Project Ident	OPAC	ICU 1	Dent Anes /R	UH James
October	UH 1	UH 1	Cardiology East	OPAC	UH James	Dent Anes /R
November	Fam Medicine	UH 1	UH 2	Cardiology East	UH James	Dent Anes /R
December	Fam Medicine	UH 1	UH 2	UH 2	UH James	Dent Anes /R
January	Clin Med	Pain	UH Neuro	UH 2	Dent Anes	ICU 2
February	Pain	Fam Medicine	UH 2	UH Neuro	ICU 2	Dent Anes
March	Pediatric 1	Fam Medicine	Pediatric 2	UH 2	Dent Anes	E
April	Pediatric 1	Clin Med	Pediatric 2	UH 2	E	Dent Anes
May	UH 1	Pediatric 1	UH 2	Pediatric 2	Dent Anes	E
June	UH 1	Pediatric 1	UH 2	Pediatric 2	E	Dent Anes

OMFS Dental Anesthesiology Orientation 2015

~ June 2015 ~									
◀ May 2015	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Jul 2015 ▶	
		1	2	3	4	5	6		
7		8	9	10	11	12	13		
14		15 Employee Health Appt. 9:30 am - Sameh Girgis 10:00 am - Sanaz Mohseni 1:00-3:00 H.R. Orientation 3089A Boucher Room	16 1:00-4:30 H & P Course Wallace Room	17 11:30-4:00 New Graduate Lunch and Seminar	18 7:30-11:30 IV Sedation 12:30-4:30 IV Sedation	19 8:00 am – 12:00 pm New Anesthesia Resident Training with Natali and Jim 1:00 pm Anes. Residents go to pharmacy in Doan to get DEA license	20		
21		22 7:45am-12:30pm Procedural Orientation 1:00-3:30 CRM Training 112 Meiling Auditorium (breakfast and lunch on your own)	23 7:30 am New Anes Residents shadowing Jim in the OR	24 7:30 am New Anes Residents shadowing Jim in the OR	25 7:30-8:00 Breakfast 8:00-11:30 Operative orientation 12:30-4:30 IV Sedation	26 New Anesthesia Residents only 8:00am-3:30pm ACLS Provider Course 660 Ackerman Rd, Rm 321 (This class is for the 2 new incoming anesthesia residents)	27 8:00-11:30am CE course-Wallace Room 5:30-7:00pm Cocktails 7:00-9:30pm MLA graduation banquet Faculty Club		
28		29 7:30-11:30am H & P course In place of Educational Seminar	30 7:30 – 12:20 pm IV Sedation 2:30-4:30 ? OMFS/ANES orientation Wallace Room	Notes:					

~ July 2015 ~

◀ Jun 2015

Aug 2015 ▶

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1 7:00am-5:30pm Housestaff Orientation (breakfast and lunch will be provided) Location: #112 Meiling Hall (new omfs/anes residents/interns)	2 New OMFS only residents/interns 8:00am-3:30pm ACLS Provider Course 660 Ackerman Rd, Rm 321 (This class is for the 4 new incoming oral surgery residents/interns)	3 OFFICE CLOSED July 4 th Holiday	4
5	6 8:00-12:00 1:00 – 4:00 pm IHIS training 630 Ackerman Rd. Room 2056 New Anes residents only	7 8 - 11am IHIS Provider Inpatient Workflow 12:00-12:30pm Benefits – Sharon Adams Doan N 410 12:30- 2:30pm History of Anesthesia Dr. Hohmann	8 8:00-12:00 IHIS training New Anes residents only Doan N410 2:30-5pm OR Orientation. Dinner Following Orientation 5:30pm-7:00pm Graduate Reception Faculty Club	9 Doan N410 7:45- 9am Welcome and Intro Breakfast 9-10am Review Goals and Objectives- Dr. Moran 10 -10:30am Rotation Schedule- Chief Residents 10:30-11am E*Value Duty Hours ACGME Case Logs- Sarah Robertson 11- 1pm Pharmacy- Kristin Brewer Lunch Provided 1:00- 3:00 pm AKT Pretest	10 SIM LAB Prior Health Sciences Library	11
12	13 Doan N 410 9-11am am OR Safety 12-2pm Cardiovascular Physiology Basic- Adam Dalia 2-3pm Preop Evaluation 3-4pm Fluid Therapy-Russell Legg	14 Doan N 410 6-7am Cardiovascular Basics 7-9am Opioids and neuromuscular blockers -Darc Russell 9-11am Machines and Monitors-Adam Dalia 12-1 Blood Products	15 Doan N 410 10-11am IV Anesthetics 11am-12pm Airway Lecture 12-1pm Lunch 1-2pm Airway Workshop	16 Doan N 410 9-10am Inhalational Anesthetics 10-11am The Autonomic Nervous System- Brittany Straka 12-2pm Respiratory Physiology, Breathing Systems, and Ventilators	17 SIM LAB Prior Health Sciences Library	18 Ohio Society of Oral and Maxillofacial Surgeons Annual Meeting

~ July 2015 ~

◀ Jun 2015

Aug 2015 ▶

Sun	Mon	Tue	Wed	Thu	Fri	Sat
19 	20 10-11am Perioperative Considerations 11-12 Part 2 1-2pm Local Anesthetics- Brittany Straka	21 6-7am Renal and Hepatic Physiology 9-10am Vasoactive physiology- Daric Russel 12-1 Regional Anesthetics 1-1:30 Epidural Pump/Bag Changes	22 10-11:30am Common electrolyte abnormalities- Russell Legg 11:30 -12:30 Post Op Visits 1:30 to 2:30 Patient positioning Dr. Sandhu	23 8:30- 11am Crew Resource Management 11-12 Neurophysiology 12-1 PONV	24 SIM LAB Prior Health Sciences Library	25
26 	27 11-12 Math and Stats 12-2 Impaired Physician and Ethics Lunch Provided 2-3pm Patient Handoffs	28 6-7am Acute and Chronic Pain 11:15 MH and Perioperative Complications	29 White Coat Photos 1-2 Difficult Airway 2-3 Neuraxial Anesthesia	30 11-12 Post Op Visits 12-1 Billing	31 SIM LAB Prior Health Sciences Library	Notes:

OSU Dental Clinics

Comprehensive anesthesia services are provided for various departments throughout the College of Dentistry by the Dental Anesthesiology faculty and residents. One year of the resident's two years of training are spent here, at the dental school.

In the Dental Faculty Practice, experiences include providing general anesthesia and sedation for pediatric, medically compromised, and dental phobic patients. The graduate endodontic clinic is located within the faculty practice clinic, and comprehensive anesthesia is provided for these patients as well.

The oral surgery clinic has been designed with two fully equipped surgical suites. Here surgeries ranging from single tooth extraction to LeFort osteotomies are performed on a variety of patients of all ages. Much of the resident's dental clinic rotation will be spent here, providing anesthesia for faculty and resident surgeries, as well as attending lectures and conferences.

Many mentally and physically handicapped patients requiring dental treatment are served through the clinic's general practice residency. These patients unfortunately must wait long periods of time to be treated under anesthesia due to the overwhelming demand for these services.

Healthy children aged 18 months and older are treated by pediatric dentistry residents in the school's pediatric dental clinic. These are patients who would ordinarily require dental treatment in a hospital operating room were it not for the anesthesia services provided by the dental anesthesiology faculty and residents.

Philosophy of Master's Program

Dental Anesthesiology Residency Training at The Ohio State University is a fully accredited 36-month program. The residents in this program participate in a significant service commitment with heavy clinical obligations. However, research is of critical importance to the program and specific time is dedicated to performance of meaningful research throughout the resident's training.

Philosophy of the Program Director, Chair, and other full-time faculty is that the true measure of the success of any specialty program is the ability to provide meaningful research that further strengthens the specialty. To accomplish this goal, the residents enrolled in the dental anesthesiology program are required to perform research. A Master's degree is required for receipt of a certificate of training.

The commitment to research at The Ohio State University Division of Dental Anesthesiology is unique to advanced training programs in dental anesthesiology throughout the country.

Research and Publication

An integral component of graduate education in dental anesthesiology is the performance of a research project. This project may be done in conjunction with an ongoing faculty in an area of established research or if the student has a specific area of interest, investigators outside of the department may be enlisted to serve as the advisor and mentor for the resident.

Immediately upon commencement of the resident's training, a dentist anesthesiologist from the department is assigned to the resident. The assigned faculty serves as a mentor within the department and as a facilitator for the resident's research project. The research project may be performed with this faculty as the primary advisor or with other faculty from within the OSUMC Department of Anesthesiology or the Section of Oral and Maxillofacial Surgery, Pathology and Anesthesiology in the College of Dentistry or from outside departments. This process allows the resident to have an immediately identifiable faculty member within the department to serve as an advisor but does not limit the breadth of research to only areas where dental anesthesiology faculty may have expertise. Many of the residents will perform research with the primary advisor from dental anesthesiology; however, many will also select other Masters advisors depending upon their project.

Research Protocol - Time Line

Immediately after starting their residency, dental anesthesiology residents begin to consider possible areas of research interest. Residents are actively involved in clinical treatment of patients as well as participating in conferences and scheduled courses. These courses stimulate interest in a variety of topics allowing residents to focus their possible areas of interest for research. Residents also have a formal core course in statistical analysis which is given early on.

This allows them to develop a communication with graduate students from other departments and begin discussing possible choices of project with the faculty associated with these courses as well.

During the first 15 months, while the resident is orienting to anesthesia and on their one year off-service rotations in anesthesiology and internal medicine, the resident is encouraged to define a research project and, if a human study is contemplated, to try to submit the proposal for IRB approval as soon as possible, even while off-service. If during the development of this project it appears that an outside advisor will be appropriate, the research facilitator from dental anesthesiology assists the graduate student in developing the necessary liaison with the outside faculty member.

When the student returns to the college, the protocol is reviewed and approved by the program director. There are several half-days when anesthesia is not provided at the college which enables the student to have dedicated time for research. Additionally, the dental anesthesiology faculty is very supportive of research efforts and will adjust the residents schedule as needed, within reason, to allow for data collection. If the resident has completed his/her project and desires an elective rotation, this must be discussed with the program director at least three months before an anticipated elective rotation. A firm outline of objectives must be provided with the request for an elective rotation. Final approval will be at the discretion of the program director following discussion with the resident and possibly the proposed rotation mentor as well.

Didactic Program

Dent 800: Statistics

2 credit hours

Summer quarter PGY-1

This course is a component of the Masters of Science program. This is an introductory course designed to provide graduate students with the principles of statistical analysis. Dent 800 consists of a lecture and a laboratory portion with development of the skills necessary to perform computer-aided statistical analysis. This course aids residents in the assessment of current literature, as well as in the appropriate statistical methodology which will be employed in their thesis projects. This course occurs for one quarter of the PGY1 year.

Dent 802: Experimental Design

2 credit hours

Winter quarter PGY-1 or 2

This course is a component of the Masters of Science program. This course in basic research design, and complements the statistics course in that there is a lecture and a laboratory computer portion to the didactic program. This course helps residents organize a philosophy about a critical review of the literature, including an assessment regarding the statistical analysis and methodology. Residents are better able to design their own Masters projects as a result of the information taught in this course. This course takes place during the PGY1 or PGY2 year for one quarter.

Advanced Head & Neck Anatomy

3 hour sessions twice monthly

August-April PGY 1-2

The goals of this course are to review basic head and neck anatomy and to focus on applied surgical anatomy, including airway anatomy and tracheostomy. This course consists of a lecture portion and a laboratory portion which includes a full dissection of fresh cadaver heads.

Dent 700.01: Anesthesia Seminar

1 hour once a month

Year round PGY 1-3

This course is taught once a month and it is designed to familiarize residents with an understanding of a variety of anesthesia-related issues. This course examines anesthetic emergencies in a lecture-interactive type format, and the information learned in this course is applied to weekly sessions of the clinical practice of general anesthesia.

Physical Diagnosis

6-8 hours/day for one week (last week in June)

PGY-1

This course is designed for PGY1 residents and is designed to introduce them to the standard components of the medical history and clinical examination of patients. This course is composed of a lecture series, as well as clinical patient assessment sessions.

Introduction to Practice of Medicine (<http://ipm.knowbase.com/>)

Multiple 2 hour on-line modules

PGY 1-2

This course consists of a series of on-line lectures designed to complement the physical diagnosis course and further discuss the clinical applications of the principles of physical diagnosis and history taking.

Introduction to Anesthesiology (and Medical Center Orientation)

6 – 10 hours/day for 2 weeks

PGY 1

Introduction to the medical center, anesthesiology, simulation in preparation for main OR rotation.

Anesthesiology CA I Lectures

1-hour/week

PGY 1

This course is designed to give the PGY 1 resident a broad overview of all topics in anesthesiology as a foundation for hospital and out-patient anesthesia provision. The course is taught primarily by the physician anesthesiologists at University Hospital and is also attended by PGY 1 medical anesthesia residents.

Anesthesiology CA II & III Lectures

PGY 2 & 3 1-hour/week

This course is designed to give the PGY 2 & 3 resident more in-depth review of all topics in anesthesiology as case management becomes more complex. The course is taught primarily by the physician anesthesiologists at University Hospital and is also attended by PGY 2 & 3 medical anesthesia residents.

Anesthesiology Morbidity and Mortality Conference

PGY 1, 2 & 3 45min/wk

This conference occurs weekly and residents are asked to present complications with patient care, and are questioned regarding the appropriateness of care, as well as management of complications. Also attended by all medical anesthesia residents.

Anesthesia Conference

PGY 1, 2 & 3 45min/wk

This Grand Rounds style conference presents a variety of anesthesia topics by faculty and invited lecturers. Also attended by all medical anesthesia residents

OMFS/Anesthesiology Morbidity and Mortality Conference

1.5 hours per month

PGY 1, 2 &3

This conference occurs in our department once monthly, and residents are asked to present complications with patient care, and are questioned regarding the appropriateness of care, as well as management of complications.

Journal Club

Anesthesiology monthly meeting Year round PGY 1, 2 & 3

The journal clubs take place on a monthly basis. The purposes of journal club are several: firstly, residents are asked to apply the principles which were taught in the statistics and experimental design courses in order to critically evaluate the current literature (medical, dental, surgical, anesthesiology, etc.). Also, journal clubs are designed to serve as topical sessions where specific topics are the focus, and key articles are presented and discussed in relation to our current understanding. Finally, an assessment of the current literature is performed in order to expose dental anesthesiology residents to the most applicable journals in our field of practice.

OMFS/Anesthesiology Case Conference

1.5 hours weekly (except when M&M conference is held)

Year round PGY 1, 2 & 3

On a weekly basis, the anesthesia residents present a case which they have been involved in the recent past, while in the presence of the full- or part-time anesthesia faculty, who serve as critical questioners in order to have the resident defend the diagnostic and treatment approaches which were employed for their patient. This forum is a simulation of the ASDA format of oral examination, and serves to acquaint residents with the process, and familiarize them with the stressful task of case defense.

Rotations

College of Dentistry Anesthesiology Rotation

Object of Assignment:

The purpose of the anesthesia rotation is to

1. Gain practical experience in adult, special needs & pediatric dental anesthesia and sedation
 - a. Pre-operative patient assessment for general and regional anesthesia
 - b. Techniques of premedication
 - c. Use of intravenous, inhalational and regional anesthetic techniques
 - d. Anesthetic management of medically complex patients, including management of the difficult airway in an office setting
 - e. Management of anesthetic urgencies and emergencies
2. Gain in-depth knowledge of human physiology, pathophysiology, pharmacology, and clinical medicine that underlies anesthetic practice.

Duties of resident responsibilities:

Dental anesthesiology residents will have assignments to the operating suites within the College of Dentistry, including the Oral & Maxillofacial Clinic, General Practice Residency, Dental Faculty Practice and various resident clinics throughout the College. ASA I – IV patients will be managed in this out-patient setting. There will be no call responsibility. The dental anesthesia resident, once completing the main hospital rotation, will be expected to manage in an increasingly independent way the anesthetic care of dental, oral and maxillofacial surgery patients, including for major surgeries such as LeFort osteotomies and iliac crest bone grafts. Residents are responsible of performing preoperative evaluation of each patient treated, to independently (under indirect supervision) manage the anesthetic plan and plan for appropriate transfer to the Post Anesthesia Care Unit or recover patients themselves in the operating suite. They are also responsible for postoperative follow-ups on the patients as required.

Training received on assignment:

Dental anesthesiology residents will devote full time to the dental anesthesia service when scheduled and also attend all meetings and teaching sessions offered to the anesthesia residents during the rotation. Time will be set aside to pursue a research project.

Faculty member responsible for the rotation:

Dr. Simon Prior, Assistant Professor of Clinical Anesthesiology at the College of Dentistry is responsible for this portion of the dental anesthesia rotation.

Assessment of training and supervision:

The dental anesthesiology residents are evaluated by the attendings of the dental anesthesia and OMFS services. The performance evaluations are forwarded to the Dental Anesthesiology Program Director at the end of the rotation who reviews them. The reports are then included in the resident's permanent file.

Expectations while at the college:

Residents are to present cases to the attending the evening before. Resident is also expected to review patient medical history and intended anesthetic plans with the attending immediately prior to bringing the patient into the operating room.

University Medical Center Anesthesia Training

Object of Assignment:

The purpose of the anesthesiology training here is to

- 1) Gain practical experience in adult
 - a. Pre-operative patient assessment for general and regional anesthesia
 - b. Techniques of premedication
 - c. Use of intravenous, inhalational and regional anesthetic techniques
 - d. Anesthetic management of medically complex patients, including management of the difficult airway
 - e. Management of anesthetic urgencies and emergencies
- 2) Gain in-depth knowledge of human physiology, pathophysiology, pharmacology, and clinical medicine that underlies anesthetic practice.

Duties of resident including on-call responsibilities:

Dental anesthesiology residents have daily assignments to the operating room that are identical to those of the CA 1 – 2 medical anesthesia residents, including all types of surgery and patient ASA Physical Status 1 - 6. They participate equally in the anesthesia on-call roster. The nine-month rotation is completed over one year starting in month 4 and completed in month 16. At least 6 months are completed prior to attendance at the Nationwide Children's Hospital Anesthesia Rotation and the Grant Hospital Internal Medicine Rotation. The remaining 3 months is usually obtained starting July 1 of year 2 and completed on September 30 thereafter. Residents are responsible of performing preoperative evaluation of each patient treated, to independently (under indirect supervision) manage the anesthetic plan and plan for appropriate transfer to the Post Anesthesia Care Unit or Intensive Care Unit. They are also responsible for postoperative follow-ups on the patients treated admitted to the hospital after surgery as required.

Training received on assignment:

Dental anesthesiology residents devote full time to the anesthesia service and receive identical training as the medical anesthesia residents. The residents on assignment attend all meetings and teaching sessions offered to the anesthesia residents during the rotation.

University Hospital is accredited by The Joint Commission.

The resident has no commitments to the College of Dentistry Anesthesia Service while on assignment.

Faculty member responsible for the rotation:

Dr. Ron Harter, Assistant Professor of Anesthesiology at The Ohio State University College of Medicine is responsible for the portion of the anesthesia rotation at The Ohio State University Medical Center.

Nationwide Children's Hospital Anesthesia Rotation

Object of Assignment:

The objectives of the anesthesia rotation are to

- 3) Gain practical experience in pediatric
 - a. Pre-operative patient assessment for general and regional anesthesia
 - b. Techniques of premedication
 - c. Use of intravenous, inhalational and regional anesthetic techniques
 - d. Anesthetic management of medically complex patients, including management of the difficult airway
 - e. Management of anesthetic urgencies and emergencies
- 4) Gain in-depth knowledge of pediatric physiology, pathophysiology, pharmacology, and clinical medicine that underlies anesthetic practice.

Duties of resident including on-call responsibilities:

Dental anesthesiology residents have daily assignments to the operating room that are identical to those of the CA 1 – 2 medical anesthesia residents rotating on the Children's Hospital Anesthesia Service, including all types of surgery and patient ASA Physical Status 1 - 5. They participate equally in the anesthesia on-call roster. The one-month rotation is completed late in the first year after three months at the College of Dentistry and approximately 6 months on the University Hospital Anesthesia Service. Residents are responsible of performing preoperative evaluation of each patient treated, to independently (under indirect supervision) manage the anesthetic plan and plan for appropriate transfer to the Post Anesthesia Care Unit or Intensive Care Unit. They are also responsible for postoperative follow-ups on the patients treated admitted to the hospital after surgery as required. Pre-operative evaluation of in-hospital patients is also performed while on call.

Training received on assignment:

Dental anesthesiology residents devote full time to the pediatric anesthesia service and receive identical training as the medical anesthesia residents. The residents on assignment attend all meetings and teaching sessions offered to the anesthesia residents during the rotation.

Nationwide Children's Hospital is accredited by The Joint Commission.

The resident has no commitments to the College of Dentistry Anesthesia Service while on assignment.

Faculty member responsible for the rotation:

Dr. David Martin, Associate Professor of Anesthesiology at The Ohio State University College of Medicine is responsible for the residents' anesthesia rotation at Children's Hospital of Columbus.

Grant Hospital Medicine Rotation

Object of Assignment:

The objectives of the medical rotation are to learn to take a complete and comprehensive medical history, to do physical examinations, order and interpret laboratory studies, and manage patients with general medical problems.

Duties of resident including on-call responsibilities:

Residents are assigned inpatients that are admitted to the internal medicine service and manage their care under the supervision of the attendings and senior medical residents. The dental anesthesiology resident participates in the diagnosis and management of the patients. The dental anesthesiology resident has the same responsibilities as the medical students and residents of the medicine team. The rotation is two months long and it is completed during the second half of the first year of training. This rotation is done at Grant Medical Center, which is an affiliated teaching hospital of The Ohio State University.

Training received on assignment:

Dental anesthesiology residents devote full time to the medical service and their responsibility for patients is increased by the supervising senior residents and attendings as their level of confidence and skill increases. The residents on assignment attend all meetings and teaching sessions offered to the medical students and residents during the rotation.

Dental Anesthesiology Department commitments while on assignment:

The residents have no dental anesthesiology commitments while on assignment.

Faculty member responsible for the rotation:

Dr. Alysia Herzog, Department of Internal and Family Medicine at Grant Medical Center, is responsible for the medicine rotation.

Responsibilities During Off-Service Rotations

It is each resident's responsibility to communicate with the off-service attending or chief resident to determine their clinical, academic and on-call obligations, where and when to meet on the first day etc. This should be undertaken at least 2 weeks in advance of the start of your rotation.

Assessment of Training and Supervision

The dental anesthesiology residents are evaluated by the attending faculty members of the service. The performance evaluations are forwarded to the Dental Anesthesiology Program Director at the end of the rotation who reviews them. The reports are then included in the resident's permanent file.

After completion of each month of your training, give Jamie the names of the attending faculty members with whom you had worked closely. Jamie will then send them performance evaluation forms.

Resident Evaluations

In addition to monthly assessments, resident evaluations are performed twice yearly by the Program Director in consultation with other supervising faculty (Physician anesthesiologist, dentist anesthesiologists and OMFS). Proficiency examinations are also provided to the residents and review is acknowledged by their signature. The evaluations are provided to the residents at an annual formal meeting and receipt acknowledged by resident signature on the Evaluation Form.

Should deficiencies be revealed, they will be communicated to the student/resident and a plan of corrective action undertaken. As there are only two residents per year, close supervision of concerns and organized correction is generally immediate and continuous. If persistent deficiencies are noted, these are documented at the biannual review or earlier if needed.

General Anesthesia Checklist

1) Charting

- a. Check schedule the 4 days prior
- b. Make sure staff signature is present on medical history form and consent signed
- c. Discuss cases with chief resident and anesthesia attending
- d. Diagnosis made and procedure ordered with sufficient x-rays
- e. Review medical history form the night before
- f. Anesthesia records complete
- g. Procedure recorded including meds, in progress notes
- h. Return appointment noted

2) Trays

- a. Set up by assistants, but must be checked
- b. 3 moist throat-packs
- c. 2 blades on handles
- d. Suture in needle holder
- e. Burr in handpiece
- f. Irrigation - sterile saline or water in cup and syringes
- g. Instruments in good condition (sharp, not broken)

3) Suction

- a. Proper function (back-up suction readily available)
- b. Clean daily
- c. New tubing for each patient
- d. Turned on to both patient and anesthesia machine
- e. Throat suction attachment on tubing prior to start

4) Backstand

- a. Appropriate drugs drawn into syringes
- b. Assorted NP and ET tubes ready and lubricated
- c. Nasal spray present
- d. 2 working laryngoscopes present
- e. Magill forceps out
- f. Emergency drugs present and not expired
- g. Assorted nasal hoods and face masks available
- h. ETT lubricant

5) I.V. Set-up

- a. Propofol appropriately mixed; 5gm in 500 of sterile water; place in labeled 20cc syringes (only chief resident to mix)
- b. One 500 mL bag of IV solution hanging prior to the start of case
- c. Extension tubing in place

- d. Appropriate selection of angiocatheters available
 - e. Complete set-up changed with every patient
 - f. No set-up carryover to next day
 - g. Adequate supply of tape, tourniquets, alcohol pad
- 6) Anesthesia Machine
- a. O2 and N2 hoses plugged in, vaporizers filled
 - b. Check failsafe and flow safe
 - c. Have auxiliary O2 supply
 - d. Check machine for proper operation and lack of leaks
 - e. Check CO absorber
 - f. Check scavenger system
 - g. Change mask and filter on circuit for every patient
 - h. Spare reservoir bag
 - i. Spare circuit
- 7) Miscellaneous
- a. CO2 monitor - calibrated each day
 - b. Blood pressure equipment - Dynamap requires a back-up (manual b.p. cuff)
 - c. Precordial stethoscope and patches
 - d. EKG functional and EKG pads readily available
 - e. Pulse oximeter functional
 - f. Patient drapes available
 - g. Nitrogen tank full and turned on
 - h. Good stethoscope
 - i. N2O and O2 supply adequate in basement - no new case is to be started with any warning lights on
 - j. Biopsy - slips and formalin bottles available
 - k. Culture tubes and slips for microbiology available
 - l. Gloves, masks, and eye protection available
- 8) Recovery Room
- a. Suction machine present with throat suction attached
 - b. Tissues
 - c. Towels
 - d. Emesis basins
 - e. Chairs in order
 - f. Clean
 - g. Blood pressure monitor and pulse oximeter present and functional
- 2) Emergency Drugs
- a. Albuterol (Provental) - metered dose inhaler
 - b. Atropine - 20 multidose vial (0.4 mg/)

- c. Calcium chloride 10% injection syringe - 1gm (100 mg/)
- d. Dexamethasone (Decadron) – 5 multidose vial (4 mg/)
- e. Diphenhydramine (Benadryl) – 10 multidose vial (10 mg/)
- f. Dopamine (undiluted) – 5 single dose vial (80mg/)
- g. Ephedrine (undiluted) - 1 ampule (50 mg/)
- h. Epinephrine (Adrenalin) –
 - 1mg 1 ampule of 1:1000 solution
 - 10 injection syringe of 1:10,000 solution
- i. Esmolol (Brevibloc) – 10 single dose vial (10 mg/)
- j. Furosemide (Lasix) - 2 or 10 single dose vial (10 mg/)
- k. Hydralazine (Apresoline) - 1 ampule (20 mg/)
- l. Hydrocortisone – 100 mg powder or with 2 H
- m. Lidocaine – 5 injection syringe (20 mg/)
- n. Naloxone (Narcan) - 1 ampule (0.4 mg/)
- o. Nitroglycerine
 - 0.4 or 0.3 mg tablets (in refrigerator)
 - 2% paste
- p. Phenylephrine (Neosynephrine) - 0.5% nasal spray
- q. Physostigmine (Antilirium) – 2 ampule (1 mg/)
- r. Propranolol (Inderal) - 1 ampule (1 mg/)
- s. Scopolamine - 1 vial (0.4 mg/ml)
- t. Succinylcholine (Anectine) – 10 multidose vial (20 mg/)
- u. Terbutaline (Brethine) - 1 ampule (1 mg/)
- v. Verapamil – 2 single dose vial (2.5 mg/)

MS-MAIDS

M: Machines

- plugged in and working
- O₂ and N₂O plugged into the wall and working
- vaporizers filled
- tubing and bag attached in proper place and 25psi available without leaks
- check lime color in CO₂ absorber, change if blue
- scavenger system
- check reserve O₂ and N₂O tanks

S: Suction

- both suctions in working order

M: Monitors

- EKG
- pulse oximeter
- blood pressure
- ETCO

A: Airway

- oral airways (3 sizes) and tongue blades
- assortment of ET tubes, at least one 5.5, 6.0mm, 6.5mm, 7.0mm tubes
- McGill forceps
- Two laryngoscopes in working condition with blades attached
- small laryngoscope blades in supply (including pediatric)

I: IV

- tourniquet
- 20ga and 22ga angiocaths
- tape
- extension tubing
- alcohol pads
- 500 mL IV bags (one per patient)

D: Drugs

- enough Propofol for cases
- drug tray: Succinylcholine, Atropine, Lidocaine; Optional: Versed, Valium, Demoral, Fentanyl, Decadron, etc. (out and accessible but NOT opened)
- check stock and expiration dates of emergency drugs

S: Supplies

- Lidocaine ET tube lubricant
- stethoscope
- cotton rolls
- anesthesia records and clip board
- tape precut to secure IV
- precordial adhesives and ear piece
- check nitrogen tank pressure for hand piece
- EKG pads

General Guidelines for Anesthesia

- 1) All patients must have a current past-medical history immediately available for review prior to the start of the sedation procedure.
- 2) Pre-sedation pulse rate, respiration rate, and blood pressure must be taken and recorded.
- 3) No patient shall receive intravenous sedation unless a responsible adult escort is present and the patient has met NPO instructions.
- 4) Prior to the sedation, patients and escorts must both understand that the patient is not to drive, operate dangerous machinery or make important decisions until at least the next day.
- 5) Dosages of all drugs and route of administration must be recorded. Pre-operative, intra-operative, and post-operative vital signs must be recorded. The “street” fitness of the patient (i.e. ability to walk, level of alertness, etc.) as well as the name of the escort also must be documented.

Levels of Anesthesia

minimal sedation - a minimally depressed level of consciousness, produced by a pharmacological method, that retains the patient's ability to independently and continuously maintain an airway and respond *normally* to tactile stimulation and verbal command. Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected.

Note: In accord with this particular definition, the drug(s) and/or techniques used should carry a margin of safety wide enough never to render unintended loss of consciousness. Further, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of minimal sedation. When the intent is minimal sedation for adults, the appropriate initial dosing of a single enteral drug is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use. The use of preoperative sedatives for children (aged 12 and under) prior to arrival in the dental office, except in extraordinary situations, must be avoided due to the risk of unobserved respiratory obstruction during transport by untrained individuals. Children (aged 12 and under) can become moderately sedated despite the intended level of minimal sedation; should this occur, the guidelines for moderate sedation apply. For children 12 years of age and under, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentistry Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures. Nitrous oxide/oxygen may be used in combination with a single enteral drug in minimal sedation.

moderate sedation - a drug-induced depression of consciousness during which patients respond *purposefully* to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Note: In accord with this particular definition, the drugs and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Repeated dosing of an agent before the effects of previous dosing can be fully appreciated may result in a greater alteration of the state of consciousness than is the intent of the dentist. Further, a patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a state of moderate sedation.

The following definition applies to the administration of moderate or greater sedation:

titration-administration of incremental doses of a drug until a desired effect is reached. Knowledge of each drug's time of onset, peak response and duration of action is essential to avoid over sedation. Although the concept of titration of a drug to effect is critical for patient safety, when the intent is moderate sedation one must know whether the previous dose has taken full effect before administering an additional drug increment.

deep sedation - a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

general anesthesia - a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Specific Techniques Guidelines

(These may need to be more restrictive depending on the physical status of the patient)

Conscious Sedation

- 1) The minimum number of personnel needed to perform conscious sedation is two – a resident and another person acting as an assistant
- 2) A continuous intravenous infusion or access is required
- 3) Patient should be NPO for at least 8 hours for solids and 2 hours for clear liquids
- 4) Blood pressure, heart rate, and respiratory rate to be recorded every 15 minutes
- 5) The resident must not leave the patient until he/she is discharged to the escort's care

Deep Sedation

- 1) Procedures utilizing ultra-short acting barbiturates and similar drugs with narrow margins of use for conscious techniques are considered to fall into the class of deep sedation; other techniques with large doses or multiple drugs may be used for deep sedation
- 2) Deep sedation is limited to those residents who have completed the hospital anesthesia rotation
- 3) The minimum number of personnel needed to perform deep sedation is three, a resident with hospital anesthesia experience, another resident, and a person acting as an assistant; the resident who continuously monitors the patient must record the vital signs every 5 minutes
- 4) A continuous intravenous infusion is required
- 5) The patient must be NPO for 8 hours for solids and 2 hours for clear liquids
- 6) Supplemental oxygen is required for deep sedation
- 7) A pre-cordial stethoscope is the minimal requirement to continuously monitor the patient's heart rate and rhythm as well as respirations; vital signs must be recorded every 5 minutes
- 8) Appropriate emergency drugs and equipment must be immediately available in the cubicle as would be required for general anesthesia
- 9) Permission for deep sedation and general supervision by a faculty who possesses an Ohio General
- 10) Anesthesia permit is required
- 11) The resident who has completed his hospital anesthesia rotation must be readily available in the clinical area until the patient is discharged to leave for home

Guidelines for Out-Patient General Anesthesia

- 1) All patients must have a current past-medical history immediately available for review prior to the start of the general anesthetic.
- 2) Only oral surgery residents, teaching fellow, or faculty shall pre-op GA patients, and faculty approval must be obtained with a signature prior to the appointment being scheduled.
- 3) Only healthy patients are candidates for outpatient GA (ASA 1 & II)
- 4) All patients for GA must be NPO for a minimum of 8 hours for solids and 2 hours for clear liquids.
- 5) From the start of induction until the patient responds verbally to command, a faculty member with a State Anesthesia Permit must provide continuous, direct personal supervision in the operating room. At least one oral surgery resident must have had the hospital anesthesia rotation.
- 6) Pre-anesthetic pulse rate, respiration rate, and blood pressure must be taken and recorded.
- 7) No patient shall receive general anesthesia unless a responsible adult escort is present.
- 8) Prior to the anesthetic, patients and escorts must both understand that the patient is not to drive, operate dangerous machinery or make important decisions until at least the next day.
- 9) Dosages of all drugs and route of administration must be recorded. Pre-operative, intra-operative, and post-operative vital signs must be recorded. The "street fitness" of the patient (i.e. ability to walk, level of alertness, etc.) as well as the name of the escort must also be documented.
- 10) Only conscious patients are acceptable to enter the recovery room and they must never be left alone until discharged (see Recovery Room Protocol).
- 11) Ultra-light GA's as well as deep intravenous sedations (especially anytime propofol is used) must be administered in an operating room fully equipped for GA with appropriate supervision of faculty.
- 12) All residents must know where the emergency cart for advanced life support is located, and they must be familiar with its contents. Portable emergency oxygen/suction must be available as well as an EKG/defibrillator.
- 13) The anesthesia resident must assume the responsibility that all drugs, supplies and equipment are available and in working order.

Recovery Room Protocol

- 1) Patient to be brought to recovery room when fully responsive and with good airway.
- 2) Vital signs (BP, heart rate) will be taken and recorded upon arrival in the recovery room. The resident will not leave until this has been done.
- 3) When patient is stable, the resident will leave the patient in the care of the recovery room nurse (or any person capable of handling this duty).
- 4) Vital signs are to be taken periodically and recorded.
- 5) The recovery room staff person will take care of all the patient's physical needs (this would include problems such as nausea and vomiting) unless it is felt that the patient has a serious problem at which time the resident will be alerted and will evaluate the problem.
- 6) When patient is fully AWAKE, recovered and ready for discharge, the escort will be allowed to enter the recovery room.
- 7) Although the patient's escort is permitted in the recovery area, the escort will not be responsible for patient's supervision until the patient is discharged.
- 8) Either the surgeon or nurse can discharge the patient and give post-operative instructions (or this may be delegated to the nurse).

UNRECOVERED PATIENT CANNOT BE LEFT ALONE AT ANY TIME!

PACU Discharge Criteria

Phase I PACU

Initial Assessment:

Postanesthetic management of the patient includes periodic assessment and monitoring of respiratory and cardiovascular function, neuromuscular function, mental status, temperature, pain, nausea and vomiting, drainage and bleeding, and urine output.

Guidelines for discharge from Phase I PACU:

- 1) Clinical judgment must always supercede these guidelines if the patient's condition is not satisfactory in a given area. Whenever doubt exists about diagnosis or patient safety, discharge should be delayed.
- 2) If discharge criteria are not met or if there are any questions regarding a patient's condition, the anesthesiologist and/or surgeon should be contacted prior to discharging the patient from Phase I PACU.
- 3) *Patients transferred to a critical care unit* may be discharged with a Post-Anesthesia Recovery (PAR) score ≥ 8 or at the discretion of the anesthesiologist or surgeon.
- 4) *Patients transferred to Phase II PACU or to a hospital room* may be discharged with a PAR score ≥ 8 or at the discretion of the anesthesiologist or surgeon and must meet the requirements listed below.
- 5) Patients should achieve preoperative level of consciousness and mental status. Patients whose mental status was initially abnormal should have returned to their baseline.
- 6) Vital signs should be stable and within acceptable limits.

Appropriate as evidenced by:

- Maintenance of pain intensity at $< 4/10$, or documented as "tolerable"
- Vital signs within preoperative range
- A calm, comfortable appearance
- Control of any nausea and vomiting
- Patency of tubes, catheters, drains, intravenous lines
- Adequate hydration status
- Stable vital signs
- Adequate urine output, if measured
- Appropriate skin color, condition and integrity in relation to the surgical procedure and to preoperative baseline status.

Appropriate surgical site conditions:

- Appropriate condition of surgical site and/or dressing.
- Appropriate output from surgical drainage systems.

Patients recovering from regional anesthesia:

- Should expect the same standard of postoperative care as those who have undergone general anesthesia (GA).
- Should have progressively increasing sensory and motor control over involved extremities.
- Should exhibit hemodynamic stability.

Patients will not be discharged home directly from Phase I PACU. Patients anticipating discharge within twenty-four hours will be transferred to their assigned room for discharge home after the recovery phase.

Fast-Track Postoperative Care

Selected patients who meet the PACU discharge criteria at the end of the operation can bypass the PACU and be transferred from the operating room directly to a discharge area (Phase II recovery or hospital room).

Guidelines for discharge from Phase II PACU:

If discharge criteria are not met or if there are any questions regarding a patient's condition, the anesthesiologist and/or surgeon should be contacted prior to discharging the patient from Phase II PACU.

Initial assessment and documentation for discharge from Phase II PACU should be in addition to Phase I Criteria and include the following:

- 1) Re-documentation of vital signs and PAR score.
- 2) Adequate control of pain intensity at $< 3/10$ or documented as "tolerable".
- 3) Ability to ambulate consistent with developmental age level.
- 4) Patients recovering from regional anesthesia
- 5) Patients who have had a peripheral nerve block need not be detained until full return of sensation if discharge criteria have been achieved. It is acceptable to send a patient home with an anesthetized limb properly protected, with careful written and verbal instructions, and with a 24-hr contact telephone number.
- 6) Patients must achieve a PAR score of ≥ 8 or at the discretion of the anesthesiologist or surgeon to be discharged home.
- 7) Patients must be discharged to a responsible adult who will accompany them home and be able to report any post-procedure complications.
- 8) Provided with written instructions regarding post-procedure diet, medications, activities, and a phone number to be called in case of emergency.
- 9) Written discharge instructions given to patient/accompanying responsible adult.
- 10) Documentation that patient and home care provider understand discharge instructions.
- 11) Verify the correct phone number for follow-up phone call. The peri-anesthesia nurse will complete a post-op follow-up phone call to assess and evaluate patient status the next business day or per department protocol.

The patient is discharged in a wheelchair, or, if able, ambulates with assistance to the discharge area. Patients admitted to the hospital for observation are transported to the inpatient unit by ambulance from the Presbyterian Day Surgery Unit (PDSU), stretcher, or wheelchair from Kaseman Main OR (KMOR), and a nursing report is called to the floor prior to the patient's arrival.

Clarification of some discharge issues

Requiring that patients urinate before discharge

The requirement for urination before discharge should not be part of a routine discharge protocol and may only be necessary for selected patients.

Requiring that patients drink clear fluids without vomiting before discharge

The demonstrated ability to drink and retain clear fluids should not be part of a routine discharge protocol but may be appropriate for selected patients.

Requiring that patients have a responsible individual accompany them home

As part of a discharge protocol, patients should routinely be required to have a responsible individual accompany them home.

Requiring a minimum mandatory stay in recovery

A mandatory minimum stay should not be required. Patients should be observed until they are no longer at increased risk for cardiorespiratory depression.

Table 1

PAR Score	Admission	15 min	30 min	60 min	Discharge
ACTIVITY					
Able to move voluntary					
4 extremities	2				
2 extremities	1				
0 extremities	0				
RESPIRATION					
Breathes deeply, coughs freely	2				
Dyspnea, shallow or limited	1				
Apneic	0				
CIRCULATION					
BP \pm 20% of pre-op	2				
BP \pm 20-49% of pre-op	1				
BP \pm 50% of pre-op	0				
CONSCIOUSNESS					
Fully awake	2				
Arousable with minimal stimulation	1				
Not responding	0				
O₂ SATURATION					
>92% on room air	2				
needs O ₂ to maintain > 90%	1				
>90% even with O ₂	0				
TOTAL	0-10				

Policy for Controlled Substance Distribution

To: All Residents, Fellows and Teaching Interns From:
Greg Ness, DDS
Peter Larsen DDS, Division Chair

Date: 7/5/13

Re: Policy for Controlled Substance Distribution

We use individual lock boxes to distribute our most commonly used controlled substances.

1. Each resident or teaching intern will receive a combination lock securing a drug lockbox in the PACU. New locks with new codes will be given to incoming residents on July 1. These will not be the same as outgoing residents/interns from the previous year. You will be responsible for keeping your combination secure at all times. Do not give your combination away to anyone else. If you forget your combination, after being off-service for instance, see Dr. Ness who will have a master list of combinations.
2. Each lock box is initially supplied with fentanyl (50 mcg/ml), diazepam (5mg/ml), and midazolam (1mg/ml). Other controlled drugs may be added or substituted periodically according to patient care needs and drug availability. Each drug has a corresponding record sheet. Do not share drugs with each other or "loan" each other drugs.
3. Each time you draw up any drug for a patient, the date, patient's name, and the quantity dispensed must be indicated on the sheet. The record sheets are designed to easily reflect the usual quantities we dispense per patient, but any deviation in quantity must be clearly marked. You MUST record wasted drug on these sheets and this MUST be witnessed and initialed by a licensed individual (DDS/DMD, RN, MD, etc).
4. The actual amount of drug given to the patient must be recorded on the Anesthesia Record in the spaces provided. An Anesthesia Record must be completed for every i.v. sedation or general anesthetic performed. The doctor who physically gives the drugs, whether resident or attending, is responsible for completing the form. Each form has three copies: the original for the patient chart, the second for the anesthesia case logbook, and the third for the anesthesiologist's personal records. A box in Room 2131 will be used to turn in the second (yellow) copy of every Anesthesia Record. These copies will be kept in a binder in chronological order. It is the responsibility of the resident or intern to see that a legible copy is placed in the basket at the completion of each case. These records are necessary for credentialing and for drug record audits.
5. If you draw up a drug and then use NONE of it, you may return the unused drug to your lockbox for use on another patient. The drug must be dated and used within 24 hours, or else wasted. Its disposition must be clearly marked on the same record sheet line where it was originally signed out (e.g. returned then "wasted" or is returned used for "Bob Jones 2/22/14" etc.)
6. Any drug remaining in a syringe or ampule after PARTIAL use on a patient is to be wasted and not used on another patient. The amount wasted and the total amount used must be recorded on the Anesthesia Record form in the blanks provided.
7. When you finish your drug allotment you should have completed the corresponding record sheet(s). These can be turned in to any of the persons listed in item 11 below and new drug vials and record sheets will be issued to you. Never leave these forms on a desk or mailbox - exchange them for a new drug supply in person. New drugs cannot be issued unless a complete, accurate record form is presented. It is your personal responsibility to maintain current accurate records at all times.
8. Record sheets are to be kept in the lock box at all times. These boxes are subject to random, unannounced inventory checks. If the record sheets are not present, all drugs not present in the lock box will be presumed missing and unaccounted for. Disciplinary action as described below may result.
10. Other controlled substances, such as hydromorphone, remifentanyl and ketamine will continue to be available for use with attending approval only. These drugs will be dispensed on a case-by-case basis by any one of the persons listed below. Used, wasted, or returned drug will be recorded the same way as described above.

11. The following persons will have access to the drug cabinet outer door key: Drs. Ness and Prior and the clinic nurse. All of these persons will also have access to the PACU safe and can dispense new medications for your supply, or with attending approval, provide other controlled substances on a case-by-case basis.

12. **DISCIPLINARY ACTION:** This drug dispensing protocol has been developed with input from faculty, residents, and the OSU Campus Police Narcotics Division. Full compliance with all of the above procedures is expected. Inventory audits will include spot checks of Anesthesia Record completion and correlation with the lock box record sheets. The controlled substances issued to you are your sole responsibility, and at any given time the quantity on hand, record sheets in your lockbox, and notations on the Anesthesia Records filed in the logbook must account for every milligram/microgram. Audit discrepancies will be reported to the Residency Program or Clinic Director as appropriate. These reports will be retained in your permanent record, and will become part of your regular evaluations. They may also be used as a part of the confidential evaluation you will need to obtain hospital privileges, society memberships, etc. Repeated violations may be punishable by suspension without pay (second offense) or loss of controlled substance use privileges, which may lead to dismissal from the program (third offense).

13. If you discover any irregularity in your drug inventory or records, report it to one of the above persons immediately.

I have received a copy of this policy. I have read and understand it and will fully comply.

Resident/Intern Signature

Print Name

Date

Vacation and Travel

All residents are permitted 3 weeks per year of vacation

- 1) Vacations need to be approved by the program director and chairman of the oral surgery department.
- 2) One week of vacation will be approved between July – September for chief residents.
- 3) Chief residents cannot take vacation during the last two weeks of the residency program.
- 4) Residents cannot take two consecutive weeks of vacation.
- 5) Vacation requests for the upcoming year should be turned in to the program director/coordinator by the end of June.
- 6) It is inappropriate to use a week's vacation by taking one day at a time to make long weekends or in conjunction with planned department holidays.
- 7) Chief residents will be given 3 additional days for job interviews, if needed.
- 8) Vacations cannot be taken during the Pediatric Anesthesiology & Internal Medicine rotations. In PGY I, one or two weeks of vacation should be taken during the first six months of the UH anesthesia rotation and should be arranged as soon as possible in the PGY I year with the anesthesiology chief residents and program coordinator.
- 9) The faculty supports the philosophical concept that resident education must be as broad as possible. To this end, resident attendance at professional meetings outside of the University will be encouraged, consistent with budgetary limitations, availability of funds, and clinical obligations. Obviously, not all residents will attend all meetings. The following guidelines will describe the overall policy which should provide equality of opportunity
- 10) The senior residents will attend the American Society of Dental Anesthesiology Annual Meeting. Prerequisite is submission (not necessarily acceptance) of an abstract.
- 11) Second and third year residents may be able to attend selected regional meetings, i.e. Ohio Society. This will usually be limited to a total of four days during the year. Approval is required by the program director.
- 12) All residents may attend local meetings with first opportunity given to first year residents. Adequate coverage of hospital clinics, operating rooms, and emergency rooms must be arranged. Approval is required by the program director.
- 13) Attendance at other meetings (regional or national) may be possible if after consultation with the resident's faculty advisor, program director and chairman, an abstract is submitted and accepted for presentation.
- 14) Requests for attendance at meetings will be made as far in advance as possible by the residents with details for coverage made available to the program director.
- 15) Mission trips are available to all residents. If approved by the program director and chairman, some financial support may be given by the department for the trip.
- 16) The appropriate Leave Forms must be completed **BY THE RESIDENT** for leave and reimbursement of expenses, if applicable. Travel arrangements and Leave Forms, along with any information relative to the trip, must be turned into the program coordinator at least six weeks prior to leaving.
- 17) Reimbursement depends on per diem rates.
- 18) Sick leave is limited to 5 days per year. Any sick time over this period will be paid but the days missed may need to be made up with extra unpaid days after September 30th of the third year, at the discretion of the program director. Malpractice coverage will be paid during these additional days and all College policies for graduate students followed, including the requirement for medical insurance coverage. This same policy applies to maternity leave, i.e., if more than 5 "sick" days are taken in maternity leave, then the additional days will have to be made after September 30th of the third year with unpaid days as the resident will be paid during the maternity period. Vacation days can be used for maternity leave. If the resident is the mother, she may take no more than 6 weeks of maternity leave, which includes any sick

or vacation days used. Three (3) weeks is allowed for maternity leave for the father who is the resident, with the same rules applying as above.

Travel Requests

All travel requests for payment and/or reimbursement must be submitted prior to departure. These are processed in the Administration Office. "After the Fact" requests will not be honored. Complete the travel request form and return to the program coordinator **at least four weeks in advance.**

Existing standards, policies and procedures that apply to advanced education and graduate students in the College of Dentistry

Source document	Applies to:
Code of student conduct (Office of Student Life, Student Conduct Office) http://studentaffairs.osu.edu/csc/	All students at the Ohio State University
Human Resources policies and procedures (Office of Human Resources) http://hr.osu.edu/policy/	All students employed as Graduate Associates
Code of Honor and Professional Conduct (College of Dentistry) http://dentalintranet.osu.edu/archive/OAA/student_affairs/resources-pdf/ProfessionalConductHandbook.pdf Operating Procedures (College of Dentistry) (Intranet log-in required for access)	All CoD students
Graduate School Handbook (especially sections on academic and professional standards and research standards and misconduct) http://www.gradsch.ohio-state.edu/Depo/PDF/Handbook.pdf	All students in master's and doctoral programs
Hospital standards and procedures (e.g., OSUMC Standards for Employee Conduct) (hospital log-in required for access)	All residents who are employed by hospitals
Policies and standards articulated in individual advanced education program handbooks	Residents in an advanced education program
Policies and standards articulated in individual graduate program handbooks	Students in one of the College's three graduate programs

Updated May 1, 2015

Miscellaneous Policies

1. **Moonlighting:**

Moonlighting by dental anesthesiology residents is not allowed unless arranged with UH Anesthesiology. Violation will lead to dismissal from the program.

2. **Xeroxing:**

Xeroxing is provided free of charge to residents with the following guidelines.

- a. Make **single** copies on department xerox when at all possible.
- b. Utilize the dental school document service for all multiple copies.
- c. Utilize copy card in library for items that cannot be removed from library. If multiple copies are needed, make one master copy and have duplicates made at dental school.

3. **Photography:**

A clinic camera is available for:

- a. Documentation of clinical findings as they pertain to the patient's permanent record. Three photographs of each view will be taken. The faculty will provide one copy for the senior resident involved in the case, which may be duplicated at resident's expense for other residents.
- b. Photography of interesting clinical and surgical items as deemed appropriate by the attending faculty with all photos going to said faculty with resident option to make copies at his/her expense.
- c. Exception to the above would be any photograph done by a resident for the expressed purpose of a specific presentation, under approval of faculty.
- d. The department will also provide film and developing for the slide maker for resident presentations.

Stipends

	2014-2015 (FY15)	2015-2016 (FY16)	Monthly pay over 52 weeks*	Monthly pay over 53 weeks*	Monthly pay over 54 weeks*
PGY-1	\$ 49,582	\$ 50,495	\$ 4,207.92	\$ 4,122.04	\$ 4,039.60
PGY-2	\$ 51,214	\$ 52,016	\$ 4,334.67	\$ 4,246.20	\$ 4,161.28
PGY-3	\$ 52,763	\$ 53,679	\$ 4,473.25	\$ 4,381.96	\$ 4,294.32
PGY-4	\$ 54,474	\$ 55,520	\$ 4,626.67	\$ 4,532.24	\$ 4,441.60
PGY-5	\$ 56,295	\$ 57,309	\$ 4,775.75	\$ 4,678.29	\$ 4,584.72
PGY-6	\$ 57,673	\$ 59,096	\$ 4,924.67	\$ 4,824.16	\$ 4,727.68
PGY-7	\$ 59,592	\$ 59,592	\$ 4,966.00	\$ 4,864.65	\$ 4,767.36
PGY-8	\$ 63,080	\$ 63,080	\$ 5,256.67	\$ 5,149.39	\$ 5,046.40
PGY-9	\$ 63,600	\$ 63,600	\$ 5,300.00	\$ 5,191.84	\$ 5,088.00
PGY-10	\$ 64,237	\$ 64,237	\$ 5,353.08	\$ 5,243.84	\$ 5,138.96

Performance Guidelines

CORRECTIVE ACTION AND DUE PROCESS FOR HOUSE STAFF

Department of Oral and Maxillofacial Surgery

Ohio State University Hospitals

1. GENERAL PROVISIONS

A. Expected Performance

Members of the Oral and Maxillofacial Surgery House Staff are expected to conform to the Bylaws of the Medical Staff of the Ohio State University Hospitals and the Rules and Regulations adopted by that organization, the Rules and Regulations governing employment at the Ohio State University and state and federal laws.

Members of the OMFS house staff are also expected to make regular progress toward meeting the expectations of the Department of Oral and Maxillofacial Surgery House-staff Evaluation Committee and the criteria for satisfactory clinical competence as stipulated by the American Dental Association.

B. The Evaluation Process

Written evaluations completed by the attending staff members to whose services the resident is assigned will be kept in a permanent file. Other evaluation exercises will be administered by the faculty as necessary to meet its obligation to document the clinical competence of house-staff members. The overall evaluation process may include formal exercises as well as the informal observations of the faculty.

2. RIGHTS OF A RESIDENT IN THE EVALUATION PROCESS

A. The permanent file of written evaluations of performance will be accessible to the resident.

B. The resident has the right to challenge the accuracy of the written report of his/her performance. The resident may discuss the report with the Director of the Training Program, or if the problem is not satisfactorily resolved, may choose to meet with the House-staff Evaluation Committee to present rebuttal evidence.

C. The Due Process procedure (see below) will not be used in the course of challenging a written performance report unless that report contains accusations of such magnitude that they would, if proven accurate, lead to dismissal from the training program or would preclude certification of clinical competence.

D. Each resident has the right to expect advancement to the next level of training in Oral and Maxillofacial Surgery unless his/her performance is sufficiently below the standards set by the American Dental Association.

E. A decision by the House staff Evaluation Committee to deny advancement of a resident to the next level of training must be given with adequate notice along with reasons for the decision.

F. The House-staff Evaluation Committee must meet its obligation to document the clinical competence of residents recommended to the American Board of Oral and Maxillofacial Surgeons. With this understanding, the Oral and Maxillofacial Surgery house staff has the right to expect a hearing for their suggestions or advice regarding the evaluation process.

G. The house staff has the right to elect a committee of its members to meet with the Director of the Training Program, the Chairman of the Department or the House-staff Evaluation Committee for the purpose of discussing problems related to the evaluation process, the content of the training program or other problems of mutual concern.

3. THE RIGHT OF DUE PROCESS

A. An Oral and Maxillofacial Surgery resident is entitled to the right of due process when a charge is brought forward which would lead to dismissal from the residency training program or failure to achieve certification of clinical competence by the House-staff Evaluation Committee.

B. A charge calling for corrective action may be initiated by a member of the regular attending staff of the Department of Oral and Maxillofacial Surgery, the Director of the Training Program or the Chairman of the Department.

C. Charges which would result in corrective action against an Oral and Maxillofacial Surgery resident shall include:

1. Failure to adhere to the code of ethical professional conduct as stipulated in the Bylaws of the Medical Staff of the Ohio State University Hospitals.
- 2.. Behavior in a manner detrimental to the best interests and safety of patients in The Ohio State University Hospitals or to the aims and goals of the Department of Oral and Maxillofacial Surgery and its educational programs.
3. Violation of State or Federal laws.
4. Failure to demonstrate knowledge, expertise, competence or clinical judgment commensurate with his/her level of training such that the resident is judged incapable of accepting ordinary and expected clinical and educational responsibilities.
5. Consistent performance at a level which provides cumulative evidence that he/she is unlikely to satisfactorily complete the training program and be certified by the American Board of Oral and Maxillofacial Surgeons.
6. Grave misconduct other than specified above.

4. DUE PROCESS PROVISIONS

1. For an adverse decision regarding advancement in the training program. The decision to offer advancement to the next level of training in Oral and Maxillofacial Surgery at The Ohio State University Hospitals is the joint responsibility of the Director of Training Program, the House-staff Evaluation Committee and the Chairman of the Department. An adverse decision will ordinarily be based on items 4 and 5, Section III, Paragraph C of this document and will take into account the best interests of the overall educational goals of the Department of Oral and Maxillofacial Surgery, the care of patients in the University Hospitals, and the career aspirations of the resident. If a resident is not offered a position at the next level of training, and wishes to challenge the decision, he/she may meet with the House-staff Evaluation Committee to review the evaluations which led to that decision. If the outcome of that meeting does not resolve the problem, the resident may choose to have a second meeting with the House-staff Evaluation Committee. The second meeting will also include the Chairman of the Department, the Director of the Training Program, and two Oral and Maxillofacial Surgery residents elected for that purpose by the Oral and Maxillofacial Surgery house staff. The meeting will be chaired by the Chairman of the House-staff Evaluation Committee. At this meeting the resident may submit rebuttal evidence and may be accompanied and represented by a member of the attending staff. If the question of advancement is not mutually resolved during the discussion, the matter will be decided by majority vote of those present in the absence of the resident and his representative. This decision will be final.

Charges calling for immediate dismissal of a resident from the training program or other correct action. An OMFS resident charged with a serious breach of medical ethics, major violation of state or federal law, or other grave misconduct will be immediately removed from the program. The resident is entitled to due process as follows. The faculty member(s) or other persons, including the Chairman, who initiates the charge against the resident may not serve as the investigator of the charge(s); chair or conduct any hearing or be a participant in an appellant procedure. The faculty member may, however, submit evidence, documentation, be present, provide testimony, serve as a witness, but may not otherwise participate in deliberations and shall not vote in any of these proceedings.

Any such charge must be promptly reported in writing with supporting documentation to the Chairman of the Department or his designee. The resident will then be promptly and confidentially apprised of the charge and details of the reasons leading to it.

The Chairman, or his appointee, will investigate the charge and evidence pro and con to determine if the charge is substantiated or not and make a recommendation whether corrective action should or should not proceed. His findings, evidence, documentation and recommendation will be reviewed with the accused resident and reported in writing to the Chairman or Director of the Training Program within two weeks.

The Chairman, or his designee, will review the findings; evidence and recommendation provided by the investigator and decide whether the charge is sufficiently substantiated to proceed with corrective action. If the Chairman or his designee agrees that grounds for further action are substantiated, he will recommend appropriate disciplinary action or dismissal and so notify the resident in writing. He will then appoint a grievance committee of three faculty members, with no conflict of interest, and three oral surgery residents, elected for that purpose by the oral surgery house staff, to conduct a hearing with the charged resident present. The committee so appointed will elect one among them to chair the hearing. The documentation of action or actions leading to the charge will be presented to the resident. The resident shall have the right to refute the charge orally, in writing, by any other documentation, or witness(es) and may cross examine any participant and may likewise be cross examined. The resident may not have an attorney present before this hearing. The grievance committee will forward its findings and recommendations to the Chairman or Director of the Training Program. The Chairman or Director of the Training Program, after receiving the report and recommendation of the grievance committee, will evaluate these and decide:

a) If corrective measures should continue, b) the specific disciplinary measure, including dismissal, or c) that the charge is not sufficiently substantiated to continue further action. The Chairman or Director of the Training Program will promptly notify in writing the committee and the resident as to his decision.

If further corrective action is justified, the Chairman will convene the Senior faculty members (acting as the Executive Committee for the Department and as a hearing body) for a hearing to ascertain the validity of previous actions, evidence, and documentation and recommend what, if any, disciplinary action is appropriate. The accused resident will be notified both verbally and by certified return receipt mail at least ten days in advance as to the time and place of the hearing. The notice shall also contain a concise statement of the acts, omissions or behavior prompting the charge as well as a list of evidence documents, reports, names of potential witnesses to be called, or any other relevant material that may be considered during the hearing.

Unless the accused resident waives his rights to such a hearing in writing to the Chairman, he must personally attend at the specified time and place. If the resident waives his right to the hearing or fails to appear, unless for a good cause, the decision of the grievance committee and the Chairman or his designee shall become final and the disciplinary action will be implemented. If the resident appears before the hearing he or she shall have the right to: a) submit evidence, documentation, memoranda or procedural issues either prior to or during the hearing, b) be

represented by an attorney of law, c) challenge or cross examine any witness or rebut any evidence, If the resident does not testify in his or her own behalf, she or he may be cross examined.

At the conclusion of the hearing, and in the absence of the resident, or any witnesses, the members holding the hearing may proceed forthwith to deliberate and make a decision by majority vote as to whether the charge and recommended disciplinary measure(s) shall be sustained or not, the hearing body, at its own discretion, may recess either for its own convenience or to pursue further evidence or investigations. In the latter event, the body will reconvene promptly at its own convenience to make a final decision. Within seven days after the decision is made, a written report of its findings and decision along with all evidence and supporting documents will be forwarded to the Chairman or his designee. The decision and recommendation resulting from the hearing will be submitted to the resident by certified return receipt mail.

5. APPELLATE PROCESS

In the event of an adverse finding resulting in a recommendation of disciplinary measure(s) or dismissal of the resident, he or she shall have access to due process in the form of an appeal. If the resident chooses this course, a request for such action in writing within ten days of receipt of notice from the hearing body must be forwarded to the Chairman or his designee.

Within fourteen days after receipt of such a request, the Chairman or his designee shall convene an appellate hearing committee composed of the Dean of the College of Dentistry, who will chair the hearing, the Medical Director of University Hospitals, the Executive Director of University Hospitals, and the Chairman of the Department of Oral and Maxillofacial Surgery or his designee.

The same rules, format, procedures and rights of the resident shall apply to such hearing as those described concerning the hearing before the hearing body.

After such an appellate hearing and deliberation by this body, the disciplinary measure(s) or dismissal of the resident may be sustained altered or reversed. The decision of the appellate body will be considered final and its recommendation will be implemented.

Policy on Third Party Comments

The Commission currently publishes in its accredited lists of programs the year of the next site visit for each program it accredits. In addition, the Commission publishes in its spring and fall newsletter, Communications Update those programs being site visited January through June or July through December. Developing programs submitting accreditation eligible applications may be scheduled for site visits after the publication of Communications Update; thus, the specific dates of these site visits will not be available for publication. These programs will be listed in Communications Update with a special notation that the developing programs have submitted accreditation eligible applications and may or may not be scheduled for site visits. Parties interested in these specific dates (should they be established) are welcomed/encouraged to contact the Commission office. The United States Department of Education (USDE) procedures now also require accrediting agencies to provide an opportunity for third-party comment, either in writing or at a public hearing (at the accrediting agencies' discretion) with respect to institutions or programs scheduled for review. All comments must relate to accreditation standards for the discipline and required accreditation policies. In order to comply with the department's requirement on the use of third-party comment regarding program's qualifications for accreditation or pre-accreditation, the following procedures have been developed.

WHO CAN SUBMIT COMMENTS: Third-party comments relative to the Commission's accredited programs may include comments submitted by interested parties such as faculty, students, program administrators, Commission consultants, specialty and dental-related organizations, patients, and/or consumers.

HOW COMMENTS CAN BE SOLICITED: The Commission will request written comments from interested parties in the spring and fall issues of Communications Update. In fairness to the accredited programs, all comments relative to programs being visited will be due in the Commission office no later than 60 days prior to each program's site visit to allow time for the program to respond. Therefore, programs being site-visited in January through June will be listed in the fall issue of CU of the previous year and programs scheduled for a site visit from July through December will be listed in the spring issue of the current year. Any unresolved issues related to the program's compliance with the accreditation standards will be reviewed by the site visit team while on-site.

Those programs scheduled for review are responsible for soliciting third-party comments from students and patients by publishing an announcement at least 90 days prior to their site visit. The notice should indicate the deadline of 60 days for receipt of third-party comments in the Commission office and should stipulate that comments must pertain only to the standards for the particular program or policies and procedures used in the Commission's accreditation process. The announcement may include language to indicate that a copy of the appropriate accreditation standards and/or the Commission policy on third-party comments maybe obtained by contacting the Commission at 211 East Chicago Avenue, Chicago, IL 60611, or by calling 1/800-621-8099, extension 4653.

TYPES OF COMMENTS CONSIDERED: All comments submitted must pertain only to the standards relative to the particular program being reviewed or policies and procedures used in the accreditation process. Comments will be screened by Commission staff for relevancy. For comments not relevant to these issues, the individual will be notified that the comment is not related to accreditation and, where appropriate, referred to the appropriate agency. For those individuals who are interested in submitting comments, requests can be made to the Commission office for receiving standards and/or the Commission's Evaluation Policies and Procedures (EPP).

MANAGEMENT OF COMMENTS: All relevant comments will be referred to the program at least 50 days prior to the site visit for review and response. A written response from the program should be provided to the Commission office and the site visit team 15 days prior to the site visit. Adjustments may be necessary in the site visit schedule to allow discussion of comments with proper personnel.

Complaints

A complaint is defined by the Commission on Dental Accreditation as one alleging that a Commission-accredited educational program, or a program which has an application for initial accreditation pending, may not be in substantial compliance with Commission standards or required accreditation procedures.

REQUIRED NOTICE OF OPPORTUNITY AND PROCEDURE TO FILE COMPLAINTS WITH THE COMMISSION

Each program accredited by the Commission on Dental Accreditation must develop and implement a procedure to inform students of the mailing address and telephone number of the Commission on Dental Accreditation. The notice, to be distributed at regular intervals, but at least annually, must include but is not necessarily limited to the following language:

The Commission on Dental Accreditation will review complaints that relate to a program's compliance with the accreditation standards. The Commission is interested in the sustained quality and continued improvement of dental and dental-related education programs but does not intervene on behalf of individuals or act as a court of appeal for individuals in matters of admission, appointment, promotion or dismissal of faculty, staff or students.

A copy of the appropriate accreditation standards and/or the Commission's policy and procedure for submission of complaints may be obtained by contacting the Commission at 211 East Chicago Avenue, Chicago, IL 60611-2678 or by calling 1-800-621-8099 extension 4653.

The accredited program must retain in its files information to document compliance with this policy so that it is available for review during the Commission's on-site reviews of the program.

(01/94)

REQUIRED RECORD OF COMPLAINTS: The program must maintain a record of student complaints related to the Commission's accreditation standards and/or policy received since the Commission's last comprehensive review of the program.

(07/96)

DUE PROCESS RELATED TO INVESTIGATION OF COMPLAINTS

The following procedures have been developed to handle the investigation of complaints about an accredited program, or a program which has a current application for initial accreditation pending, which may not be in substantial compliance with Commission standards or established accreditation policies.

Policy on Complaints Directed at CDA-Accredited Educational Programs

Students, faculty, constituent dental societies, state boards of dentistry, and other interested parties may submit an appropriate, signed complaint to the Commission on Dental Accreditation (CDA) regarding any CDA accredited dental, allied dental or advanced dental education program, or a program which has an application for initial accreditation pending. The Commission is interested in the continued improvement and sustained quality of dental and dental-related education programs but does not intervene on behalf of individuals or act as a court of appeal for individuals in matters of admission, appointment, promotion or dismissal of faculty, staff or students.

In accord with its responsibilities to determine compliance with accreditation standards and required policies, the Commission does not intervene in complaints as a mediator but maintains, at all times, an investigative role. This investigative approach to complaints does not require that the complainant be identified to the program.

The Commission, upon request, will take every reasonable precaution to prevent the identity of the complainant from being revealed to the program; however, the Commission cannot guarantee the confidentiality of the complainant.

Only written, signed complaints will be considered by the Commission; oral and unsigned complaints will not be considered. The Commission strongly encourages attempts at informal or formal resolution through the program's or sponsoring institution's internal processes prior to initiating a formal complaint with the Commission. The following procedures have been established to manage complaints:

Inquiries:

When an inquiry about filing a complaint is received by the Commission office, the inquirer is provided a copy of the Commission's Evaluation Policies and Procedures (EPP) manual (includes the Complaint Policy) and the appropriate Accreditation Standards document.

The initial screening is usually completed within thirty (30) days and is intended to ascertain that the potential complaint relates to a required accreditation procedure (i.e., one contained in Evaluation Policies and Procedures [EPP]) or to one or more accreditation standard(s) or portion of a standard which have been or can be specifically identified by the complainant.

Written correspondence clearly outlines the options available to the individual. It is noted that the burden rests on the complainant to keep his/her identity confidential. If the complainant does not wish to reveal his/her identity to the accredited program, he/she must develop the complaint in such a manner as to prevent the identity from being evident. The complaint must be based on the accreditation standards or required accreditation procedures. Submission of documentation which supports the non-compliance is strongly encouraged.

Written Complaints:

When a complainant submits a written, signed statement describing the program's non-compliance with specifically identified procedure(s) or standard(s), along with the appropriate documentation, the following procedure is followed:

1. The materials submitted are logged in and reviewed by staff.
2. Legal counsel, the chair of the appropriate review committee, and the applicable review committee members may be consulted to assist in determining whether there is sufficient information to proceed.
 - a. If the complaint provides sufficient evidence of probable cause of non-compliance with the standards or required accreditation procedures, the complainant is so advised and the complaint is investigated using the procedures in the following section "formal complaints."
 - b. If the complaint does not provide sufficient evidence of probable cause of non-compliance with the standards or required accreditation procedures, the complainant is so advised. The complainant may elect
 - 1) to revise and submit sufficient information to pursue a formal complaint
 - 2) not to pursue the complaint. In that event, the decision will be so noted and no further action will be taken.
 - c. Initial investigation of a complaint may reveal that the Commission is already aware of the program's non-compliance and is monitoring the program's progress to demonstrate compliance. In this case, the complainant is notified that the Commission is currently addressing the non-compliance issues noted in the complaint. The complainant is informed of the program's accreditation status and how long the program has been given to demonstrate compliance with the Accreditation Standards.

Formal Complaints:

Formal complaints (as defined above) are investigated as follows:

3. The complainant is informed in writing of the anticipated review schedule.
4. The Commission informs the chief administrative officer (CAO) of the institution sponsoring the accredited program that the Commission has received information indicating that the program's compliance with specific required accreditation procedure(s) or designated standard(s) has been questioned.
5. Program officials are asked to report on the program's compliance with the required procedure(s) or standard(s) in question by a specific date, usually within thirty (30) days.
 - a. For standard(s)-related complaints, the Commission uses the questions contained in the appropriate sections of the self-study to provide guidance on the compliance issues to be addressed in the report and on any documentation required to demonstrate compliance.
 - b. For procedure(s)-related complaints, the Commission provides the program with the appropriate policy or procedural statement from EPP. Additional guidance on how to best demonstrate compliance will be provided to the program. The chair of the appropriate review committee and/or legal counsel may assist in developing this guidance.
6. Receipt of the program's written compliance report, including documentation, is acknowledged.
7. The appropriate committee(s) and the Commission will investigate the issue(s) raised in the complaint and review the program's written compliance report at the next regularly scheduled meeting. In the event that waiting until the next meeting would preclude a timely review, the appropriate committee(s) will review the compliance report in a telephone conference call(s). The action recommended by the committee(s) will be forwarded to the Commission for mail ballot approval in this later case.
8. The Commission may act on the compliance question(s) raised by the complaint by:
 - a. determining that the program continues to comply with the procedure(s) or standard(s) in question and that no further action is required.
 - b. determining that the program does not or may not continue to comply with the procedure(s) or standard(s) in question and going on to determine whether the corrective action the program would take to come into full compliance could be (i) documented and reported to the Commission in writing or (ii) would require an on-site review.
 - i. If by written report: The Commission will describe the scope and nature of the problem and set a compliance deadline and submission date for the report and documentation of corrective action taken by the program.
 - ii. If by on-site review: The Commission will describe the scope and nature of the problem and determine, based on the number and seriousness of the identified problem(s), whether the matter can be reviewed at the next regularly scheduled on-site review or whether a special on-site review will be conducted.
 - (1) If a special on-site review is required, the visit will be scheduled and conducted in accord with the Commission's usual procedures for such site visits.
9. Within two weeks of its action on the results of its investigation, the Commission will also:
 - a. notify the program of the results of the investigation.
 - b. notify the complainant of the results of the investigation.
 - c. record the action.

10. The compliance of programs applying for initial accreditation is assessed through a combination of written reports and on-site reviews.
 - a. When the Commission receives a complaint regarding a program which has an application for initial accreditation pending, the Commission will satisfy itself about all issues of compliance addressed in the complaint as part of its process of granting initial accreditation to the applicant program
 - b. Complainants in will be informed that the Commission does provide developing programs with a reasonable amount of time to come into full compliance with standards that are based on a certain amount of operational experience.

(revised 07)

Policy and Procedures on Complaints Directed at the Commission on Dental Accreditation

Policy: Interested parties may submit an appropriate, signed complaint to the Commission on Dental Accreditation regarding CDA policies or the implementation thereof. The CDA will determine whether the information submitted constitutes an appropriate complaint and will follow-up according to the established

Procedures:

1. Within two (2) weeks of receipt, the CDA will acknowledge the received information and provide the complainant with the policy and procedures.
2. The CDA will collect additional information internally, if necessary, and then conduct an initial screening to determine whether the complaint is appropriate. The initial screening is completed within thirty (30) days.
3. The CDA will inform the complainant of the results of the initial screening.
4. If the complaint is determined to be appropriate, the CDA (and appropriate committees) will consider the complaint at its next regularly scheduled meeting. The complaint will be considered in closed session if the discussion will involve specific programs or institutions; otherwise, consideration of the complaint will occur in open session. In the event that waiting until the next meeting would preclude a timely review, the appropriate committee(s) will review the complaint in a telephone conference call(s). The action recommended by the committees will be forwarded to the Commission for mail ballot approval in this later case.
5. The CDA will consider changes in its policies and procedures if indicated.
6. The CDA will inform the complainant of the results of consideration of the complaint within two (2) weeks following the meeting or mail balloting of the Commission.

(Adopted: 07/96) (Revised: 01/98) EPP (. 2000) Page 52.

Campus Resources

*** Can receive a formal written complaint at Ohio State**

FOR STUDENTS:

*Human Resources
Consulting Services, 403
Archer House, 292-2800

*Student Judicial Affairs,
2050 Drake Union, 292-0748

*Dean, Chair, Supervisor,
Professor, Advisor, Residence
Hall Director

Counseling and Consultation
Service, 4th floor Ohio Union,
292-5766

2nd floor Wilce Student
Health Center, 292-5726

Women Student Services, 464
Ohio Union, 292-8473

Rape Crisis Center, 221-4447

Ohio Civil Rights
Commission, 466-5928

Equal Employment
Opportunity Commission,
466-8380

FOR STAFF:

* Human Resources
Consulting Services, 403
Archer House, 292-2800

*Supervisor/Unit Head

Faculty and Staff Assistance
Program, 140 Battelle, 1375
Perry Street, 293-2442

Rape Crisis Center, 221-4447

Ohio Civil Rights
Commission, 466-5928

Equal Employment
Opportunity Commission,
466-8380

FOR FACULTY:

*Human Resources
Consulting Services, 403
Archer House, 292-2800

*Department Chair/Dean

Academic Affairs, 203 Bricker
Hall, 292-5881

Faculty and Staff Assistance
Program, 140 Battelle, 1375
Perry Street, 293-2442

Committee on Academic
Freedom and Responsibility,
126 University Hall, 292-2423

Rape Crisis Center, 221-4447

Ohio Civil Rights
Commission, 466-5928

Equal Employment
Opportunity Commission,
466-8380

Blood or Body Fluid Exposure

The procedure below refers to exposed persons as students. However, the same process applies to faculty and staff except that they are to report to Employee Health (if it is before 4:00 p.m.) instead of Student Health or their own physician. After hours all exposed persons must go to the OSU ED if they require urgent treatment per results, as described below. If there are any questions about this process after hours contact Dr. Ness on pager 848-2401.

1. The Student is to fill out Accident and Injury Report Form and the College of Dentistry Incident Report Form, found in the bottom drawer of the cabinet by the exam chairs in the front of the clinic. Make a copy of both and leave them in Oral Surgery for the clinic nurse.
2. Explain to patient that an exposure occurred and that protocol is to ask if we can draw blood to be tested for HIV, Hepatitis B and Hepatitis C. Also explain that the patient should not receive a bill and that if they do, to please let the College of Dentistry know so it can be taken care of.
3. If patient refuses the blood draw, thank the patient and send them on their way, and send the student to Student Health immediately. If it is late in the afternoon call the office of Dr. Roger Miller (Student Health) at 2-5019. They will tell you if the student can still be seen there or if they should go to the OSU ED. If they have private insurance they can go to their doctor, but they should do this immediately because the assumption is that no test means HIV positive. If it is after 4:00 pm the student should go to OSU ED. They need to tell the triage nurse that they are there for a Blood and Body Fluid exposure. They should expect to be treated as high priority and be counseled and prescribed meds very quickly.
4. If patient OK's blood draw, then we have patient sign the HIV Consent Form. At the top of the HIV Consent Form fill out the patient's name, address, date of birth, social security number and phone number. Attach it to the other papers the student completed. The blood draw kits are in the bottom drawer of the file cabinet by exam chairs up front. A single red/grey vacutainer of blood is drawn and labeled with the patient's name, social security number, date, and blood drawer's initials. On the lab requisition:
 - put the patient's name and SS# in the upper right corner,
 - put the name and phone/pager of the person who will receive results in the blank provided.,
 - check the box next to the name of the test (the only test on the form, but you have to check it anyway or they will call you about it).

- The blood is then placed in the sealed part of a specimen bag, and the requisition in the open pocket.
5. The student may return to work on the patient, or whatever other things they need to do. However, they must provide a phone number where they can be reached in the next 1-2 hours. Give them a copy of the Accident and Injury report form to take with them to Student Health.
 6. Take the specimen packet to the OSU Labs Central Processing - Stat specimen's area on the 3rd floor of Rhodes/Doan (almost exactly under OR 17).
 7. The lab will call/page the rapid HIV results to the person who drew the blood in about 60 – 90 minutes. If it is non-reactive, inform the student. They must follow up at student health in the next day or two for evaluation of Hepatitis B and C. If the result is reactive (i.e. positive) they need to report to Student Health (if it is before 4:00) or the OSU ED immediately. Call Dr. Miller at 292-3301 if they will be going to Student Health.
 8. When describing the results to the student their response will probably be somewhere between mildly alarmed and hysterical. It is important that they take the result seriously and seek prophylaxis, but it is also fair to remind them that the rapid HIV screen is oversensitive and tends toward false positives by design. Instruct them to immediately go to Student Health or to the OSU ED if it is after 4:00. If they will be going to the OSU ED, you will need to call the triage nurse and them that the student is coming. You must also tell them that the rapid HIV result will not be in the computer! The ED will need to call the hematology lab and ask for it by name and social security number (of the source patient), so give them this information. The way these samples are logged in they will never appear on the usual system, and results must be retrieved over the phone.

Blood and Body Fluid Exposure Protocol

An exposure includes cuts or punctures with blood contaminated needles or sharps, and/or blood and body fluid splashes to eyes, nose, mouth, and/or broken skin. The incident must be addressed IMMEDIATELY (Stop treatment at once.) according to the following protocol

Perform wound care: Wash area thoroughly with soap and running water. If splash to the face, thoroughly flush eyes and/or mouth with water

Weekdays: Inform supervising faculty and report to Oral & Maxillofacial Surgery reception desk on 2nd floor (take patient and chart with you.)
 Evenings or after hours: report to Clinic Director/Faculty and page Oral Surgery Resident on call. If your own bleeding is fully stopped, you may continue to treat the patient until the resident arrives. See back for additional information.

Employees: Complete Accident Report (#40928) and Blood and Body Fluid Exposure Form (8773), available from Oral Surgery

Students: Complete Blood and Body Fluid Exposure Report #8773) available from Oral Surgery

Written consent to test patient for HIV (obtained by Oral Surgery)

Yes

No, OR source patient is unknown

Exposed individual MUST remain in area or be accessible by phone over the next 2 to 3 hours so that results can be relayed and further instructions provided as needed

Report to treatment area* for evaluation

The following steps are taken by the Oral Surgery Dept.

Person drawing blood receives results from lab and reports results to exposed individual

Draw red/gray speckled tube of blood. Complete test. Request Form for Blood and Body Fluid Exposure Profile, including phone or pager number where lab can call results. Place blood tube in Biohazard Specimen bag and seal. Place request form in pocket of bag. Take to OSU Labs Central Processing – STAT Specimens area, 3rd floor Rhodes/Doan.

Negative HIV

Positive HIV

Instruct individual to follow up promptly at treatment area* for evaluation of Hepatitis B and C

Call results to treatment area*. Exposed individual should report to treatment area immediately. If seen in Emergency Dept., must still follow-up with Employee/Student Health for evaluation of Hepatitis B and C.

***Treatment Areas:**

Employees: Employee Health Services, 2A University Hosp. Clinic, 456 W. 20th Ave. (293-8146)**

Students: Student Health Services, 1875 Millikin Rd, 292-3301)**

**If closed: Report to OSU Hospitals Emergency Dept. (292-9333) only if rapid HIV test is positive, or patient is unavailable or refused testing.

To contact the Oral Surgery resident, call 293-8000 and ask for the name and pager number of the individual on call.

1. Results of rapid HIV antibody tests are usually available within 2 hours of the time the specimen arrives in the lab. If HIV prophylaxis needs to be initiated, it is most effective if begun within 2 hours of the exposure.

If results are not received in an appropriate length of time, call the OSU Hospitals Critical Care Lab @293-8375

2. Injured individual should:
 - Inform patient that an exposure occurred.
 - Notify a faculty member. If injured person is faculty, remaining faculty will attend to injured person's student load as needed.
 - Make a notation in patient's record indicating the time, site and nature of the injury. If injured person is unable to make note, a faculty member should do so.
 - Make sure the patient's phone number is available (verify folder information).
3. The patient does not need to remain in building after blood has been drawn and dental work is completed.
4. Results of patient testing are confidential and may be shared only with the exposed individual and the physician in the treatment area. Patient's name is not to be disclosed.