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CHAPTER 4 – DENTAL CARE

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ELIGIBILITY OF PERSONS FOR PUBLIC ORAL HEALTH CARE IN NSW (PD2017_027)**PD2017_027 rescinds PD2016_050****PURPOSE**

This Policy Directive establishes the eligibility criteria for NSW residents who wish to access NSW Health public oral health services.

MANDATORY REQUIREMENTS

Public Oral Health Services managed by NSW Local Health Districts (LHD) must provide oral health care to persons who meet the eligibility criteria set out in this document.

At each appointment, staff of NSW Public Oral Health Services must ensure a person meets the eligibility criteria set out by this document prior to providing care.

IMPLEMENTATION

The NSW Ministry of Health is responsible for ensuring the requirements of this policy and attached procedures are monitored and acted on accordingly, and that the eligibility criteria are openly communicated to the public.

LHD Chief Executives are responsible for ensuring the public oral health services in their LHD provide oral health care to eligible persons in accordance with this document.

Oral Health Managers, Clinical Directors and staff of public oral health services are responsible for ensuring compliance with the eligibility criteria set out in this policy and attached procedures, and that the eligibility criteria are openly communicated to the public.

This Policy Directive should be read in conjunction with the following NSW Health policies:

- [Priority Oral Health Program and Waiting List Management](#)
- [Oral Health Fee for Service Scheme \(OHFFSS\)](#)
- [Oral Health Specialist Referral Protocols](#)
- [Oral Health Chart & Referral Form for Medical Emergency Departments](#)

1 BACKGROUND**1.1 About this document**

NSW Public Oral Health Services provide a range of dental care services through funding provided or managed by the NSW Government. To ensure available resources are used efficiently, NSW Health limits access to these services to those populations at higher risk of dental disease or who are less able to afford dental care through private providers. This is achieved through the setting of eligibility criteria through this Policy Directive.

Section 2 sets out the criteria for a person to be eligible to receive dental care through NSW Public Oral Health Services. Public Oral Health Services managed by NSW Local Health Districts (LHDs) must provide oral health care to persons who meet these criteria.

Staff of NSW Public Oral Health Services must ensure a person meets the eligibility criteria set out by this document prior to providing care (section 2.3).

Section 3 provides additional detailed information on how staff from public oral health services should manage the delivery of patient care. It provides information on variations and exceptions to eligibility criteria, including patients admitted to hospital for other health care, ineligible patients, and patients who are accessing care outside their LHD.

The NSW Ministry of Health is responsible for ensuring the requirements of this policy are monitored and acted on accordingly, and that the eligibility criteria are openly communicated to the public (section 4).

LHD Chief Executives are responsible for ensuring the public oral health services in their LHD provide oral health care to eligible persons in accordance with this document.

Oral Health Managers, Clinical Directors and staff of public oral health services are responsible for ensuring compliance with the eligibility criteria set out in this policy and that the eligibility criteria are openly communicated to the public (section 4).

1.2 Key definitions

An episodic course of care is defined as a limited course of care provided with the intent of only addressing a specific, clinically urgent presentation.

An oral health emergency is defined as a child or adult patient categorised as Priority 1 through the [PD2017_023 Priority Oral Health Program and Waiting List Management](#) policy directive triage. Dental pain by itself is not considered an oral health emergency.

2 ELIGIBILITY

2.1 Eligibility of Adults for Non-admitted Oral Health Care Services

For an adult to be eligible for free public oral health services they must:

- Be normally resident within the boundary of the providing LHD , **and**
- Be eligible for Medicare, **and**
- Be 18 years of age or older, **and**
- Hold, or be listed as a dependent on, one of the following valid Australian Government¹ concession cards:
 - ⇒ Health Care Card
 - ⇒ Pensioner Concession Card
 - ⇒ Commonwealth Seniors Health Card.

Note that holders of the State Seniors Card are not eligible for care unless they also hold one of the other concession cards listed above.

2.2 Eligibility of Children and Young Persons for Non-admitted Oral Health Care Services

For a child or young person to be eligible for free public oral health services they must:

- Be normally resident within the boundary of the providing LHD , **and**
- Be eligible for Medicare, **and**
- Be less than 18 years of age.

Additional eligibility criteria may apply for some specialist oral health care. These are detailed in the [Oral Health Specialist Referral Protocols](#).

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¹ Includes Centrelink and the Department of Veterans Affairs.

2.3 Confirmation of Eligibility

At each visit the patient is responsible for proving their eligibility prior to receiving treatment, by showing a valid Medicare card and, for adults, a valid concession card. Electronic versions of cards may be used through the Centrelink mobile app on a smart phone.

If a valid concession card cannot be produced, the patient must seek a temporary concession card to establish that they are eligible for treatment, except where the person requires emergency treatment (as defined in Section 1.2).

The patient may also be asked to produce secondary identification such as a drivers licence to confirm their identity. A formal letter of identification from a homelessness agency is also acceptable as a secondary identification.

Where programs exist that involve partnerships and referral pathways between Oral Health Services and Aboriginal Community Controlled Health Services or LHD Aboriginal Service, LHDs may apply discretion to waive eligibility requirements for the clients of these programs. This may also be extended to client's partners and children.

3 PATIENT CARE

3.1 Inter-district agreements

Due to funding and reporting arrangements, dental care will normally be provided by the LHD in which a patient lives. However, LHD's may have inter-district arrangements that allow for patients to receive care in a bordering LHD to facilitate accessibility to an appropriate service.

3.2 Admitted or Day Only Oral Health Care Patients.

Where a patient's oral health treatment requires them to be treated as an inpatient, they may be treated as:

- Non Chargeable Patients
- Compensable Patients
- Private Patients.

Standard LHD procedures for processing and charging patients should be followed, in accordance with Section Two of the NSW Health [Fees Procedures Manual](#).

3.3 Patients Admitted for Other than Oral Health Treatment

Free oral health care will only be provided to adult patients admitted for care other than oral health treatment where:

- The oral health treatment is an emergency (as defined in Section 1.2), or
- The oral health treatment is an essential part of the surgical or medical management of the patient, and
- They hold, or are a listed dependent of the holder of, a current concession card (see section 2).

Treatment of hospital inpatients referred for oral health care will be negotiated with the LHD oral health clinical director if the oral health treatment is not an intrinsic part of their medical treatment. Patients who do not hold, or are not listed dependents on, a current concession card may be charged for services. The treatment sought will need to be prioritised in adherence with current LHD and NSW Health prioritisation policies for access to public oral health care.

Note that private admitted patients must pay for oral health care provided.

3.4 Services Provided to Ineligible Patients at Oral Health Clinics or at an Emergency Department

Persons not meeting the eligibility criteria set out above, including interstate visitors, may receive emergency treatment only and should see their own private general dental practitioner for all other treatment. Emergency treatment (as defined in section 1.2) may be provided to such patients who present at either a public oral health clinic or at a hospital emergency department.

Unless covered by an inter-district agreement, residents of NSW who are outside of their LHD of residence, but are otherwise eligible for free public oral health care, should only be provided with an episodic course of care (as defined in Section 1.2) and / or an Oral Health Fee For Service voucher if required. Additional dental care may be provided at the discretion of the clinical director, taking into account any additional personal circumstances of the patient.

In consultation with the patient, the LHD that provides this episodic care should make arrangements for the patient to receive any follow-up treatment required from the patient's LHD of residence.

Emergency oral health treatment and an episodic course of care (as defined in Section 1.2) may be provided to a person who is unable to prove eligibility because they are experiencing homelessness or are seeking asylum on humanitarian grounds. The person must be referred to the oral health service by an established agency and the requirement for proof of eligibility may be waived in these circumstances. Identification and treatment of these patients should be provided in accordance with PD2016_055 [Medicare Ineligible and Reciprocal Health Agreement – Classification and charging](#)

Compensable patients are to be charged at the compensable rate for an occasion of service (see [Fees Procedures Manual](#)). These patients should be advised that oral health treatment does not attract Medicare rebates and may not attract private health insurance rebates.

4 COMMUNICATION STRATEGY

Eligibility criteria and information on how eligible persons can access NSW Public Oral Health Services is made available through the NSW Health website at <http://www.health.nsw.gov.au/oralhealth/Pages/eligibility.aspx>.

The Centre for Oral Health Strategy, NSW Health has developed brochures that identify the eligibility criteria and process for accessing public dental care. The brochures that are available include; 'Public Dental Services', 'Oral Health Fee for Service Scheme', 'Child Dental Benefits Schedule Fact Sheet', 'Child Dental Benefits frequently asked questions'.

These brochures can either be downloaded from Centre for Oral Health Strategy website (<http://www.health.nsw.gov.au/oralhealth/Pages/resources.aspx>) or, alternatively, be ordered free of charge from Better Health Centre – Publications Warehouse 02 9887 5450

ORAL HEALTH FEE FOR SERVICE SCHEME (PD2016_018)**PD2016_018 rescinds PD2008_065****PURPOSE**

This Policy Directive establishes a clear, patient focused, referral pathway that ensures a care management focus between public oral health services and private practitioners who participate in the scheme.

MANDATORY REQUIREMENTS

Local Health Districts and participating private dental businesses and practitioners must establish business rules that address the requirements in this policy's procedures and change from a paper based administration system to the NSW Health web-based administration system.

IMPLEMENTATION

The responsibilities of the key parties to ensure the mandatory requirements and standards of this policy are monitored and acted on accordingly.

Chief Executives:

Assign responsibility and personnel to implement the policy.

Oral Health Clinical Directors and Oral Health Managers:

Ensure timely and open communication to establish a patient focused outsourcing dental program with participating private practitioners.

All Local Health District Staff and contracted Private Dental Practitioners and Businesses:

Comply with the policy directive and actively participate in establishing efficient patient referral processes and effective dental care.

1 BACKGROUND

The Oral Health Fee for Service Scheme (Scheme) provides a framework by which Local Health Districts (LHDs) may engage private dental practitioners (practitioners) and associated dental businesses (businesses) to provide care to public oral health service patients.

This document provides an overview of the Scheme and outlines the processes for:

- Web based administration
- Approving businesses and practitioners to participate in the Scheme
- Utilisation and payment for services under the Scheme
- Terms and conditions, and
- Governance of the Scheme.

1.1 Key definitions

In this document the term:

- **Must** – indicates a mandatory action required that must be complied with.
- **Should** – indicates a recommended action that should be followed unless there are sound reasons for taking a different course of action.

The following is clarification of key terms used throughout the document:

Episodic dental care voucher	Is the voucher type for emergency or acute course of care that is associated with a limited examination (013).
General dental care voucher	Is the voucher type for a general course of care (excludes dentures) that is associated with a full examination (011).
Denture provision voucher	Is the voucher for full or partial dentures and is associated to a limited examination (013) for dentists and consultation (014) for dental prosthetists.
Business	Is a facility where dental services are rendered either by a single dental practitioner or a group of dental practitioners, and/or, a business purely associated with an ABN that has been identified as a place for payment of services.
Practitioner	Is a dental practitioner registered with the Dental Board of Australia in the appropriate division (dentist, dental therapist, dental hygienist, oral health therapist and dental prosthetist) under the Health Practitioner Regulation National Law http://www.dentalboard.gov.au/Registration.aspx
Clinical Director	Is an LHD/Speciality Network clinician who is employed as an Area Clinical Director Level 1 – 3, or is a LHD delegated senior clinician.

1.2 Regulatory and legislative framework

The regulatory and legislative framework within which this procedure operates is set out in the *Health Practitioner Regulation National Law (NSW)* (<http://www.legislation.nsw.gov.au/maintop/view/inforce/act+86a+2009+cd+0+N>), and further information in relation to the registration of practitioners can be sourced from the Dental Board of Australia and the Australian Health Practitioner Regulation Agency.

1.3 Related NSW Ministry of Health policies, guidelines and information bulletins

The implementation of this procedure should be read in conjunction with the following NSW Ministry of Health policy directives, guidelines and information bulletins as updated from time to time:

- Clinical Procedure Safety
- Complaint Management Policy
- Complaint or Concern about a Clinician - Management Guidelines
- Complaint or Concern about a Clinician - Principles for Action
- Complaints Management Guidelines
- Consent to Medical Treatment – Patient Information
- Employment Checks – National Criminal Record Checks and Working with Children Checks
- NSW Health Privacy Manual for Health Information
- OHFFSS Schedule of Fees
- Oral Health - Eligibility of Persons for Public Oral Health Services in NSW
- Oral Health Record Protocols
- Oral Health: Cleaning, Disinfecting and Sterilizing
- Priority Oral Health Program and Wait List Management

NSW Ministry of Health policy directive, guidelines and information bulletins are public documents and are available on their website. (<http://www.health.nsw.gov.au/policies/pages/default.aspx>)

2 SCHEME OVERVIEW

The Scheme allows LHDs to engage private businesses and practitioners to provide dental care for eligible child and adult patients that have requested care from the LHD directly. LHD representatives will issue a voucher to eligible patients. Vouchers can be redeemed by patients at a business approved to participate in the Scheme. Once the patient's treatment is completed, the business or practitioner, forwards the voucher to the LHD for payment. The principal of the business and practitioner agrees to a set price schedule and the terms and conditions as listed in the current OHFFSS Schedule of Fees. The Schedule of Fees is updated annually and is indexed against the Department of Veterans Affairs fee schedule for dental care - <http://www.dva.gov.au/Pages/home.aspx>.

2.1 Participating Practitioners

All dental practitioners registered with the Dental Board of Australia are encouraged to apply to be approved practitioners under the Scheme.

All dentists and oral health practitioners must only provide dental services within their scope of practice under the OHFFSS.

The LHD may indicate to the patient the practitioner type most suitable for the treatment required.

2.2 Service Types

The OHFFSS provides the opportunity for referred public dental patients to receive dental care through the following service types:

- Episodic care for children and adults
- General care for children and adults
- Dentures
- Domiciliary, and
- Specialist services such as oral surgery and periodontics.

2.3 OHFFSS Voucher

An OHFFSS voucher can only be provided through the Priority Oral Health Program triage questionnaire, which assesses the patient's oral health need, or an authorised mechanism approved by NSW Health.

There are three types of vouchers that may be issued, these are:

1. Episodic care – The intent of this voucher is to address the most urgent treatment needs of a patient
2. General care – A voucher that covers comprehensive care identified by a full examination of a patient
3. Denture provision – A voucher that specifically includes denture care.

2.3.1 Voucher expiry timeframes

An OHFFSS voucher has an expiry date from the date of issue. The expiry timeframes for the three voucher types are:

- One (1) month for episodic care, and
- Three (3) months for general care and dentures.

2.4 Specific conditions related to the provision of dental treatment under the Scheme.

- The items claimable are restricted by the voucher type (refer to Point 2.3) and the Schedule of Fees.
- Generally dentures will be acrylic, unless specified by the LHD. If a patient wishes to have a chrome denture that is not specified or approved on the voucher, or any other additional feature, the business and/or practitioner may enter a private agreement with that patient to cover the additional expense.
- Dentures are to comply with the Therapeutic Goods Administration (TGA) Standards (<http://www.tga.gov.au/>).
- Surgical removal of tooth needs to be supported by a pre-surgical radiograph
- The provision of pulp extirpation and Root Canal Therapy (RCT) is limited to those vouchers where the need for this item is specifically recorded/authorised.
- The provision of orthopantomogram radiographs (OPGs) is limited to those vouchers where the need for this item is specifically recorded/authorised.

2.5 Recording of dental treatment provided under the Scheme.

The recording of dental care items for the Scheme is to be in accordance with the Australian Schedule of Dental Services and Glossary (<http://www.ada.org.au/publications/schedule.aspx>).

3 OHFFSS ADMINISTRATION PROCESSES**3.1 Web Based System**

To participate in the Scheme a business and practitioner must agree to the OHFFSS conditions of access (Attachment A) and establish an electronic profile within the OHFFSS web based administration system (System) that is located at <http://ohffss.health.nsw.gov.au/>

This web based participation process is divided into two profile pathways - business and practitioner - each containing mandatory requirements (Point 5).

These two pathways support the process of the business profile allocating practitioner(s) to their services, nominating the service type and LHD(s) of their choice. The practitioner's profile independently maintains their contact details and relevant mandatory requirements (refer to Point 5).

Upon receipt of the mandatory information (refer to Point 5) and subsequent processing by the relevant LHD(s) and/or OHFFSS State-Wide Coordinator, all businesses and practitioners will be notified of their participation status as accepted or not accepted via a system email.

3.1.1 Conditions of Access

To start a business and practitioner profile, or to login as an existing participant, the conditions of access (refer to Attachment A) must be agreed to.

3.1.2 Conditions of Use

To access the System authorised LHD staff must agree to conditions of use (refer to Attachment B).

3.1.3 System Security

All business and practitioner information uploaded to the OHFFSS online profile will be stored securely and only authorised Local Health District staff, OHFFSS and Scheme administrators will have access to this information. Business and practitioner information will only be used and disclosed for the purposes of the OHFFSS.

The LHD must only allocate authorised staff to the System. The LHD must also ensure that any staff who have left the employment of the LHD have their profile to access the System made obsolete.

3.1.4 Confidentiality

To ensure confidentiality businesses and practitioners will only be able to view and edit their profile. Businesses and practitioners maintain responsibility for the username and password of their profile, including changing the password regularly and ensuring proper use and access.

Authorised LHD staff and OHFFSS State-Wide Coordinator must comply with NSW Health Privacy Manual for Health Information.

3.1.5 Finding a Participating Practitioner

The web-based System provides easy access for NSW residents and LHD staff to find a current participating OHFFSS practitioner, dental clinic contact details, type of service/s provided, scope of practice and other services such as languages spoken and disability access.

3.1.6 Mandatory Expiry Date Alerts

The System will send businesses and practitioners a reminder email twenty one (21) days, fourteen (14) days and seven (7) days prior to the expiry date, and on the expiry date of the mandatory requirements identified in Point 5.

If the associated information has not been updated, the business and/or practitioner name will be suspended from the OHFFSS and patient referrals will be postponed until this has been rectified. After 30 days from the expiry date the business and/or practitioner profile will be made obsolete. If this occurs the business and/or practitioner will be required to contact either the LHD or OHFFSS State-Wide Coordinator to reactivate their profile.

3.2 NSW Ministry of Health Caveat

NSW Health and/or the relevant LHD/s retain discretion with regards to accepting a business or practitioner for approval to the Scheme. A business or practitioner may be denied approval for a number of reasons, including and not limited to:

- Not providing the required documentation
- Concerns about service standards, or the practitioner's registration with the Dental Board of Australia
- Infection control standards are inadequate and/or
- No demand for the Scheme in the geographical region where the practitioner or business are located.

3.3 Complaints and Disputes

Complaint/dispute handling processes are to follow NSW Ministry of Health policies and guidelines.

Complaints can be managed:

- At the point of service
- Through a staged process, or
- Through referral to an external body/agency or NSW Health OHFFSS Governance Committee (refer to Point 3.3.2).

If a dispute cannot be satisfactorily resolved or the business and/or practitioner does not comply with the terms and conditions of this policy NSW Health and/or the relevant LHD retain discretion to remove a business or practitioner from the Scheme.

3.3.1 Complaint/Dispute Issues

Complaint/dispute issues may include but are not limited to:

- Receipt of a complaint from a patient, family member or person external to the NSW Health System
- Complaints or concerns raised by other clinicians
- Coronial Inquiries or Health Care Complaints Commission (HCCC) investigations
- Investigation of an incident
- Concerns about questionable claims or the quality of care, or
- Compliance with Code of Conduct and Scope of Practice.

3.3.2 OHFFSS Governance Committee

The OHFFSS Governance Committee is to be established and will meet on an as needs basis to provide the following functions:

- Review clinical treatment procedures or manage waiting lists/times
- Provide a forum where issues can be discussed in a confidential manner
- Mediate unresolved disputes concerning the nature/quality or application of the OHFFSS
- Provide recommendations/actions for unresolved disputes to the Chief Health Officer and Chief Executives of LHDs, and
- To allow opportunities for a complainant to contact the Chair regarding their grievance.

The membership of this Committee consists of:

- A NSW Health Manager (Chair),
- NSW Chief Dentist
- An LHD Clinical Director
- One representative of the Australian Dental Association NSW Branch and/or the Australian Dental Prosthetists Association and/or the Australian Dental and Oral Health Therapists Association, as relevant to the issues being discussed, and
- A minimum of two community representatives.

3.4 Leave Notification

Businesses and practitioners may either withdraw or have periodic leave from the Scheme at any time by using the 'leave request' functionality in the System.

It is preferable to give two weeks written notice to the relevant LHD. Any outstanding claims must be forwarded to the relevant LHD(s) prior to their withdrawal date.

4 NSW HEALTH AND LOCAL HEALTH DISTRICT CONTACT DETAILS**4.1 OHFFSS State-Wide Coordinator**

NSW Health provides a state-wide administration service for the implementation of the Scheme, complaints/dispute handling and support to businesses, practitioners and LHDs in relation to the System.

Contact details are:

Centre for Oral Health Strategy NSW
1 Mons Road, Westmead NSW 2145
Phone: 1800 938 133 (toll free)
Email: WSLHD-ohffss@health.nsw.gov.au
Fax: (02) 8821 4302.

4.2 Local Health Districts OHFFSS Coordinators

Each LHD employs an OHFFSS Coordinator whose role is to implement the Scheme and to respond to businesses or practitioners inquiries regarding clarification of patient dental history, patient's treatment, approval status or non-payment.

Contact details for LHD OHFFSS Coordinators can be located in the OHFFSS System or oral health call centre numbers at www.health.nsw.gov.au/oralhealth.

5 BUSINESSES AND PRACTITIONERS**5.1 Mandatory Participation Requirements****5.1.1 Businesses**

- Company/Trading name
- Australian Business Number (ABN)
- Relevant bank details
- Certification of Public liability insurance to the value of \$20 million*
- Relevant Workers Compensation Insurance policy*
- Radiation Management Licence* (excluding Dental Prosthetists), and
- Completed Health Share vendor form*. (<http://www.healthshare.nsw.gov.au> / or ring the Master File Maintenance Team on 1300 477 679 option)

5.1.2 Practitioners

- Australian Health Practitioner Regulation Agency (AHPRA) registration number and conditions of registration
- Certification of Professional indemnity insurance of \$20 million*, and
- Working with Children Check number. (www.kidsguardian.nsw.gov.au)

Key: * indicates documents requiring uploading into the System.

5.2 Terms and conditions

5.2.1 Proof of Documentation

All mandatory documentation (*) must be certified by an appropriately authorised person before being uploaded on the OHFFSS System.

5.2.2 Environmental Protection Agency

For those practitioners who offer OPGs under the Scheme, evidence of a current Environmental Protection Agency (EPA) licence (<http://epa.nsw.gov.au/>) will be required and uploaded into the OHFFSS System.

5.2.3 Maintaining Participation

To maintain approval to participate in the Scheme:

- Businesses must update their profiles on changes to: their contact and banking details; practitioner(s), service delivery type(s) and LHD(s); and the annual renewals of:
 - Public Liability Insurance certificate*
 - Workers Compensation Insurance policies*, and
 - Radiation Management Licence*.
- Practitioners must immediately update their profiles with any changes of their AHPRA registration status including AHPRA registration number and any conditions on registration; contact details; banking details (if applicable); and also the renewal of:
 - Professional indemnity insurance annually*, and
 - Working with Children Check (WWCC) every five (5) years.

5.2.4 Patient Care

All practitioners are required to:

- Review and be satisfied with the patient's medical history
- Review the treatment proposed (if provided) and if necessary to adjust the treatment plan according to the current condition, first consult with the LHD for approval
- Document the informed consent from the patient before carrying out any treatment that is covered by the voucher
- Complete all the required details of treatment provided on the voucher form (i.e. tooth number, surfaces, denture teeth replaced, and date of service)
- Ensure that the patient signs the voucher at completion of treatment verifying that they have received the treatment claimed, and
- Provide post-treatment instructions and any reasonable after care management.
- All practitioners understand they:
 - must fully discuss any treatment that is not covered by the voucher with the patient for which they will be charged (as part of a private agreement);
 - they may be asked to provide radiological evidence for all surgical extractions, and any pre-approved endodontic treatment;
 - they must provide at least three or more denture adjustments, as necessary, following the issue of a denture(s).

5.3 Businesses and Practitioners Joint Roles and Responsibilities

- All businesses and practitioners are required to:
 - Be compliant with current infection control standards (<http://www.nhmrc.gov.au/guidelines-publications/cd33>)
 - Cooperate with the LHDs in resolving complaints from patients and disputes about claims
 - Check that vouchers have not exceeded the expiry date and, if expired, contact the relevant LHDs prior to commencement of the treatment
 - Check the patient's identity, current Medicare Card, and Centrelink concession status if the patient is an adult before treatment is started

5.3.1 Processing of Vouchers

- To ensure payment the following must occur:
 - The patient must provide an original OHFFSS voucher that has been approved by a LHD (refer to Point 6)
 - The dental care outlined on the voucher must have been completed by the expiry date on the voucher, unless otherwise agreed with the LHD
 - All details of the voucher must be completed
 - The voucher must be forwarded to the LHD within 30 days after completion of treatment, and
 - The treatment must have been authorised by a LHD staff member.
- If payment is greater than the maximum entitlement, as identified in the Schedule of Fees, it must be approved by the LHD Manager or Clinical Director before the treatment is carried out
- If goods and services tax (GST) is to be claimed a tax invoice is to be submitted for processing as per LHD policy and procedures.
- Non-payment of a voucher may result if:
 - Dentures provided are non-compliant with TGA standards
 - There has been a surgical removal of a tooth that is not supported by a pre-surgical radiograph
 - A pulp extirpation has been provided where the voucher has specifically stated 'No Root Canal Therapy (RCT)'
 - The voucher is received after 30 days from the date treatment is completed
 - Treatment items have been provided after the voucher expiry date (unless prior authorisation has been obtained from the LHD)
 - Services have been provided by a business or practitioner not currently approved to participate in the OHFFSS
 - Treatment has been provided that is over and above that recommended
 - The treatment provided is not of a required standard, or
 - If treatment items used are not identified in the Schedule of Fees

6 LOCAL HEALTH DISTRICTS

6.1 Administration Requirements

Once a business or practitioner is approved in one LHD, other LHDs can engage that business or practitioner. Businesses and practitioners should therefore be advised that authorised officers from all LHDs and System administrators can access their profiles.

LHDs are required to:

- Use the OHFFSS System to process and communicate with private businesses and practitioners to approve participation in the Scheme
- Ensure that there is a designated employee who is responsible for the implementation of the Scheme
- Confirm via email that the business or practitioner has been approved to participate in the Scheme
- Ensure that all fields in the System have been completed
- Provide an explanation to the business or practitioner if they are not approved
- Request an Environmental Protection Agency (EPA) licence for those practitioners who have offered to provide OPGs
- Provide accurate and complete information to patients about the Scheme and the patient's right to choose an approved practitioner
- Issue voucher(s) with or without undertaking a clinical assessment
- Either post the voucher to the patient or hand to the patient at the time of the appointment
- If an initial appointment is not made for the patient by the LHD, the patient should be advised to make an appointment within ten working days
- Maintain a process of auditing and governing the efficient use of the Scheme, including periodic audits of relevant businesses and practitioners records. This auditing should encompass the following areas:
 - Financial accountability (errors of accounting and claiming) and
 - Clinical auditing (ensuring the quality of clinical care is within a reasonable standard and that accurate and complete medical records are kept for each patient and each visit).

Note that: NSW Health agencies may not apply for or pay for WWCCs on behalf of individuals (Section 5.3 Employment Checks – National Criminal Record Checks and Working with Children Checks PD 2013_028)

6.2 OHFFSS Voucher

The OHFFSS voucher is a combined authority, claim form, and treatment plan.

- The LHD must use the OHFFSS voucher that is required to have:
 - An oral health IT system unique ID authority number and bar code
 - Patient details
 - Date of issue
 - Maximum amount of the voucher as per Schedule of Fees, and
 - Treatment required (if applicable).

- The public dental practitioner should include on the voucher information relevant to the patient's clinical need:
 - Assessed treatment need and related tooth numbers,
 - Whether an OPG is authorised for the patient,
 - Number of teeth required for a denture, or
 - Indicate pre-prosthetic mouth preparation for clasps and rests if required.

6.2.1 Payment

- To ensure payment the following must occur:
 - Payment for one (1) diagnostic service per authorised voucher (episodic, general and denture) as per the Schedule of Fees
 - Issue of the appropriate voucher type for the service type required
 - The voucher was submitted for payment by an approved business or practitioner, and
 - The business or practitioner has complied with the policy's roles and responsibilities (refer to Point 5).
- The following may result in non-payment of the voucher:
 - The business and practitioner has not complied with the policy's roles and responsibilities (refer to Point 5)
 - Vouchers received more than 30 days after the treatment has been completed
 - Vouchers with treatment items that were provided after the voucher expiry date (unless prior authorisation has been obtained from the LHD)
 - Services provided by a business or practitioner that is not currently approved to participate in the OHFFSS
 - Treatment over and above recommendation
 - Treatment not to a required standard, or
 - Treatment items not included in Schedule of Fees.
- Once the above procedures have been followed, the LHD are required to:
 - Return any radiograph(s) supplied by the business or practitioner unless double radiographic films have been used, and
 - Forward the claim to the relevant LHD Manager, or nominee, for authorisation and HealthShare payment processing.

6.3 Quality Assurance

LHDs are accredited institutions and therefore undertake quality assurance activities on a regular basis. The operation of the OHFFSS and the care provided under the Scheme is included in these accreditation processes.

The NSW Ministry of Health, the Australian Dental Association NSW Branch and the Australian Dental Prosthetist Association NSW support the use of quality assurance measures.

The evaluation of the Scheme may include relevant Australian Council of Healthcare Standards clinical indicators and other quality activities.

Attachment A: Conditions of Access to Web-based Oral Health Fee for Service Scheme

The conditions of access set out below need to be read in conjunction with the Oral Health Fee for Service Scheme Implementation Procedures. Non-compliance with the conditions of access set out here and in that Policy Directive could lead to suspension or removal from the OHFFSS.

1. Access to the facility is via a user name and password. The user is responsible at all times for the proper use of an allocated password and for all access under the password, which should be changed regularly to prevent misuse.
2. To protect both business and practitioner personal information that is uploaded onto the OHFFSS web based system, users will only be able to view and edit their own profile.
3. It is the policy of NSW Health (the administrator of the Oral Health Fee for Service Scheme) that:
 - Access to the web-based scheme be monitored on an ongoing, continuous basis to guard against intentional inappropriate use and
 - Records of access are maintained and routinely audited to ensure appropriate use of the web based system.

Personal information – In agreeing to be registered with the OHFFSS, you acknowledge that your personal information will be stored and backed up securely and that only authorised Local Health District or OHFFSS administrators will have access to the information. Your personal information will only be used and disclosed for the purposes of the Oral Health Fee for Service Scheme or as lawfully required.

If at any time you have concerns about how your personal information is being used, accessed or disclosed, please contact the Local Health District's Privacy Liaison Officer or State-Wide OHFFSS Coordinator on 1800 938 133 or WSLHD-ohffss@health.nsw.gov.au.

Acceptance

In accepting entry I confirm that I have read, understood and will comply with the NSW Health Policy Directive on the Oral Health Fee for Service Scheme and Schedule of Fees, and agree to the conditions and requirements set out in that Policy Directive and Schedule of Fees. I agree that my use of the web-based administration tools will be in accordance with the conditions and requirements set out in the conditions of use and the Policy Directive. I understand and accept that my access and usage is liable to be monitored on an ongoing and continuous basis. I understand and accept that my registration on the OHFFSS may be suspended or removed if I breach the Policy Directive or the conditions of access.

If I provide dentures I will comply with the Therapeutic Goods Administration Standards (<http://www.tga.gov.au/>). I understand and accept that my participation in the Oral Health Fee for Service Scheme will be monitored on an ongoing and continuous basis.

To read the Oral Health Fee for Service Scheme Policy and Schedule of Fees, click on **Read** for the Policy and click on **Read** for the Schedule of Fees.

Click **Accept** to comply and to access the Oral Health Fee for Service Scheme and Schedule of Fees.

If you click on **Reject** it means that you do not wish to comply and you will not be able to proceed any further.

Attachment B: Conditions of Use to Web-based Oral Health Fee for Service Scheme

These conditions of use apply to staff of the relevant Local Health District and the NSW Ministry of Health who as part of their role, have access to the Web-based Oral Health Fee for Service Scheme system.

All staff are required to comply with the *Health Records and Information Privacy Act (HRIP) 2002* to protect the privacy of health information in NSW. All staff are also required to comply with the *Privacy and Personal Information Protection (PPIP) Act 1998* which covers other personal information such as employee records.

NSW Health is committed to safeguarding the privacy of patient, employee and personal information and has implemented measure, to comply with these legal obligations.

Guidance for staff in relation to their legal obligations is provided in the *NSW Health Privacy Manual for Health Information*. All staff are also bound by a strict code of conduct to maintain confidentiality of all personal and health information which they access in the course of their duties.

In addition to the legislative and policy related obligations, staff must comply with the following conditions of access:

1. Staff may only access patient/employee, personal or health information where this is required in the course of their employment.
2. Access to the OHFFSS web-based system is by staff employee number and password. The user is responsible at all times for the proper use of an allocated password and for all access under the password, which should be changed regularly to prevent misuse.
3. Personal and health information contained in the OHFFSS web based system must not be used or disclosed for improper purposes.
4. To protect both business and practitioner personal information that is uploaded onto the OHFFSS web based system LHD staff, unless approved to have super users rights, will only view and edit records of businesses and practitioners who are participating in the OHFFSS within their LHD.
5. It is the policy of NSW Health, the administrator of the Oral Health Fee for Service Scheme, that:
 - Access to the web-based scheme be monitored on an ongoing, continuous basis to guard against intentional inappropriate use and
 - Records of access are maintained and routinely audited to ensure appropriate use of the web based system.

If at any time you have concerns about how system information is being used, accessed or disclosed, please contact the State-Wide OHFFSS Coordinator on 1800 938 133 or [WLSLHD-ohffss@health.nsw.gov.au](mailto:whlhd-ohffss@health.nsw.gov.au).

Acceptance

In accepting entry I confirm that I have read, understood and will comply with the NSW Health Privacy Manual for Health Information, the Code of Conduct (PD2015_049), the OHFFSS Policy Directive and these Conditions of Use. I understand and accept that my access and usage will be monitored on an ongoing and continuous basis.

To read the NSW Health Privacy Manual for Health Information

(<http://www.health.nsw.gov.au/policies/manuals/Documents/privacy-manual-for-health-information.pdf>), click on **Read** and click on **Read** for the Code of Conduct PD2015_049.

(http://www0.health.nsw.gov.au/policies/pd/2015/pdf/PD2015_049.pdf)

Click **Accept** to comply with NSW Health Privacy Manual for Health Information and Code of Conduct PD2015_049. If you click on **Reject** it means that you do not wish to comply and you will not be able to proceed any further.

SCHEDULE OF FEES FOR ORAL HEALTH FEE FOR SERVICE SCHEME (IB2023_015)

IB2023_015 replaced IB2022_017

PURPOSE

This Information Bulletin provides information on the current Oral Health Fee for Service Scheme (OHFFSS) Schedule of Fees. Fees have been indexed in alignment with movement in the Department of Veteran's Affairs Fee Schedules of Dental Services.

The Schedule of Fees can be found on the NSW Health Oral Health webpage [Oral Health Fee for Service Scheme](#).

KEY INFORMATION

This Information Bulletin is to be read in conjunction with NSW Health Policy Directive Oral Health Fee for Service Scheme ([PD2016_018](#)), and Australian Dental Association *The Australian Schedule of Dental Services and Glossary, (Twelfth Edition)*.

Voucher limits

The maximum amounts payable for authorised vouchers are:

- Episodic Voucher: **\$450.00 or as printed on voucher**
- General Voucher: **\$1000.00 or as printed on voucher**
- Denture Voucher: **\$1750.00 or as printed on voucher**

NSW Public Health Organisations may:

- raise or lower voucher limits in line with local policy
- pre-authorise and fund other Australian Dental Association items not listed in this schedule where it is applicable to an individual patient or model of care.

Note that actual limits are printed on each voucher.

ORAL HEALTH PATIENT RECORD PROTOCOL (GL2015_017)**GL2015_017 rescinds PD2008_024****PURPOSE**

The Oral Health Patient Record has been updated to assist oral health care providers within NSW Health maintain records that meet the Dental Board of Australia Guidelines on Dental Records (July 2010).

(<http://www.dentalboard.gov.au/Codes-Guidelines/Policies-Codes-Guidelines.aspx>)

KEY PRINCIPLES

The Oral Health Patient Record has been reviewed and updated to reflect a contemporary view of patient centred care. The guideline applies to dentists, dental therapists, dental hygienists, oral health therapists, dental prosthetists and dental specialists.

USE OF THE GUIDELINE

The Oral Health Patient Record will result in a review of current work practices in such areas of odontogram, charting techniques and abbreviations. This will ensure that all Oral Health practitioners create and maintain a high level of quality in record keeping including detailed documentation of relevant patient information, both current and historical.

These practices are to serve the best interests of NSW residents who access public oral health services and that contribute to their safety, confidentiality and continuity of dental care. This guideline describes the base line requirements for oral health patient records whether they are in paper-based or electronic form.

1 BACKGROUND**1.1 About this document**

The Oral Health Record Procedures provides a standard of documentation in clinical dentistry with a list of commonly accepted abbreviations and charting symbols for both paper based and electronic software programs across NSW. Electronic software programs will differ in charting methods and symbols. It is however prudent that these charting methods and symbols provide a clear definition of presenting condition(s), treatment required and treatment provided.

This document provides an overview of the key elements of an oral health clinical record:

- Medical history
- Examination and treatment planning
- Primary and permanent odontograms and
- Charting symbols and definitions.

1.2 Key definitions

Examination	Includes the examination of both soft and hard tissues, and findings are recorded using an odontogram and/or text. The charting needs to comply with the World Dental Federation (FDI) system and should include: (i) restored teeth (tooth code, surface/s involved and materials used) (ii) sound and unrestored teeth (iii) missing teeth (iv) hard tissue and soft tissue abnormalities (v) occlusion, including tooth mobility (vi) periodontal status including periodontal pocket depth, supra-gingival calculus, sub-gingival calculus and oral hygiene status and type of prosthetic appliances present.
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1.3 Evaluation framework

LHDs to put in place an audit process to ensure compliance with the minimum requirements of this guideline.

1.4 Associated NSW Health policies and guidelines

It is the role and responsibility of treating dental practitioner and supporting dental staff to read the Oral Health Patient Protocol guideline in full and implement them accordingly. This guideline is to be read in conjunction with:

- Clinical Procedure Safety
- Consent to Medical Treatment – Patient information
- Health Care Records – Documentation and Management
- Privacy Manual
- Record Management – Department of Health
- Records_ Disposal Authority (DA 25) (Use of functional) by NSW Department of Health
- State Health Forms
- Student Training and Rights of Patients

Ministry of Health policies and guidelines are public documents and are located on NSW Health website. www.health.nsw.gov.au/

2 KEY ELEMENTS

2.1 Patient identification

Patient identification by the dental practitioner needs to be in compliance with NSW Health Clinical Procedure Safety policy.

To ensure compliance the dental practitioner and clinical team must undertake the time out procedure and note accordingly in patient's progress notes with relevant signatures.

2.2 Medical History

The patient dental record should document a medical history as taken by the dental practitioner. A medical history should include the following elements:

- Positive and negative responses
- Any adverse reactions, allergies, or events

- Medical history updates are to be completed at the beginning of each course of care. Check verbally, and if there are:
 - No changes, document 'medical history checked, no update' (MH – nil update)
 - Amend changes to the existing history or if necessary document a new medical history.
- Each dental practitioner has to ensure and sign off that the medical history is completed to their satisfaction.

2.3 Consent for treatment

Obtaining consent for treatment needs to be in compliance with the NSW Health 'Consent to Medical Treatment – Patient Information' and Multilingual Health Resources by AHS, DoH and NGOs Funded by NSW Health (Guidelines for Production).

2.4 Emergency Care

Clinical notes should indicate the following elements:

- Chief complaint/reason for attendance
- Diagnostic data
- Clinical findings
- Radiograph(s) taken
- Results of investigations – imaging, vitality tests etc
- Management plan or treatment given.

2.5 Examination and Treatment Plan for a Course of Care

Clinical notes should indicate the following elements:

- Presenting complaint
- Past dental history
- Full dental charting of dentition on examination when providing a full course of care
- A separate charting of treatment required (which may be amended to note the progress of treatment)
- Notes regarding:
 - Soft tissues,
 - Extra-oral findings,
 - Intra-oral findings,
 - Periodontal health,
 - Preoperative and postoperative risks and treatment options,
 - Sterilization tracking labels, and
 - Brochures, fact sheets and Oral Health Fee for Service vouchers provided, if required.
- A treatment plan of appropriate detail.

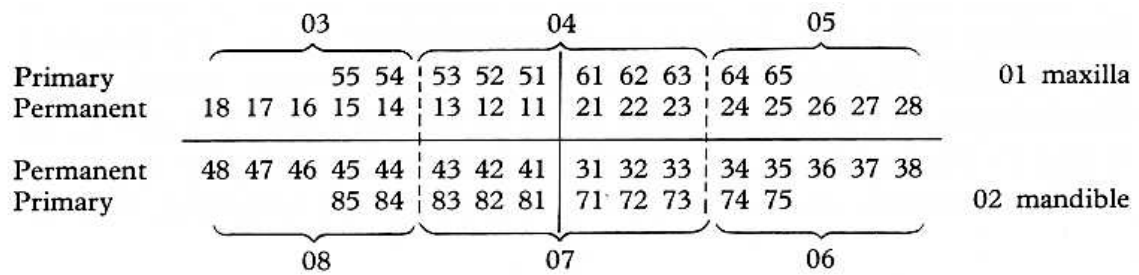
2.6 Charting and Tooth Identification

The Federation Dentaire Internationale (FDI) notation for recording tooth number is to be used (Refer to Diagram A), as follows:

Two digit codes for the jaws and sextants of the mouth are:

- 00 indicates the mouth
- 01 indicates the maxilla
- 02 indicates the mandible
- 10 to 40 indicate the quadrants in clockwise order starting on the top right.

Diagram A

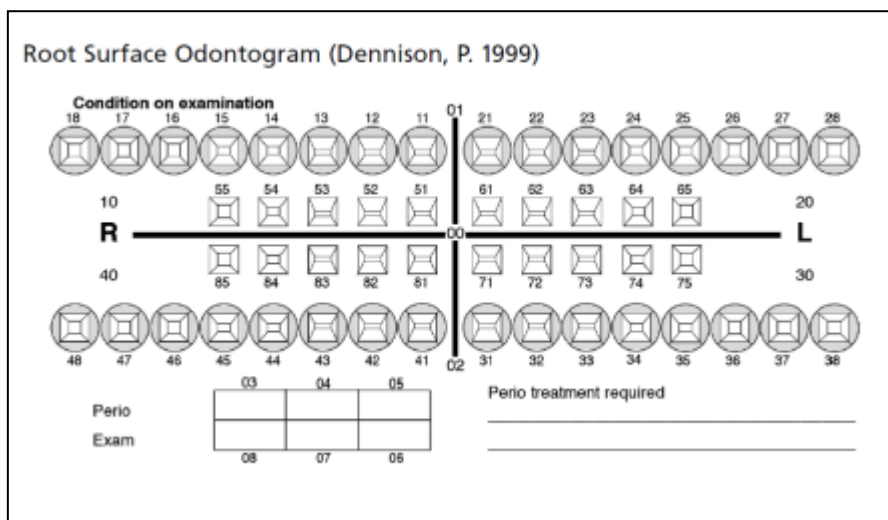


2.6.1 General Odontogram

The odontogram for permanent teeth may have root surfaces and a primary odontogram should be available where applicable (refer to Diagram B).

Diagram B

Dennison, P (1999) 'A Modified Odontogram to enable Root Surface Charting' Community Oral Health and Epidemiology, Westmead Centre for Oral Health, Faculty of Dentistry University of Sydney Australia.



2.6.2 Periodontal Charting

When a periodontal charting is required it should include the recording of:

- Recession
- Pocket depth
- Suppuration
- Bleeding on probing
- Furcation involvement
- Mobility.

2.7 Anaesthetics

Clinical notes should indicate the following elements:

- Type of anaesthetic used
- Amount of anaesthetic used
- Type of injection given
- Any adverse reactions, allergies, or events.

2.8 Restorations

Clinical notes should indicate the following elements:

- Tooth involved
- Surface/s involved
- Base/linings used
- Restoration material and shades used
- Unusual depth or other features
- Pin placement, if used
- Pulp exposure (size, location, mechanical/carious), if this has occurred.

2.9 Exodontia

Clinical notes should indicate the following elements:

- Tooth to be extracted
- Reasons for extraction
- Tooth extracted
- Radiographic evidence to support decision for extraction
- Any complications
- An indication if post-operative instructions were given
- An indication if haemostasis has been achieved
- Need for review, as required.

2.10 Minor Oral Surgery

Clinical notes should indicate the following elements:

- Reason for procedure
- Procedure undertaken including technique used
- Supporting test/data/symptoms
- Any complications
- An indication if haemostasis has been achieved
- An indication if post-operative instructions were given
- Need for review, as required.


2.11 Medication

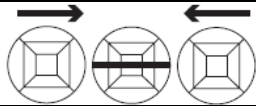



Clinical notes should indicate the following elements:






- The type of medication prescribed
- Reason for administration of prescription
- The dose of medication and indication of the method of delivery
- If antibiotic prophylaxis is used, the time of administration and the time of commencement of treatment
- Any adverse reactions, allergies, or events
- Results of antibiotic sensitivity testing, as required
- Discussions with the patient's medical practitioner.

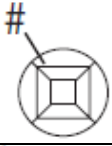

3 TERMS, ABBREVIATIONS AND SYMBOLS



Abbreviations and symbols may vary depending on the patient record type (paper or electronic).

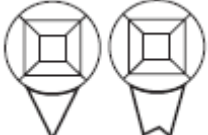
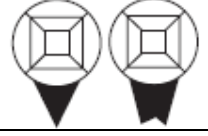
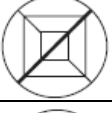

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
ANATOMY			
Anterior	Ant		
Arrested Caries	AC		
Bilateral(ly)	bilat		
Buccal	B		
Cardiovascular System	CVS		
Caries Free	CF		
Cemento-enamel junction	CEJ		
Central Nervous System	CNS		

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Centric Occlusion	CO		
Centric Relation	CR		Contextual note
Distal	D		
Drifted Tooth			
Incisal	I		
Labial	Lab		
Lateral	Lat		
Left			
Left Hand Side	LHS		
Lingual	L		
Lower Left	LL		LL – not to be used when referring to teeth
Lower Right	LR		LR - not to be used when referring to teeth
Maxillo-Mandibular Relationship/record	MMR		
Mesial	M		
Mesial-occlusodistal	MOD		Sample of combination for tooth surfaces
Missing tooth			
Occlusion (notes)	Occl		
Occlusal Vertical Dimension	OVD		
On Examination	O/E		
Over Retained	O/R		
Overbite	O/bite		
Overjet	O/jet		
Palatal	P		
Partially erupted	PE		
Posterior	Post		




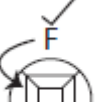
TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Quadrant	Q		
Quadrant, lower left	Q3		
Quadrant, lower right	Q4		
Quadrant, upper left	Q2		
Quadrant, upper right	Q1		
Secondary Caries	2°C	2°C 	
Retained Root	RR	RR 	
Retruded Position	RP		
Right			
Right Hand Side	RHS		
Supernumery			
Temporo-mandibular joint	TMJ		
Unerupted	UE	UE 	
Upper Left	UL		
Upper Right	UR		
Vertical Dimension	VD		
EXAMINATION			
Assessment	Assess		
Bite Wing radiograph/s or film/s	BW		
Cephalometry/ic	Ceph		
Cerebro-Vascular Accident	CVA		
Chief Complaint	CC		
Cigarettes	Cigs		







TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Community Periodontal Index of Treatment Needs	CPITN		
Complains (ing) of	C/O		
Cone Beam Imaging	CBCT		
Consultation	Consult		
Decrease (d) (ing)	↓		
Dental History	DH		Contextual note
Diagnosis	Dx		
Differential Diagnosis	DDx		
Division	Div		
Emergency	Emerg		
Examination	Exam		
Extra-oral	E/O		
Family History	FH		
Family and Social History	F/SH		
Father	⊙ F		
Female	♀		
Fracture	#	# 	Fractured tooth – contextual note
		# 	Fractured root
General Dental practitioner	GDP		
General Medical Practitioner	GMP		
History of Present Complaint	HPC		
Increase (d) (ing)	↑		



TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Intra-Oral	I/O		
Lateral Cephalometric radiograph	LCeph'		
Male	♂		
Medical History	MH		
Mother			
Motor Vehicle Accident	MVA		
No Abnormalities Detected	NAD		
Non Vital	NV		
Occlusal radiograph/s or film/s	Occl		
On Examination	O/E		
Orthopantomogram	OPG		
Past Medical History	PMH		
Periapical Film/s or Radiograph/s	PA		
Periodontal screening and recording	PSR		
Prognosis	Px		
Provisional Diagnosis	PDx		
Social History	SH		
Tender to Percussion	TTP		
Toothache	T/ache		
Treatment	Tx		
Treatment Plan	TP		
Within normal limit(s)	WNL		
ANAESTHESIA			
Inferior Alveolar Dental Block	IANB		

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Infiltration	Infilt		
Local Anaesthetic	LA		
Nitrous Oxide	N ₂ O		
Relative Analgesia	RA		
ENDODONTIC			
Cotton Pellet	CP		
Endodontic (s)	Endo		
Ferric sulphate	FeSO		
Gutta Percha	GP		
Hydrogen Peroxide	H ₂ O ₂		
Ledermix	led		
Master Apical File	MAF		
Number, size, gauge of endo file	No.		
Root Canal Therapy	RCT		
Root Filling			Root filling required
			Root filling present
Sodium hypochlorite	NaOCl		
Working length	WL		
ORAL SURGERY			
Black Silk Suture	BSS		
Extraction or Exodontia	Exo		Tooth to be extracted
			Tooth extracted

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Haemostasis Achieved	HA		
Inter-maxillary Fixation	IMF		
Interrupted Cat Gut Suture	ICGS		
Oral & Maxillo Facial Surgery	OMFS		
Oral Surgery	OS		
Post-operative instructions given	POIG		
Removal of sutures	ROS		
Surgical removal	SR		
ORTHODONTIC			
Cross bite	X-bite		
Full Fixed Orthodontic Appliance	FFA		
Index of Orthodontic Treatment Needs	IOTN		
Mandibular Removable Orthodontic Appliance	LRA		
Maxillary Anterior Crowding	UAC		Upper
Maxillary Removable Orthodontic Appliance	URA		
Orthodontics	Ortho		
Rapid Maxillary Expansion	RME		
PAEDIATRIC			
Paediatric dentistry	Paedo		
Pulpectomy	Pulpect		
Pulpotomy	Pulpot		
Stainless Steel	SS		
Stainless Steel Crown	SSC		
To-be-left	TBL		
PERIODONTIC			

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Acute Necrotising Ulcerative Gingivitis	ANUG		
Bleeding on Probing	BOP		
Hand Scale	H/Scale		
Loss of Attachment	LOA		
Mucogingival junction	MGJ		
Periodontics	Perio		
Root Planing	RP		Contextual comment
Subgingival	Subging		
Supragingival	Supraging		
PREVENTIVE			
Acidulated phosphate fluoride	APF		
Fissure Sealant	FS	FS 	Fissure Sealant required
		✓ FS 	Fissure Sealant present
Fluoride	F ⁻	F 	Fluoride application required
		✓ F 	Fluoride application given
Mouthguard	M/guard		
Oral Health Promotion	OHP		
Oral Hygiene	OH		
Oral Hygiene Instruction	OHI		
Preventive Resin Restoration	PRR		
Prophylaxis	Prophy		

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Scale & Clean	S+C		
Sodium Fluoride	NaF		
Stannous Fluoride	SnF ₂		
Toothbrushing Instruction	TBI		
PROSTHETICS FIXED			
Acrylic Dentures	Acr		
Acrylic Jacket Crown	AJC		
Crown			Crown required
			Crown present (insert other examples)
Crown and Bridge	C+B		Crown and bridge required
			Crown and bridge present
Full Gold Crown	FGC		
Implant	Implant		
Metallo-ceramic restoration/metal ceramic crown	MCC		
Porcelain Jacket Crown	PJC		
Post core	P/core		
PROSTHETICS REMOVABLE			
Addition	Add		
Chrome Cobalt	CrCo		
Full Denture, Mandibular Only	-/F		
Full Denture, Mandibular and	F/F		

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Maxillary			
Full Denture, Maxillary only	F/-		
Immediate Denture	Immed		
Partial Denture, Mandibular Only	-/P		
Partial Denture, Mandibular and Maxillary	P/P		
Partial Denture, Maxillary only	P/-		
Primary Impression	1° Imp		
Prosthetic	Pros		
Secondary Impression	2° Imp		
RESTORATIVE			
Amalgam	Amal		
Calcium Hydroxide	Ca(OH) ₂		
Class	Cl		
Composite Resin	CR		
Glass Ionomer Cement	GIC		
Interim Restoration	Temp		
Intermediate restorative material	IRM		
Overhang	o/hang		
Resin Modified Glass Ionomer	RMGI		
Restoration	Rest		Restoration required – outline entire surface where lesion is identified (eg. is two surfaces)
Vitrebond	Vbond		
Zinc Oxide Eugenol	ZOE		
Zinc Phosphate	Z _n PO ₄		
OTHER			

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Adjustment	Adj		
Alginate	Alg		
Biopsy	Bx		
Carbon Dioxide	CO ₂		
Chlorhexidine	CHx		
Impression	Imp		
Issue	Iss		
Management	mgt		Contextual note
Not Caries Free	NCF		
Post-operative (ly)	Post-op		
Post-Operative Instructions given	POIG		
Pre-operative	Pre-op		
Prescribe	Rx		
Rubber Dam	RDam		
Advise	Adv		
Appointment	Appt		
Date of Birth	DOB		
Dental Assistant	DA		Contextual note
Dental Hygienist	DH		Contextual note
Dental Officer	DO		Contextual note
Dental Prosthetists	DP		Contextual note
Dental Therapist	DT		Contextual note
Oral Health Therapist	OHT		
Fail to attend	FTA		
Further appointment made	FAM		
New Patient	N/P		
Next Visit	N/V		

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Patient	Pt		
Primary Oral Care	POC		
Priority Oral Health Program	POHP		
Recall	R/C		
Refer	Ref		
Relief of Pain	ROP		
Required	Req		
Review(ed)	Rev		
School Assessment Program	SAP		
Unable to attend	UTA		
Visiting Dental Officer	VDO		
Waiting list	W/L		

ORAL HEALTH SPECIALIST REFERRAL PROTOCOLS (PD2011_071)

PD2011_071 rescinds PD2010_027.

PURPOSE

This policy statement and attached protocol aim to improve referral pathways from public and private medical and dental practitioners to public specialist oral health services by establishing clear and consistent patient flow pathways for eligible NSW residents who require specialist oral health services.

MANDATORY REQUIREMENTS

Referral centres and referring practitioners are to ensure compliance with specific oral health speciality referral criteria, as approved by Public Dental Services and the processes as detailed in the Oral Health Specialist Referral Protocol.

The oral health specialist referral form is to be completed by a referring practitioner when referring a patient to a specialist service.

IMPLEMENTATION

Chief Executives must:

- assign responsibility and personnel to implement the guidelines;
- approve specific public dental services specialist referral criteria.

Medical and Dental Practitioners, Oral Health Clinical Directors and Oral Health Managers must:

- promote efficient patient flow pathways;
- monitor the implementation of the policy and specific public dental services criteria.

Referral Centres must:

- comply with the responsibilities detailed at section 3.3

Local Oral Health Staff must:

- comply with public dental services approved specialist referral processes and specific public dental services criteria.

1. BACKGROUND**1.1 About This Document**

This policy directive is aligned to the NSW Oral Health Strategic Directions 2005-2010, which sets the platform for oral health action in NSW into the next decade. The Oral Health Specialist Referral Protocols reflects the operating principles:

- Create better experiences for people using health services.
- Make smart choices about the costs and benefits of health services.

The Oral Health Specialist Referral Protocols aims to improve referral pathways from public and private medical and dental practitioners to public specialist oral health services. By standardising procedures and protocols between referring practitioners and specialist oral health services the policy will:

- increase the efficiency of specialist oral health services;
- improve the continuum of patient care;
- improve the level of feedback to referring practitioners.

The Oral Health Specialist Referral Policy and Protocols have been prepared by the Centre for Oral Health Strategy NSW and the State Oral Health Executive through a specialist referral review working group.

1.2 Key Definition

In this document the term:

- **Must** – indicates a mandatory action required that must be complied with.
- **Should** – indicates a recommended action that should be followed unless there are sound reasons for taking a different course of action.

NSW Public Dental Service

Throughout this document the term public dental service is used to describe the team of administration and clinical staff who provide public oral health services to eligible NSW residents.

1.3 Patient Management

As stated in NSW Health Policy Directive [PD2008_056](#) 'Priority Oral Health Program and List Management Protocols', dental treatment provided during a general course of care will depend on the patient's oral health needs, as determined by the treating clinician and as per public dental service's policies. In a general course of care the treatment that is provided should result in the patient being dentally fit.

Treatment flows depend on the severity and urgency of the condition; patients may be offered an appointment or placed on a list. List options are: assessment, treatment, referral and managed care. Should a patient require a specialist service following an assessment appointment, and they meet the clinical criteria for that service, a referral to a specialist Dental Officer can be made.

It is important that each dental patient referred for specialist consideration has a general dental clinician to act as his/her case manager. This clinician acts as the patient's advocate, first point of contact for specialist advice and follow-up and co-ordinator for referrals to other dental or medical specialists. Without a general dental practitioner as case manager, patients have the potential to undergo multiple cycles of specialist assessment and treatment, preventing other patients from accessing specialist assessments and treatments.

A guiding principle of the referral process, in both medical and dental practice, is that the patient remains under the clinical case management of the referring general practitioner. As such, the patient is to be managed at the referring oral health clinic for all emergency dental procedures, and for all presentations which are not covered by the referral and for ongoing management and follow-ups after the specialist course of care is completed.

1.4 Eligibility for Public Oral Health Services

The NSW Health 'Eligibility of Persons for Public Dental Care' policy directive defines eligibility for public dental care for NSW residents. Adult patients will require a valid health care card or pension card to qualify for specialist oral health care.

Only adults (18yrs and over) who are self holders of a valid Centrelink concession card are eligible for inpatient specialist dental services including orthodontic surgery and for non-admitted procedural dental specialist services such as endodontics, orthodontics, oral surgery, prosthodontics and periodontics.

All children and young persons (0-<18yrs) are eligible:

- to be referred for consultation;
- for the provision of non-admitted treatment in all specialties, except orthodontics;
- for admitted paediatric dental specialty services for conditions outlined in 11.2.1 – 11.2.4.

However, only children and young persons (0-<18yrs) who are self holders or whose parents/guardians are holders of a valid Centrelink concession card, are eligible for admitted paediatric dental specialty services for conditions outlined in 11.2.5 and 11.2.6 and for any orthodontic specialty service.

Exemption to these eligibility criteria can only be made for patients for teaching purposes and those patients with special clinical needs as authorised by Clinical Directors of Local Health District Oral Health Services or their formally authorised delegate/s. For these cases a service charge may be applicable.

1.5 Related Policy Directives and Guidelines

This Policy Directive should be read in conjunction with:

- Prevention of Osteonecrosis of the Jaw (ONJ) in Patients on Bisphosphonate Therapies¹
- Consent to Medical Treatment - Patient information²
- Correct Patient, Correct Procedure and Correct Site³
- Data collections - Disclosure of unit record data held for research or management of health services⁴
- Eligibility of Persons for Public Dental Care⁵
- Medical Records in Hospitals and Community Care Centres⁶
- Oral Health Record Protocols⁷
- Priority Oral Health Program and Wait List Management⁸
- Student Training and Rights of Patients⁹
- Waiting Times and Elective Patient Management Policy¹⁰

2. ORAL HEALTH SPECIALIST SERVICES

2.1 Referral Centres

Public oral health services in NSW provide specialist dental care at the three major oral health teaching facilities (Referral Centres) which are mainly associated with the University of Sydney, Faculty of Dentistry.

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¹ http://www.health.nsw.gov.au/policies/gl/2010/GL2010_010.html

² http://www.health.nsw.gov.au/policies/PD/2005/PD2005_406.html

³ http://www.health.nsw.gov.au/policies/pd/2007/PD2007_079.html

⁴ http://www.health.nsw.gov.au/policies/pd/2015/PD2015_037.html

⁵ http://www.health.nsw.gov.au/policies/PD/2009/PD2009_074.html

⁶ http://www.health.nsw.gov.au/policies/pd/2012/PD2012_069.html

⁷ http://www.health.nsw.gov.au/policies/pd/2008/PD2008_024.html

⁸ http://www.health.nsw.gov.au/policies/pd/2008/PD2008_056.html

⁹ http://www.health.nsw.gov.au/policies/pd/2005/PD2005_548.html

¹⁰ http://www.health.nsw.gov.au/policies/pd/2012/PD2012_011.html

These Referral Centres are:

- Sydney Dental Hospital (SDH), 2 Chalmers Street, Surry Hills 2010, telephone: 02 9293 3200.
- Westmead Centre for Oral Health (WCOH), Darcy Road, Westmead 2145 or PO BOX 533, Wentworthville 2145, telephone: 02 9845 7178.
- The Children's Hospital Westmead, Dental Department, Westmead, corner of Hawkesbury Road and Hainsworth Street, NSW 2145, 02 9845 2582.

Other NSW Local Health District Oral Health Services may also provide a limited range of specialist services. For further information contact the local Oral Health Service Call Centre (refer to <http://www.health.nsw.gov.au/cohs/contacts.asp>) closest to the patient's place of residence.

2.2 Specialist Service Type

The following specialist services are offered:

- General Anaesthesia
- Conscious sedation for dental procedures
- Endodontics
- Oral and maxillofacial surgery
- Oral radiology
- Oral medicine, oral pathology
- Orthodontics
- Paediatric Dentistry
- Periodontics
- Prosthodontics
- Special Care Dentistry

2.3 List Management

Referral Centres who place referred patients on a wait list for either assessment or treatment are required to inform both the patient and the referring practitioner. NSW Health has developed a policy directive for Waiting Times and Elective Patient Management, which identifies benchmark waiting times.

Note: that specialist waiting lists are not to be included in LHD general wait lists (refer to POHP and List Management Protocol Policy Directive).

3. REFERRAL PROCESSES

3.1 Reason for Referral

Referrals may be made for the following reasons:

- an opinion only, regarding a specific condition or particular aspect of the patient's care;
- management of a specific complaint or condition, subject to acceptance of the referral; or
- ongoing management of a patient whose oral health condition/overall medical status dictates that his/her oral health treatment needs be undertaken by a specialist clinician/institution, subject to acceptance of the referral.

3.2 Referring Practitioner Responsibilities

- Complete the oral health specialist referral form and write the date of the referral on the form.

- Ensure that all fields are completed for every patient. This includes:
 - patient's full name, address details and phone number;
 - Medicare card number, including the eleventh digit and expiry date;
 - any entitlement card numbers, stipulating type and expiry dates;
 - copies of relevant radiographs including OPGs (to avoid unnecessary repeat radiation exposure);
 - access issues and special requirements where relevant;
 - any medical test results; and
 - a brief medical history and indication of disability
- Ensure that the contact details of the referring practitioner are clearly recorded on the form.
- Ensure that the contact details (including telephone numbers) of the patient's general and specialist medical practitioner/s are clearly recorded on the form.
- When complete, post or transmit the referral form to the appropriate specialist service/referral centre.
- Send only one referral per clinical issue. That is, do not send a referral to multiple referral centres to increase the probability of an early outcome. Similarly, do not refer for multiple clinical issues on the same referral form, e.g TMJ, exodontia and endodontics, as this risks the referral being held up in one specialist department, while the second or third issue do not get prioritised.
- Inform the patient that waiting times for assessment and treatment usually apply, and that, until a specialist course of care commences, all dental treatment is to be managed at the local general dental practice level.

3.3 Referral Centre Responsibilities

- Acknowledge receipt of the referral in a timely manner.
- Log patient details into the NSW Health Information System for Oral Health (ISOH), attach the referral form to the patient's paper record and place a scanned copy into the patient's electronic record in ISOH.
- Review the referral (to a Specialist or Department Head) in accordance with the Specialist Referral Policy and Protocols and specific LHD referral criteria.
- Prioritise the patient according to identified need.
- Contact the patient to offer a consultation appointment. Inform the patient and the referring practitioner if wait lists are applicable for either consultation or treatment appointments.
- When an offer of assessment has been returned unacknowledged, the Referral Centre is to discontinue the referral and return the referral to the referring clinician for local management.
- Advise the referring practitioner of the outcome of the consultation/s and the proposed course of care, or the reasons for not proceeding with specialist service.
- Advise the referring practitioner on how to best manage the patient whilst waiting for a general anaesthesia if deemed required.
- Consult with the referring practitioner when proposed specialist care will impact on ongoing general oral health care and when necessary return the patient for general treatment to be completed before specialist services can commence. Maintain patient records by:
 - retaining a copy of the Specialist Referral Form and the original or duplicated radiographs as appropriate; and
 - attaching relevant documentation on the feedback process
- Comply with NSW Health Consent to Medical Treatment - Patient Information policy directive by informing the patient and/or carer/guardian about the risks and benefits of procedures such as intravenous sedation or general anaesthesia.

3.4 Referral Centre Caveats

- All referrals will be logged for consultation if they meet Specialist Referral criteria.
- Depending on the outcome of the specialist consultation, including further tests or analyses, a referral may not necessarily lead to treatment.
- Patients who do not meet the criteria for specialist referral will not automatically qualify for general treatment at the Referral Centre and will be returned to the referring clinic.
- Post-graduate trainees, students, registrars, or general dentists/therapists/hygienists may provide some or all of the treatment as appropriate under supervision of a specialist.

3.5 General Advice for Referred Patients

The Referral Centre should advise the referred patient and/or their carer/guardian that:

- they need to bring their valid Medicare card and any other entitlement cards (e.g. health care card or pension card) to their consultation appointment and their first treatment appointment;
- should a patient's eligibility status change during the course of treatment, they may be required to meet the costs of completing the treatment;
- if they are unable to consent to treatment a legal guardian must accompany them to the assessment appointment;
- treatment will continue only if patients actively maintain good oral health status, including compliance with recommended changes of behaviour (e.g. effective oral hygiene, cessation of nail-biting, wearing of functional appliances) and attendance for diagnostic tests;
- patients have a right to an interpreter or Aboriginal Liaison officer/health worker if they require assistance (Consent to Medical Treatment - Patient information PD). The interpreter or Aboriginal Liaison officer/health worker may attend the patient's appointments and the Referral Centre can organise this. (*Note: that this information is to be logged into ISOH.*);
- the initial specialist appointment is a consultation only to assess dental needs;
- if accepted for a specialist course of care, patients will invariably be placed on a treatment wait list, in accordance with the urgency of their assessed dental needs;
- treatment under oral sedation, intravenous sedation or general anaesthesia will be determined by the appropriate specialist service and not by the referring clinician.

4. GENERAL ANAESTHESIA FOR DENTAL PROCEDURES

The need for general anaesthesia (GA) represents the clinician's ultimate solution to treating a patient's dental problem. The decision to recommend general anaesthesia is not to be taken lightly as a risk of serious complications always exists. When deciding to place a patient under general anaesthesia, the treating dental clinician must consider the whole care of the patient.

To be exempt from a service charge, referred patients must hold a valid Centrelink entitlement card (e.g. valid health care card or pension card) (Point 1.4).

4.1 Key Referral Information

Prior to GA assessment appointments must be made to ensure a suitable treatment plan has been proposed and consented to, the patient's behaviour is such that a satisfactory outcome can be achieved and a home-care program is established which includes such aspects as tooth brushing instruction, referral to a dietician, instruction on the use of home fluorides and follow-up visits, as appropriate.

4.2 Index of Treatment Needs

Certain clinical situations strongly indicate the need for general anaesthesia, these are:

- severe odontogenic cellulitis or abscess/s;
- facial trauma;
- surgical management of pathology;
- multiple carious teeth requiring extraction and/or restoration.

Patients indicated for GA are to be assessed in accordance with the American Society of Anaesthesiologists (ASA 2008) categories of anaesthetic risk. These are:

- ASA Class 1 Health patient
- ASA Class 2 Mild to moderate systemic disease without significant limitations
- ASA Class 3 Severe systemic disturbance without limitations
- ASA Class 4 Life-threatening systemic disorder
- ASA Class 5 Moribund patient not expected to survive >24hrs
- ASA Class E Emergency patient

Most patients who are ASA 1 or 2 will be suitable for day-stay anaesthesia.

However, patients with more severe systemic disease (ASA 3 or 4) may need overnight hospital care to ensure that they are maintaining their airway, tolerating oral food and fluids, that any pain is satisfactorily managed and that there is no ongoing bleeding. This overnight hospitalisation would be in an acute or general hospital.

4.3 General Anaesthetic Services

General anaesthetic services for dental procedures are provided by a multidisciplinary anaesthetic and anaesthetic assistant workforce with specialist dental expertise in the management of the patient's presenting oral health condition (QG 2009).

Dental treatment made available under GA can be provided by a dental specialist, a general dentist who has been appropriately credentialed by local public dental services and/or a post-graduate specialist registrar under appropriate supervision.

The patient will have a pre-anaesthetic assessment with an anaesthetist prior to the GA to ensure that the patient is in an optimal state of health for the planned procedure (QG 2009).

The GA may be postponed if the anaesthetist determines risk factors such as:

- medications have not been attested by the patient, such as warfarin and/or bisphosphonate;
- respiratory tract infection; or
- patient has not fasted according to hospital instructions.

5. CONSCIOUS SEDATION FOR DENTAL PROCEDURES

Sedation for dental procedures (with or without local anaesthesia) includes the administration by any route or technique, of all drugs that result in depression of the central nervous system. Conscious sedation offers an efficient and effective way of providing the patient with profound anxiety relief and pain management during dental procedures.

For further information, refer to the Australian & New Zealand College of Anaesthetists, Faculty of Pain Medicine Australian and New Zealand College Of Anaesthetists, Gastroenterological Society of

Australia, Royal Australasian College of Surgeons, Australasian College for Emergency Medicine, College of Intensive Care Medicine of Australia and New Zealand, Royal Australasian College of Dental Surgeons, Royal Australian and New Zealand College of Radiologists Professional Document PS9 (2010): “*Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures*”.

To be exempt from a service charge, referred patients must hold a valid Centrelink entitlement card (e.g. valid health care card or pension card) (Point 1.4).

5.1 Key Information

The choice of general anaesthesia or conscious sedation will be decided at the specialist assessment/consultation using specific criteria based on health assessment, treatment complexity, behavioural problems and an anxiety assessment.

Detailed instructions will be given to the patient before any appointment for sedation or general anaesthesia. The patient must have a responsible adult to drive them home after the procedure.

5.2 Index of Treatment Needs

Referral for Conscious Sedation procedures includes patients in the following categories:

- Paediatric.
- Dento-alveolar surgery.
- Special Care Dentistry.
- Dental and/or needle phobias.

Patients who are unsuitable for Conscious Sedation include:

- IV drug users.
- Methadone patients.
- Patients with psychiatric disorders.
- Patients with significant health problems, e.g. ASA III or higher.

6. ENDODONTICS

All referred patients must hold a valid Centrelink entitlement card (e.g. valid health care card or pension card). (Point 1.4)

Prior to referral for endodontics it is essential that:

- the tooth is functional, free of active dental caries and well temporised by the referring practitioner. This may require placement of an orthodontic band;
- the referring clinician understands and accepts responsibility for all emergency and other dental care of the patient whilst waiting for specialist treatment;
- all other restorative treatment is completed prior to referral.

Where the patient is advised that a tooth is assessed as endodontically untreatable, they will be returned to the referred clinician for management.

6.1 Key Referral Information

Teeth that can be added to an existing functional partial denture without detriment to a patient’s oral condition will not be considered for endodontic treatment.

Additional factors that must be considered are the:

- status of the root canal *per se* and the reason for treatment (calcified, blocked, perforated, incompletely filled);
- condition of apical third of the root canal (i.e. open, closed, resorbed or eroded);
- strategic value of the tooth to the patient's future restorative needs, for example, as an abutment tooth for a denture;
- patient's medical and psychological conditions, age or infirmity which may impact on treatment provision or outcome;
- number of teeth already lost in the arch and presence of a partial denture;
- overall extent of treatment required in the mouth.

6.2 Index of Treatment Needs

Patients will be placed on a waiting list for definitive endodontic treatment according to the following Priority Codes:

6.2.1 Priority 1 (High Priority)

- traumatized and avulsed teeth. These include luxated, avulsed and fractured teeth;
- teeth with resorptive lesions or abnormalities. These include dens invaginatus & dens evaginatus, external or internal root resorption.

6.2.2 Priority 2 (Medium Priority)

- multi-rooted, restorable teeth important for function with difficult access to pulp chamber, or complications following attempted endodontic treatment, in a well maintained mouth;
- re-treatment cases, with history of pain, involving removal of root filling materials, procedural errors and cases involving surgery.

6.2.3 Priority 3 (Low Priority - Unlikely to be offered specialist care)

- single rooted teeth in a well maintained mouth that require straightforward endodontic treatment not necessarily requiring specialist attention;
- unopposed multi-rooted restorable functional teeth:
 - ~ in a poorly maintained mouth with no prospects of sustainable improvement in periodontal condition, or
 - ~ in a heavily restored mouth requiring multiple endodontic therapies.

7. ORAL AND MAXILLOFACIAL SURGERY

Oral and maxillofacial surgery offers treatment to patients requiring surgical management of trauma, developmental disorders or diseases involving the dento-facial, dento-alveolar or dento-maxillary complexes and associated structures.

To be exempt from a service charge, including anaesthetic, theatre and ancillary fees, referred patients must hold a valid Centrelink entitlement card (e.g. valid health care card or pension card). (Point 1.4)

7.1 Index of Treatment Needs

The scope of Oral and Maxillofacial Surgery Services is broad and includes:

7.1.1 Emergency treatment

- trauma - management of fractures of the facial skeleton including the primary and secondary management of hard and soft tissues and other injuries involving the mouth, jaws and associated structures;
- other - management of acute infections of the jaws and associated areas including complications following dental treatment, eg bleeding, infection.

7.1.2 *Dento-alveolar surgery*

- management of complex oral surgical procedures such as, endodontic surgery, removal of impacted teeth, management of benign tumours and cysts of the oral cavity, and oral surgical management of patients with significant medical problems

7.1.3 *Orthodontic/Orthognathic Surgery*

- the investigation, diagnosis and surgical correction of deformities of the face, jaws and related structures, including cleft lip and palate, utilising the principles of, and in association with, orthodontic management

7.1.4 *Prosthetic and pre-prosthetic surgery*

- surgical preparation of hard and soft tissues for prosthodontic treatments;
- the placement of implants into the jaws to provide retention for prostheses which replace missing teeth and/or missing tissues;

the placement of extra-oral implants can provide retention for a range of prostheses, such as maxillo-facial prostheses. These procedures are usually managed in conjunction with a maxillo-facial prosthodontist.

8. ORAL RADIOLOGY

This service provides intra-oral imaging for specific diagnostic needs, extra-oral planar and panoramic imaging, including cone beam volumetric imaging for:

- pathology screening and case work-up;
- oral surgery case work-up;
- prosthodontic case work-up including implant case work-up;
- orthodontic/Orthognathic case work-up;
- endodontics screening;
- paediatric dental screening; and
- periodontal screening.

With the advent of digital radiography, it is possible to take radiographs at referral centres or remotely, e.g. at acute care hospitals or private radiology practices, and have an oral radiologist or other dental specialist interpret the images. This electronic transmission or teleradiography may assist in rapid diagnosis, or even avoid patient travel.

9. ORAL MEDICINE/ORAL PATHOLOGY

Oral Medicine/Oral Pathology provide tertiary diagnostic and clinical services to the state of NSW by referral only. Services include:

- oral medicine/oral pathology;
- management of the severely medically-compromised patient requiring oral/dental care and treatment;
- management of conditions including the diagnosis of malignancy and treatment in conjunction with the Head and Neck clinical team;
- the investigation and management of diseases of the salivary glands;
- the diagnosis and management of patients with oral manifestations of auto-immune diseases;
- facial pain.

9.1 Key Referral Information

To be exempt from a service charge, referred patients must hold a valid Centrelink entitlement card, for example valid health care card or pension card (refer to point 1.4).

9.2 Index of Treatment Needs

Indications for referral are patients with:

- any form of suspicious oral lesion or disease;
- suspected cases of mouth/oral cancer and pre-cancerous conditions;
- complex oro-facial pain whose cause has defied explanation and treatment; and
- extensive or complex medical conditions that are best treated in a hospital environment, for example:
 - haemophiliacs,
 - post organ- and bone marrow-transplant recipients; and
 - patients who have had radiotherapy treatment to the head and neck region.

There are 3 priority categories as identified below:

9.2.1 Priority 1 (to be seen within two (2) working days/48 hours)

- suspected oral malignancy;
- severe, incapacitating (unable to eat or drink) oro-pharyngeal ulceration;
- severe, intractable, incapacitating oro-dental pain unrelieved by narcotic opiate agents;
- active dental/periodontal infection in a seriously immuno-compromised patient (chemotherapy or head and neck radiotherapy recipient, patients on significant immuno-suppressant therapy, especially anti-T-cell agents or cytotoxic drugs).

9.2.2 Priority 2 (to be seen at the next available appointment, or within four (4) weeks)

- significant intractable oro-pharyngeal ulceration or oro-dental pain unrelieved by narcotic analgesics;
- patients with suspected oral malignancy awaiting definitive radical surgery, radiotherapy or chemotherapy;
- prior to head and neck radiotherapy treatment;
- pre-transplant (organ or haematopoietic stem cell) or pre-heart valve replacement dental assessment.

9.2.3 Priority 3

- all other cases.

10. ORTHODONTICS

The criteria for referral of patients for public orthodontic services are as follows:

- orthodontic treatment will not be offered to patients who are not dentally fit, that is, who have active caries, chronic marginal gingivitis or whose oral hygiene is not sound;
- referrals must include details of the malocclusion, as listed in the table of treatment need (Table A), and a recent panoramic radiograph (OPG);
- if the patient is assessed as eligible for, and in need of, public orthodontic care the supervising Dental Officer should refer the patient to a designated Dental Officer for prioritisation of care. Note: A designated Dental Officer is a public dental officer who has sufficient orthodontic knowledge and expertise which includes:
 - the ability to recognise the need for interceptive care;
 - the ability to undertake minor orthodontics; and
 - the ability to prioritise severe cases for referral to specialists.

1.1 Key Referral Information:

To be exempt from a service charge, referred patients must hold a valid Centrelink entitlement card (e.g. valid health care card or pension card). (Point 1.4)

- Orthodontic treatment will only be offered to those patients who are dentally fit and who maintain an excellent standard of oral hygiene.
- If a patient does not maintain excellent oral hygiene during treatment and does not respond to an improvement program, treatment may be discontinued.
- Patients must bring a valid health care card or pension card to every visit.
- Any patient with a severe classification is likely to be accepted for treatment.
- Any patient with a moderate classification should be referred and assessed for suitability.
- Any patient with a mild classification will not be accepted for treatment.
- Any patient falling into the 'Other' category may be referred for assessment.
- All patients accepted for orthodontic treatment who are assessed as requiring a combined orthodontic/surgical (orthognathic) treatment must be a self holder or whose parents/guardians are holders of valid Centrelink concession card at the time of Request For Admission for surgery. If the patient under orthognathic treatment is no longer the holder or dependant of a Health Card Holder, then the patient's orthognathic surgery may be treated as private or compensable and the patient or parents/legal guardian will be responsible for payment of all fees raised by the hospital and providers. Such fees may include medication, bed costs, special nursing, surgical plates and screws, anaesthesia fees etc.
- The referring clinician should be able to recognise the need for early interceptive treatments and facilitate these treatments which may prevent more serious orthodontic problems in the future.
- The patient should be at an appropriate stage of development for the proposed orthodontic care.

10.2 Index of Treatment Needs

An internationally recognised system of classifying need, the Index of Orthodontic Treatment Need (IOTN) has been adapted. It is presented in table format for ease of use and understanding by referring clinicians (refer to Table A).

Seven occlusal traits have been listed:

- overjet
- overbite
- crowding
- crossbite
- reverse overjet
- hypodontia
- open bite

For each trait, there is a description of severe, moderate and mild. This will determine whether the patient is accepted for treatment.

Table A: Orthodontic Treatment Needs

MALOCCLUSION	SEVERE (eligible)	MODERATE (Refer for opinion)	MILD (Not eligible)
Overjet	> 7 mm	5 – 7 mm	< 5 mm
Overbite	100% coverage of lower incisor or complete to palate	more than 70% coverage of lower incisor	up to 50% coverage of lower incisor
Crowding	> 9 mm per arch	5 – 9 mm per arch	< 5 mm per arch
Crossbite	anterior/posterior crossbite with: <ul style="list-style-type: none"> ▪ enamel loss ▪ gingival trauma and/or anterior/posterior crossbite with functional shift	anterior/posterior crossbite of more than 2 teeth and/or unilateral posterior crossbite	anterior/posterior crossbite of 1-2 teeth with no functional shift
Reverse overjet	Presence of reverse overjet	edge-to-edge	
Hypodontia	multiple missing teeth with major orthodontic implications	one tooth missing with moderate orthodontic implications	Hypodontia with no need for orthodontic treatment
Open bite Anterior or Posterior	>4 mm	2 – 4 mm	< 2 mm
Other	Impacted/ectopic teeth other than third molars severe skeletal malocclusions/orthognathic cases facial deformities/congenital abnormalities/cleft lip and palate (CLD)		

2. PAEDIATRIC DENTISTRY

All children and young persons (0-<18yrs) are eligible to be referred for paediatric specialist consultation, for the provision of non-admitted treatment and for admitted services for conditions outlined in 11.2.1 – 11.2.4.

However, only children and young persons who are self holders or whose parents/guardians are holders of a valid Centrelink concession card, are eligible for admitted paediatric dental specialty services for conditions outlined in 11.2.5 and 11.2.6.

Exemption to these eligibility criteria can only be made for patients for teaching purposes and those patients with special clinical needs as authorised by Clinical Directors of Local Health District Oral Health Services or their formally authorised delegate/s. For these cases a service charge may be applicable.

11.1 Key Referral Information

For children in Group 6 (Point 11.2.6 below), attempts should be made to treat them using behaviour management techniques prior to referral. Referrals in this category should document these attempts to demonstrate which techniques have been successful and which have not worked.

11.2 Index of Treatment Needs:

The sub-sections below list conditions for which specialist paediatric dental services are provided at Sydney Children's Hospitals Specialty Network (Randwick and Westmead), Sydney Dental Hospital and Westmead Centre for Oral Health.

11.2.1 Group 1: Emergency Care

phone the department directly if necessary for all children and young persons aged 0-17 years, including:

- facial swelling or acute oro-facial infection;
- haemorrhage;
- dento-alveolar trauma.

11.2.2 Group 2: Children/Young persons

whose medical condition or general health is threatened if dental care is not provided, such as but not limited to:

- congenital/acquired cardiac condition;
- oncology, and/or;
- haematological diseases.

11.2.3 Group 3: Children/Young persons

with severe/chronic disease and/or functional disability, or with special health needs, such as:

- intellectually or physically disabled;
- requiring frequent medications.

11.2.4 Group 4: Children/Young persons

with congenital or acquired malformations of the jaws, face or teeth, orofacial pathology, such as:

- craniofacial malformations, e.g. clefts of lip and/or palate;
- dental anomalies, such as amelogenesis imperfecta, multiple supernumerary teeth;
- dento-alveolar pathology such as cysts, ulcers.

11.2.5 Group 5: Children 0-5 years

at high caries risk, such as:

- early childhood caries (either white spot demineralisation or cavitated lesions);
- requiring management under general anaesthesia or sedation.

11.2.6 Group 6: Children/Young persons

with behaviour management difficulties, such as:

- children over 6 years of age with extreme dental anxiety requiring management under general anaesthesia or sedation.

3. PERIODONTICS

The criteria for referral of patients for periodontic services are:

- Assessment and management of periodontitis.
 - patients must demonstrate a commitment to good oral hygiene, smoking cessation and attendance at appointments.
- Specialist consultation for reasons other than periodontitis as follows:
 - pre-surgical consultations;
 - management of soft tissue lesions;
 - assessment for crown-lengthening;
 - management of oral manifestations of systemic disease;
 - assistance with treatment planning etc.

12.1 Key Referral Information

Patients with gingivitis only are generally not accepted for treatment in the specialist department.

4. PROSTHODONTICS

Referring practitioners are advised, when practical, to discuss the referral with a specialist before referring their patient. It is essential that the patient has received a course of comprehensive care to ensure no pathology remains and the only remaining treatment need is that for specialist consideration.

If there is found to be outstanding treatment needs other than those specifically addressed in the referral, these will be directed back to the referring clinic, resulting in delayed specialist treatment.

13.1 Key Referral Information

- Patients who have lost their dentures, who are dissatisfied with a recently fabricated denture or who have only one or two teeth missing do not need a specialist prosthodontic referral. These are general denture services which are within the capability and responsibility of Local Health Districts.
- The referring practitioner remains responsible for the oral health and well being of the patient, including pain relief during the waiting period. Provision of temporary restorations is essential to ensure the stability of the remaining dentition while awaiting a specialist appointment.
- Any additional laboratory costs arising from specialist treatment are to be borne by the patient. The patient must be made aware of this prior to the referral.
- Ocular prostheses (prosthetic eyes) are provided by ocular prosthetists and not by maxillofacial prosthodontic specialists.

13.2 Index of Treatment Needs:

Patients will be considered for:

13.2.1 *Fixed dental prosthodontics*

crown and bridge work for dentate and partially dentate patients, for example:

- excessive incisal/occlusal wear;
- coronal restoration of endodontically treated teeth;
- over-closed vertical dimension; and
- cases requiring cast-metal based dentures which are not responsive to local efforts.

13.2.2 *Removable prosthodontics*

in cases identified below:

- a history of serious problems, chronic clinical complaints or dissatisfaction where all generalist efforts have been exhausted, for example:
 - ~ chronic non-retention;
 - ~ chronic denture soreness; and
 - ~ inability to wear an otherwise satisfactory prosthesis.
- A medical condition such as
 - ~ undergoing head and neck radiotherapy;
 - ~ salivary hypofunction/xerostomia;
 - ~ severely atrophic maxillary or mandibular ridges;
 - ~ flabby ridges;
 - ~ severe gag reflex; and
 - ~ significant anatomical defects such as mandibular or maxillary tori or cleft palate.

13.2.3 *Fixed and/or removable prosthodontics*

- for complex cases involving
- precision attachments;
 - osseointegrated implants; and
 - hybrid therapies.

13.2.4 *Complex cases may include:*

- gross occlusal wear not consistent with the patient's age;
- advanced tooth wear resulting from uncontrolled erosion, attrition, abrasion;
- occlusal collapse, or
- where restorative treatment will require multi-disciplinary management.

13.2.5 *Jaw function and oro-facial pain*

where there is no untreated pathology

13.2.6 *Chronic TMJ dysfunction*

it is essential that the referring practitioner has commenced occlusal splint therapy and advised the patient on other pain relieving actions, e.g moist heat packs when the case is acute.

13.2.7 *Specialist dental prosthetic treatment*

is provided to patients with oro-facial deformities, such as:

- intraoral - dentures, speech appliances or other appliances for alveolar resections, hard or soft palate fenestrations, cleft palate, mandibular resection and deviation, velo-pharyngeal incompetence, glossectomy of deformities resulting from surgical resection, reconstruction and/or radiotherapy;
- maxillo-facial - these mostly involve developmental or acquired facial disfigurement in which plastic surgery is contraindicated and a cosmetic prosthesis is required. Typically these cases involve an auricular, nasal or orbital prosthesis.

5. SPECIAL CARE DENTISTRY

The Referral Centres offer special services to a diverse client group with a range of disabilities and complex additional needs. This includes individuals and groups who have a physical, sensory, intellectual, mental, medical, emotional or social impairment or disability or, more often, a combination of a number of these factors.

14.1 Key Referral Information

- If the patient is unable to consent for his/her own dental treatment, the treatment plan will need to be discussed and consent for treatment signed by the legal guardian prior to commencement of care. Ability to consent must be noted in the referral and, if the patient does not self-consent, the name and address and contact details of the legal guardian must also be provided.
- A parent/carer/guardian is required to be present at all appointments for those patients who are unable to consent, or have significant physical or communicative disability.

14.2 Index of Treatment Needs

To achieve positive outcomes for the referred patient, the Referral Centres offer special services to address specific medical and/or social needs. These Referral Centres need the commitment of the patient/carer/parent/guardian to aspire to good oral hygiene¹¹ and attendance of appointments.

139(24/11/11)

¹¹ Good oral hygiene is achieved by the effective removal of dental plaque through twice daily tooth brushing including interdental areas and using fluoride toothpaste and augmented with antimicrobial agents (eg. mouthwashes). Individuals must be instructed in the most appropriate technique of oral health care that includes professional feedback and reinforcement to prevent relapse and disease progression (Löe, 2000)

14.3 Special Care Dentistry Services

Specialist services are as follows:

- Persons with mental illness/disorder/condition or disability (behavioural, and/or intellectual) who are not suitable for routine dental care or are living in:
 - aged residential care (retirement villages) or nursing homes;
 - hostels, group homes or boarding houses;
 - the community with their families or with help from professional carer.
- Persons who are homeless.
- Persons with serious medical conditions.
- Persons with physical disabilities (unable to walk unattended by carers, or using wheelchairs, walking frames, callipers, scooter or other mobility aid).
- Persons with sensory disabilities of a severity which preclude routine attendance at Public Oral Health Clinics.

6. SHORTENED TERMS

ASA	American Society of Anaesthetists
CJD	Creutzfeldt-Jakob Disease
CLD	Cleft lip and palate
GA	General Anaesthesia
HIV	Human Immunodeficiency Virus
HIV/AIDS	HIV/Acquired Immune Deficiency Syndrome
IOTN	Index of Orthodontic Treatment Needs
OPG	Panoramic Radiograph
POHP	Priority Oral Health Program
SDH	Sydney Dental Hospital
TMJ	Temporomandibular Joint
WCOH	Westmead Centre for Oral Health

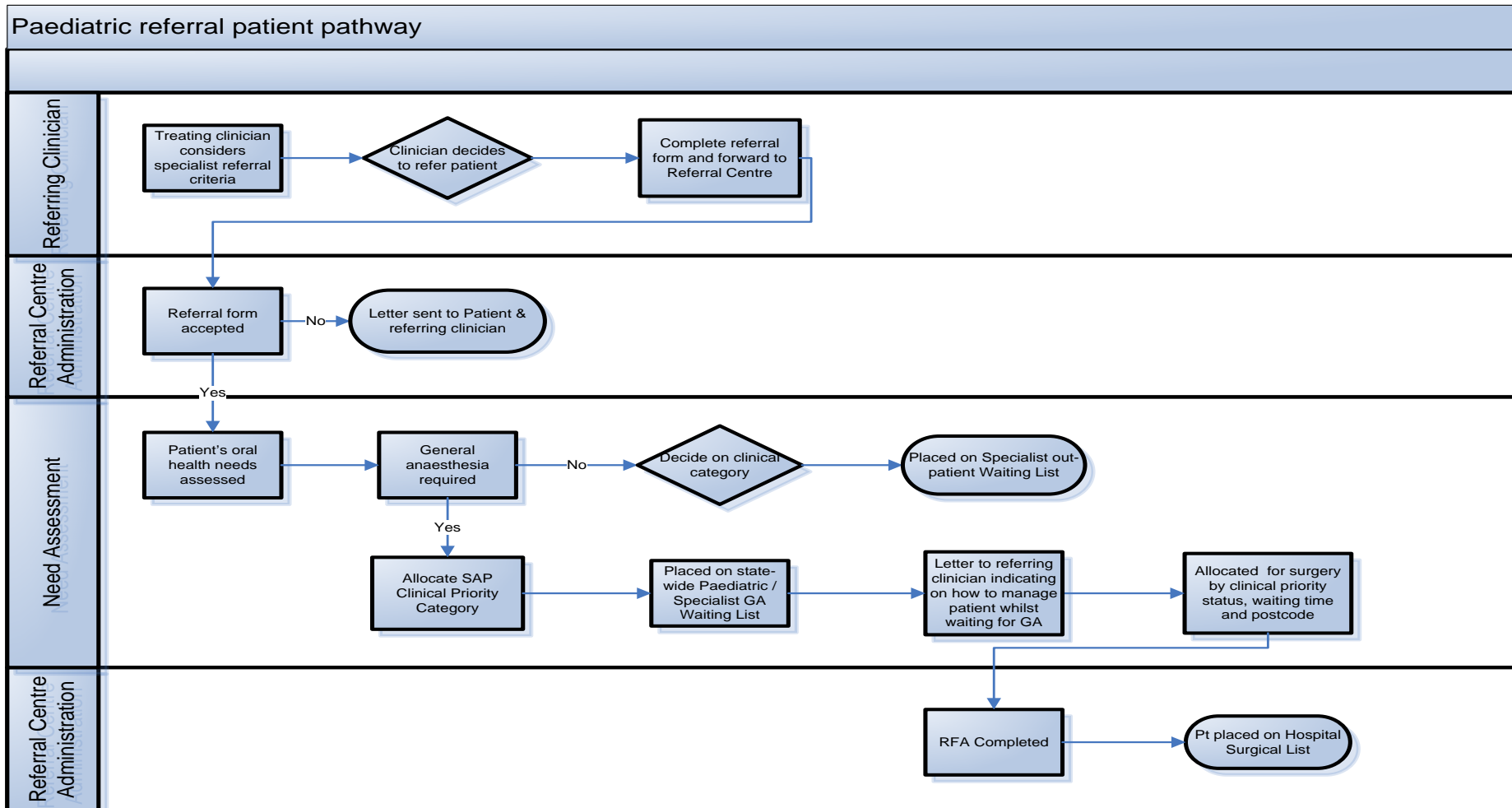
7. DEFINITION OF TERMS

Term	Definition
In-patient	Someone who stays overnight or for some time in a hospital for treatment or observation (Collins 2004 pg 198)
Non-admitted	The type of clinical service provided to a non-admitted patient in a non-admitted patient service event, such clinical services that are included are; allied health and/or clinical nurse specialist; dental; imaging; medical; obstetrics and gynaecology; paediatrics; pathology; pharmacy; psychiatric; surgical and emergency department (Australian Institute of Health and Welfare 2005)
Dental Caries	A chronic multifactorial life style based oral disease of microbial origin affecting the hard tissues of the tooth, commonly known as dental decay or cavities. Dissolution of the calcification tissues of the tooth by acid produced from ingested refined carbohydrates and micro-organisms in dental plaque. The process by which cavities are formed in teeth by gradual destruction of enamel and dentine. (Barnett, L.V 2000)

8. REFERENCES

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- Royal Australian and New Zealand College of Radiologists (2010): "Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures", Professional Document PS9

Appendix A - Paediatric Patient - Referral Flowchart (Sample)



DENTAL AMALGAM CLINICAL USE AND DISPOSAL (GL2020_015)

GL2020_015 rescinded GL2011_002

GUIDELINE SUMMARY

This Guideline provides recommendations on the clinical use and the safe disposal of dental amalgam when treating patients in public dental clinics.

It is to be read with *NSW Health Clinical and Related Waste Management for Health Services (PD2017_026)*.

KEY PRINCIPLES

NSW Health supports the specific measures outlined in the Minamata convention, by firstly improving oral health through systems and health promotion support, minimising the need for dental restorations. Where dental restorations are needed, current evidence-based approaches are supported, and cost-effective mercury free alternative materials are available to dental practitioners.

This Guideline also provides amalgam disposal practices to support environmental best practice to minimise the release of mercury compounds generated from dental clinics.

CLINICAL USE OF AMALGAM

Existing amalgam restorations remain safe and should not be removed or replaced with alternative restorative materials unless deemed strictly necessary by the dental practitioner. There is no evidence to justify the removal of dental amalgam restorations to relieve other systemic medical conditions or treat medical conditions (other than a proven allergy).

Cost effective, mercury-free alternative materials are available to dental practitioners to support modern evidence-based approaches to restorative care. These alternative materials should be favoured when treating patients who are pregnant, especially in the first trimester, breastfeeding mothers and those patients with severe renal disease and children under the age of 15.

Only pre-encapsulated amalgam is used when dental practitioners deem its necessity based on the specific medical and dental needs of the patient.

If placing or removing dental amalgam, clinical measures to reduce exposure to mercury vapour would include the use of rubber dam, ample water supply and evacuation.

WASTE MANAGEMENT OF DENTAL AMALGAM

The Minamata Convention on Mercury outlines measures to minimize the emission of mercury from dental practice into the environment to protect human health and the environment.

All clinics should be equipped with dental units that have amalgam waste traps that comply with ISO 11143.

Amalgam and amalgam-filled extracted teeth should not be placed in the 'general', yellow 'contaminated', or 'sharps' disposal containers, where contents are often incinerated.

Dental clinics should collect, store and ensure amalgam waste is sent to a licensed mercury waste processing facility for mercury recovery. These facilities recycle the mercury present in all the dental amalgam waste. If necessary, the Environment Protection Authority should be contacted for specific requirements for the disposal of mercury.

The Guideline can be downloaded from

https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2020_015

EMERGENCY DEPARTMENT DENTAL REFERRALS (GL2023_005)**GL2023_005 rescinded GL2010_008****GUIDELINE SUMMARY**

This Guideline provides direction on making appropriate dental follow-up referrals from NSW Health hospital Emergency Departments (EDs).

This Guideline is to be read in conjunction with the NSW Health Policy Directive *State Health Forms* ([PD2009_072](#)), NSW Health Policy Directive *Eligibility of Persons for Public Oral Health Care in NSW* ([PD2017_027](#)) and NSW Health Policy *Priority Oral Health Program (POHP) and Waiting List Management* ([PD2017_023](#)).

KEY PRINCIPLES

Dental conditions feature as a common reason for presentation to NSW Emergency Departments (ED). Information on the management of dental emergencies, within EDs can be accessed through the Agency for Clinical Innovation's Emergency Care Institute webpage on [Dental Emergencies](#).

At the point of discharge some patients may require further dental care related to their initial presentation at the ED. Without adequate follow-up care, these patients may re-present to the ED.

Commonly this may include patients that have presented with:

- Dental trauma
- Swelling of the face or neck of dental origin
- Swelling in the mouth of dental origin
- Significant bleeding from a dental origin
- Difficulty opening jaw and/or swallowing as a result of a dental infection
- Difficulty breathing due to a swelling of dental origin.

A discharge summary is to be provided to the patient for follow up dental care. The patients discharge summary must include:

- Details about the presenting condition
- Test completed (such as imaging, blood pathology)
- Details about the management of the presentation and any medications administered

Some patients presenting to the ED may be eligible for a referral to NSW public dental clinics.

Patients requiring routine dental care should seek care from their private dental practitioner or at a [NSW public dental clinic](#) (eligibility criteria apply). Patients are eligible to access public dental clinics if they meet all section criteria, on the [Dental Referral for Emergency Departments to NSW Public Dental Clinics](#) form. This includes all children under 18 and adults with a Pensioner Concession Card, a Health Care Card or a Commonwealth Seniors Health Card. This criterion is also outlined in the NSW Health Policy Directive *Eligibility of Persons for Public Oral Health Care in NSW* ([PD2017_027](#)).

If a referral to a NSW public dental clinic is required, the state-wide form [Dental Referral for Emergency Departments to NSW Public Dental Clinics](#) is to be used. This form is to be given to the patient on discharge.

Contact details for public dental clinics are on the form. In most cases the patient will be required to contact the public dental clinics. Vulnerable or priority patients may require staff assistance. The patient is required to bring the form to their dental appointment.

The Guideline can be downloaded at

https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2023_005

EARLY CHILDHOOD ORAL HEALTH GUIDELINES FOR CHILD HEALTH PROFESSIONALS, 3rd EDITION (GL2014_020)

GL2014_020 rescinds GL2009_017.

PURPOSE

The Early Childhood Oral Health Guidelines (the Guidelines) aim to improve the health and wellbeing of children in NSW by integrating oral health into general health interventions provided by child health professionals. The Guidelines add value to the NSW Personal Health Record, which includes oral health information for parents and a requirement to “lift the lip” and check for signs of dental disease during Child Health Checks.

KEY PRINCIPLES

The key principles of the Guidelines are that child health professionals should:

1. Advise pregnant women to visit a dentist for a dental examination and restoration of all active decay.
2. Provide preventive interventions to pregnant women and to new parents/caregivers.
3. Lift the lip of children aged 0-5 years to examine the upper front teeth and look for early signs of tooth decay (e.g. white or brown spots that don't brush off) and existing cavities.
4. Assess child's level of risk for oral disease. Provide preventive interventions to new parents/caregivers.
5. Advise parents/caregivers to reduce the frequency of sugar intake by limiting night time on-demand feeding after six months.
6. Advise mothers and carers to avoid transfer of oral bacteria to their child by maintaining good oral health themselves and by not placing food, utensils, dummies or teats into their own mouths and then into their child's mouth.
7. Provide dietary counselling to parents/caregivers that is specific to the child and their family and monitor compliance.
8. Provide oral hygiene and fluoride advice to parents/caregivers.
9. Provide information on teething to new parents/caregivers.
10. Provide an oral health assessment to a child by their first birthday.
11. Refer children at high risk for tooth decay to an Oral Health Call Centre, Early Childhood Oral Health Coordinator or Private Dentist.
12. Advise parents to talk to their children about dental visits in a positive way.
13. Provide oral health education for all child health professionals.

USE OF THE GUIDELINE

The Guidelines provide support material for child health professionals about oral health that complements their existing expertise by:

- Providing accurate oral health information to parents of children aged 0-5 years
- Assessing levels of oral disease risk for children aged 0-5 years
- Making decisions about appropriate referrals to oral health services.

To download the Guideline please go to

http://www.health.nsw.gov.au/policies/gl/2014/GL2014_020.html

EARLY CHILDHOOD ORAL HEALTH (ECOH) PROGRAM: THE ROLE OF PUBLIC ORAL HEALTH SERVICES (PD2013_037)

PD2013_037 rescinds PD2008_020.

PURPOSE

Oral Health is essential for health and wellbeing and early childhood is the time when most lifetime habits are established. It offers the greatest opportunity for prevention of disease, which, in turn, can contribute to better health in adulthood. This policy sets the framework for Public Oral Health Services in NSW to work collaboratively with key partners to implement the Early Childhood Oral Health Program in order to improve the oral health of the population.

MANDATORY REQUIREMENTS

- All child health professionals receive core oral health training and have access to regular periodic updates in oral health.
- All members of the oral health team are educated and trained to address the issues of children aged 0-5 years and are responsive to the prioritisation process for children who are at risk of Early Childhood Caries (ECC), including siblings.
- Referral information and supporting resources are available and accessible to child health professionals.
- Culturally appropriate oral health information and resources are available to Aboriginal people.
- Child health professionals who refer children receive timely feedback from the treating oral health professional.
- Administrative structures and procedures support the referral and feedback processes.

IMPLEMENTATION

An overview of responsibilities of key parties required in implementing this policy:

Centre for Oral Health Strategy (COHS) NSW:

- Develop, promote and review state-wide resources & training packages.
- Engage with Aboriginal Health personnel and communities in the development of culturally specific resources.
- Promote education of oral health personnel in early childhood oral health.
- Maintain a high level of consultation & liaison with key stakeholders.
- Monitor ECOH Program uptake.
- Monitor oral health outcomes.

LHD Oral Health Managers and Clinical Directors:

- Allocate adequate resources to implement and sustain the ECOH program.
- Support ongoing professional development for oral health staff.
- Prioritise 0-5 year olds and all eligible family members, who are in the 'high risk' category.
- Focus actions on higher risk groups, such as Aboriginal communities and others as identified by epidemiological and/or socio-demographic data.
- Ensure that administrative structures and procedures support referral, appointment, treatment and feedback processes where appropriate.
- Provide preventive information, resources and treatment to improve the oral health status of high risk groups.
- Ensure all children referred by a child health professional are enrolled in the Information System for Oral Health (ISOH).

ECOH Coordinators (or delegated Oral Health Professional):

- Train and provide periodic updates for child health professionals, including Aboriginal Health personnel.
- Distribute ECOH resources & relevant supporting information to both child health professionals and public oral health professionals.
- Monitor ECOH program uptake at the LHD level.
- Train oral health teams in ECOH prioritisation and appointment protocol.
- Participate in ECOH professional development sessions.
- Build collaborative LHD partnerships between oral health and general health professionals.
- Provide timely and accurate reports to LHD Management and to COHS.
- Provide timely feedback to referring agents.

Oral Health Clinicians:

- Provide timely feedback to referring professionals/agencies.
- Implement a family centred model of oral health care that recognises eligible family members for dental treatment where one family member has been referred for prevention and early intervention under the ECOH Program.
- Distribute resources and relevant material that support the ECOH program to parents/carers of young children.
- Liaise with and support the ECOH coordinator and participate in ECOH professional development sessions.

Oral Health Intake/Reception:

- Prioritise referrals from the ECOH Program.
- Record all children who enter the oral health service with a referral from a child health professional as a referral during their Priority Oral Health Program (POHP) triage in ISOH.
- When required, liaise with ECOH coordinators, child health professionals and oral health clinicians as required to facilitate a family centred approach to oral health care.

1. BACKGROUND

Early childhood caries (ECC) is a serious dental condition occurring during the preschool years of a child's life when developing primary (baby) teeth are especially vulnerable. ECC can occur as soon as the first tooth erupts. During the first 12 months post-eruption susceptibility of teeth to decay is high.

It can be a devastating condition often requiring hospitalisation and dental treatment under general anaesthesia (GA). The majority of children on GA waiting lists in NSW are under the age of 5 years. In 2010 - 2011, 1,509 children aged between 0-4 years of age received dental treatment under general anaesthesia in NSW¹³.

The pain, psychological trauma, health risks, and costs associated with restoration of carious teeth for children affected by ECC can be substantial.

Family circumstances, such as low socio-economic background, increase the risk of ECC. Thus, to be more effective and efficient, a holistic family-oriented approach is necessary.

The evidence strongly shows that ECC is one of the few chronic diseases that, if preventive messages are implemented, can be mostly prevented.

191(07/11/13)

¹³ Centre for Epidemiology and Evidence. Health Statistics New South Wales. Sydney: NSW Ministry of Health. Available at www.healthstatus.nsw.gov.au Accessed (Thursday, 4 April 2013).

Oral health checks are recommended during child health checks at 6-8 months, 12 months, 18 months, and 2, 3 and 4 years of age¹⁴.

2. DEFINITION OF EARLY CHILDHOOD CARIES (ECC)

The disease of ECC is defined as “the presence of 1 or more decayed (non-cavitated or cavitated lesions), missing (due to caries), or filled tooth surfaces” in any primary tooth in infants and preschool children¹⁵. In children younger than 3 years of age, any sign of smooth-surface caries is indicative of severe early childhood caries. Major contributing factors include prolonged and/or frequent bottle feeding, especially at night.

3. ASSOCIATED DOCUMENTS

This Policy Directive should be read in association with the following documents:

- Early Childhood Oral Health Guidelines for Child Health Professionals, 3rd Edition: GL2014_020.
- Pit and Fissure Sealants: Use of in Oral Health Services in NSW: PD2013_025.
- Oral Health – Eligibility of Persons for Oral Health Care in NSW: PD2009_074.
- Priority Oral Health Program and List Management Protocols: PD2008_056.

It should also be consistent with whole of government policies & plans:

- Healthy Mouths Healthy Lives: Australia’s National Oral Health Plan 2004-2013
- National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes Implementation Plan
- National Partnership Agreement for Oral Health
- Oral Health 2020: A Strategic Framework for Dental Health in NSW
- Department of Health and Aging MBS Primary Care Items: Healthy Kids Check

4. PRINCIPLES

- 4.1 Oral health is essential for health and well-being and must be integrated into the ‘general’ health agenda.
- 4.2 Poor oral health can have a serious impact on quality of life and good oral health in infancy and early childhood contributes to better health in adulthood.
- 4.3 Dental caries is a multifactorial disease and in early childhood is linked strongly to family behaviours and practices. Oral health services need to prioritise all eligible family members where one child is at high risk.
- 4.4 Intervening early makes good economic sense. Interventions targeted at young children will have much higher economic returns than later interventions. Policies that focus on the treatment of established problems or conditions are not sustainable.
- 4.5 Primary teeth are important for normal development, function and health. If children lose their primary teeth too early there can be an adverse effect on self-esteem, eating and the position of the adult teeth.
- 4.6 Generally, child health professionals¹⁶ have more opportunities to engage with and influence new parents, and to conduct risk assessments, than do oral health professionals.

191(07/11/13)

¹⁴ “My First Health Record” Personal Health Record, NSW Health 2007. SHPN (PHCP) 060174 ISBN 1741870178.

¹⁵ American Academy of Paediatric Dentistry.

¹⁶ Any health professional who works with children, including General Practitioners, Paediatricians, Child & Family Health Nurses, Aboriginal Health Workers, Speech Therapists, Dieticians, Drug and Alcohol Workers, and others as identified.

5. IMPLEMENTATION PLAN

Training

Procedure	Who	When	How
<ul style="list-style-type: none"> Provide child health professionals, including Aboriginal Health personnel, with core ECOH Program training and annual oral health updates 	ECOH Coordinators	When required	Train the trainer model developed by COHS.
<ul style="list-style-type: none"> Provide oral health teams with professional development in early childhood oral health 	COHS	In conjunction with ECOH Program roll-out	Regional in-services, supported by DVD
<ul style="list-style-type: none"> Provide oral health teams with training in referral and feedback procedures 	ECOH Coordinators	Prior to implementation. Include in AHS orientation & training programs	Develop local LHD protocols
<ul style="list-style-type: none"> Provide ECOH Program participants with access to supporting state-wide policies, guidelines and resources 	COHS	As appropriate	ECOH Policy Directive, evaluation of resources, development of culturally specific resources for Aboriginal and CALD communities

Referral and feedback

Procedure	Who	When	How
<ul style="list-style-type: none"> Check the mouth and assess the risk for dental disease in children aged 0-5, following participation in ECOH Program training 	Child health professionals	Child Health Checks and other opportunistic interventions	As per ECOH guidelines
<ul style="list-style-type: none"> Document findings and refer children at risk of dental disease to oral health services, using either paper-based or electronic referral system 		Following identification of risk of dental disease	Use referral template provided in ECOH guidelines
<ul style="list-style-type: none"> Prioritise referrals from the ECOH Program 	Oral Health Services	First client contact	Through the Priority Oral Health Program (ISOH) referral protocols
<ul style="list-style-type: none"> Routinely collect statistics on total number of referrals received 	Oral Health Services	Quarterly	Through LHD data collection processes
<ul style="list-style-type: none"> Provide timely feedback to referring professionals/agencies 	Oral Health Professional	Following the child's appointment	Develop local LHD protocols

Monitoring

Procedure	Who	When	How
<ul style="list-style-type: none"> Record all children who enter the oral health service with a referral from a child health professional as a referral during their Priority Oral Health Program (POHP) triage 	Oral Health Services	During POHP triage	Tick "Do you have a referral from an NGO, Community Health, GP, DoCS?"
<ul style="list-style-type: none"> Monitor ECOH Program uptake Report to COHS in a timely and uniform manner 	Oral Health Managers & ECOH Coordinators	Quarterly	Through LHD data collection processes
<ul style="list-style-type: none"> Monitor the number of families participating in the ECOH program 	Oral Health Services, COHS	As appropriate	Refer to Waiting list protocol. Participation in population oral health surveys
<ul style="list-style-type: none"> Develop an indicator that identifies ECOH referrals 	COHS	After general release of ISOH version 7	Through ISOH

6. ADDITIONAL INFORMATION**6.1 Web links**

- ECOH Guidelines for Child Health Professionals, 3rd Edition
http://www.health.nsw.gov.au/policies/gl/2014/GL2014_020.html
- My First Health Record: Personal Health Record
<http://www.health.nsw.gov.au/Kids/Pages/my-personal-health-record.aspx>
- Lift the Lip Posters
- Lift the Lip Translations http://www.mhcs.health.nsw.gov.au/topics/Dental_Care.html
- See My Smile brochure, Better Health Centre – Publications Warehouse
- Lift the Lip brochure, Better Health Centre – Publications Warehouse
- NH&MRC Public Statement on the Efficacy and Safety of Fluoridation 2007 www.nhmrc.gov.au
- Online learning: *early childhood oral health: case studies from general practice*
www.gplearning.com.au
- Oral Health Promotion Clearing House <http://www.adelaide.edu.au/oral-health-promotion/programs/>

6.2 For information on Oral Health Resources contact:

The Centre for oral Health Strategy (COHS) www.health.nsw.gov.au/cohs/
The Better Health Centre – Publications Warehouse (02) 9887 5450

PRIORITY ORAL HEALTH PROGRAM (POHP) AND WAITING LIST MANAGEMENT (PD2017_023)

PD2017_023 rescinds PD2008_056.

PURPOSE

This policy directive outlines the processes of dental triage, clinical assessment, and waiting list management for NSW residents who access public oral health services.

MANDATORY REQUIREMENTS

Public oral health services managed by NSW Local Health Districts (LHD) and Specialty Networks (SN) must prioritise and manage patient flows according to the processes set out in this Policy Directive.

IMPLEMENTATION**Chief Executives are responsible for:**

- Ensuring that this Policy Directive is implemented throughout the Local Health District/Specialty Health Network.
- Supporting the efficient and equitable delivery of oral health services including proactive management of demand.
- Regularly evaluating oral health service performance and ensuring that relevant reporting requirements are met.
- Ensuring that oral health services communicate effectively with patients and carers and treat all clients with respect and dignity.

Oral Health Service Clinical Directors and Service Managers are responsible for:

- Ensuring that clear administrative and clinical procedures are in place to facilitate the implementation of the Policy Directive.
- Conducting quality assurance activities to ensure that the triage, clinical assessment and waiting list management procedures and timeframes outlined in this Policy Directive are adhered to.
- Ensuring that excellent customer service practices are in place to facilitate effective and timely communication with patients. All patients and carers must be treated with respect and dignity.

Oral Health Contact Centre Staff are responsible for:

- Ensuring that excellent customer service practices are in place to facilitate effective and timely communication with patients. All patients and carers must be treated with respect and dignity.
- Ensuring that all patients are triaged in accordance with this Policy Directive.
- Ensuring that patient encounters are documented accurately and appropriately.

Dental Practitioners are responsible for:

- Complying with the procedures and clinical criteria set out in this Policy Directive.
- Prompt and appropriate communication with referring Medical Practitioners regarding the management of a referred patient.
- Contributing to the performance of the oral health service by providing services to patients in an efficient, conscientious manner.
- Providing excellent customer service to patients and carers.
- All patients and carers must be treated with respect and dignity.

Referring Health Practitioners are responsible for:

- Ensuring that adequate demographic and clinical details are provided when referring patients to oral health services.
- Initiating prompt and appropriate communication with oral health services should there be a change in indications for treatment or change in a patient's health with implications for treatment.

Patients and carers should:

- Seek public dental care by telephoning an oral health contact centre for triage.
- Inform the oral health contact centre of any change in patients' oral health complaint.
- Attend pre-treatment appointments as required by the oral health service (such as a clinical assessment appointment) and attend all appointments for treatment.
- Clearly communicate with oral health service staff:
 - Any change of address or other contact details
 - Inability to attend an appointment
 - Any change in decision to undergo a procedure

RELATED NSW MINISTRY OF HEALTH POLICIES

This Policy Directive should be read in conjunction with, but not restricted to:

- Early Childhood Oral Health (ECOH) Program: The Role of Public Oral Health Services ([PD2013_037](#))
- Health Assessment of Children and Young People in Out-of-Home-Care (Clinical Practice Guidelines) ([GL2013_010](#))
- NSW Patient Safety and Clinical Quality Program ([PD2005_608](#))
- Oral Health - Eligibility of Persons for Public Oral Health Care in NSW ([PD2016_050](#))
- Oral Health Fee for Service Scheme (OHFFSS) NSW ([PD2016_018](#))
- Waiting Time and Elective Patient Management Policy ([PD2012_011](#))
- Oral Health Specialist Referral Protocols ([PD2011_071](#))
- Oral Health Referral Form for Medical Emergency Departments (Guidelines) ([GL2010_008](#))
- Oral Health Patient Record Protocol ([GL2015_017](#))

Ministry of Health policies, guidelines and information bulletins are public documents and can be sourced from NSW Health's website: www.health.nsw.gov.au.

Priority Oral Health Program (POHP) and Waiting List Management: Procedures**CONTENTS****1 BACKGROUND**

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1 BACKGROUND**1.1 About This Document**

The Priority Oral Health Program and Waiting List Management Policy Directive has been developed to promote clinically appropriate, consistent and equitable management of patient access and waiting lists in NSW public oral health services.

1.2 Introduction

There is no Commonwealth scheme similar to Medicare that provides universal access to dental services. NSW Health provides a public dental system offering a range of services to children as well as adults who meet the eligibility criteria outlined below.

All children under 18 years of age in NSW are eligible for general dental services. To be eligible, adults must hold or be listed as a dependent on one of the following valid Australian Government concession cards:

- Health Care Card,
- Commonwealth Seniors Health Care Card or
- Pensioner Concession Card (includes Centrelink and Department of Veteran Affairs).

These criteria are outlined in more detail in the NSW Health *Eligibility of Persons for Public Oral Health Care in NSW* policy directive ([PD2016_050](#)).

Providing oral health care to eligible patients and the effective management of waiting lists is a priority for the Government and NSW Health. Public dental services are provided according to criteria that prioritise emergency situations, as well as patient groups in most need and at highest risk of disease.

Access to public dental services is mostly via an oral health contact centre, through which eligible patients are triaged and given a clinical priority depending on the seriousness of their condition. There is high demand for public dental services and therefore priority is given to the treatment of patients with urgent conditions within clinically appropriate timeframes. Patients with non-urgent conditions may be required to wait on a waiting list for care.

It is recognised that a patient may need to be re-triaged if their condition changes or deteriorates while on a waiting list. At the time of triage, patients and/or carers should be informed of what to do if their condition changes or they become concerned while waiting for care.

Patients and/or carers who are concerned about urgent medical conditions at point of contact should be encouraged to seek appropriate care through a General Practitioner, Aboriginal Medical Service or Hospital Emergency Department.

NSW Health services must actively manage access to oral health services in compliance with the contents of this document.

1.3 Key Definitions

Term	Definition
“must”	Indicates a mandatory action requiring compliance by staff at public health facilities, in accordance with a legislative requirement and/or policy directive.
“should”	Indicates a recommended action that should be followed unless there is a sound reason for taking a different course of action.
Adult	A person 18 years of age or over.
Assessment appointment	An appointment where the treating practitioner diagnoses the patient’s clinical condition and may provide treatment to stabilise the condition. The patient may then be assigned to an appropriate waiting list.
Assessment waiting list	A waiting list that patients are placed on after triage until an assessment appointment is made.
Assessment waiting time	Waiting time between the date the patient is placed on the assessment waiting list and the date an offer of care is made and/or the date they attend an assessment appointment.
Child	A person less than 18 years of age.
Comprehensive course of care	An appointment or series of appointments following a comprehensive examination (usually item number 011 or 012) that addresses all of the patient’s oral health needs.
Episodic course of care	A limited course of care provided with the intent of only addressing a specific, clinically urgent patient presentation (usually following a limited examination, item number 013).
Failure to Attend (FTA)	A patient has failed to attend a scheduled appointment when they: <ul style="list-style-type: none"> a) Do not arrive prior to the appointment time; or b) Do not ring to cancel the appointment
Oral health emergency	An oral health emergency is defined as dental trauma or injury; significant bleeding in the mouth; swelling of the face; swelling in the neck or mouth; or acute difficulty opening jaw and/or mouth. Dental pain by itself is not considered an oral health emergency.

Term	Definition
Practitioner	Dental Hygienist, Dental Officer, Dental Therapist, Oral Health Therapist, Dental Prosthetist or Specialist Dentist working in public oral health services.
Recall waiting list	The recall waiting list is only for patients waiting for treatment review of a specific clinical need within a defined timeframe where follow up dental care is required.
Recommended Maximum Waiting Time (RMWT)	A waiting period that oral health services must attempt not to exceed prior to an offer of care or an appointment being made. A RMWT is specified for all assessment and treatment waiting lists.
Specialist services	Services provided by a dental practitioner who is registered with the Dental Board of Australia as a specialist in a recognised oral health speciality.
Specialised services	Services provided by an oral health practitioner who has had specialised training or experience.
Treatment waiting list	A list that patients are placed on to wait for an appointment for a comprehensive course of care.
Treatment waiting time	Waiting time between the date the patient is placed on the treatment waiting list and the date a treatment appointment is made.
Triage	A phone or face-to-face interview using standard questions designed to determine a patient's oral health needs.

2 GENERAL DENTAL AND ORAL HEALTH SERVICES

2.1 Contact and Triage

Triage is the systematic prioritisation of patients according to the urgency of their need for care and is used to allocate oral health assessment and treatment priorities. Triage is an integral feature of the NSW Health system and allows limited resources to be allocated on the basis of clinical need and socioeconomic risk-factors. More information regarding triage can be found in the *Triage of Patients in NSW Emergency Departments* policy directive ([PD2013_047](#)).

All patients seeking access to public oral health services must be triaged by telephone, in person or by correspondence via a Local Health District or Specialty Health Network oral health contact centre. The patient is triaged and assigned an assessment priority code and then either wait listed or given an appointment, depending on the priority assigned and service capacity. A patient's triage priority is determined by a number of criteria including clinical condition, acuteness of any symptoms, and socioeconomic factors. The triage process utilises a standardised questionnaire, resulting in a triage code. The triage code will be assigned according to the patient's highest priority condition.

In addition to the telephone triage, patient referrals can be received from medical and allied health practitioners and through Local Health District/Specialty Health Network-specific strategies for priority populations (e.g. Early Childhood Oral Health, Out of Home Care).

2.1.1 Re-Triage Of Patients with Deteriorating Conditions

It is recognised that a patient may need to be re-triaged if their condition changes, deteriorates or additional relevant information is received. The purpose of re-triage is to acknowledge any change in clinical condition of the patient and reassign a new triage category if appropriate. Patients and/or carers should be informed at the time of triage what to do if their condition changes or they become concerned while waiting for care.

2.1.2 Telephone Advice

Oral health contact centre staff cannot provide clinical advice to the public. If the caller is requesting oral health clinical information, a senior dental practitioner may be asked to speak with the caller if available.

If the Triage Officer identifies that a caller requires general medical advice they should direct the caller to phone their General Practitioner or call the National Triage Telephone Advice Line (*Healthdirect Australia*) on 1800 022 222.

If the Triage Officer identifies that the call may be a medical emergency, they should direct the caller to hang up and phone 000 for assistance.

If the Triage Officer identifies that a caller is ringing about a mental health problem, they should direct the caller to phone the NSW Mental Health Line on 1800 011 511.

2.1.3 Rationale For Recommended Maximum Waiting Times

The *Priority Oral Health Program and Waiting List Management* policy directive has been developed to promote clinically appropriate, consistent and equitable management of oral health patients and waiting lists in NSW public oral health services and has been approved by the State Oral Health Executive Committee (SOHE).

Categorisation of both children and adult oral health patients by clinical priority is required to ensure they receive care in a timely and clinically appropriate manner. The priority codes and associated criteria are detailed in sections 2.1.4 Adult Triage Codes and 2.1.5 Child Triage Codes of this document.

The recommended maximum wait times used throughout this document are considered clinically appropriate in consideration of the likelihood of the patient's condition to:

- Deteriorate quickly to the point that it may become an emergency, or
- Impact on other medical conditions, or
- Impact the patient's general health and well-being

If a patient has a condition that has the potential to deteriorate quickly or become an emergency, they will be prioritised for care over a patient whose condition has less potential to become an emergency.

2.1.4 Adult Triage Codes

Priority	Adult Triage Criteria	Recommended Maximum Waiting Time
1*	<ul style="list-style-type: none"> • Patients with dental trauma or injury • Patients with symptoms of suspected dental origin that may include: <ul style="list-style-type: none"> ○ Swelling of the face or neck ○ Swelling in the mouth ○ Significant bleeding from the mouth ○ Difficulty opening jaw and/or swallowing <p><i>* Priority 1 patients should be given the earliest possible appointment and concurrently advised to attend an emergency department if they experience an acute deterioration prior to their appointment, or to seek medical attention if otherwise concerned.</i></p>	24 hours
2	Patients referred from a specialist medical practitioner requiring specific life-saving medical care (e.g. radiotherapy, chemotherapy, organ transplant, heart surgery or urgent assessment for specialist service)	3 days
3a**	<ul style="list-style-type: none"> • Patients with pain of suspected dental origin causing disturbed sleep • Patients who have had an ulcer for 3 weeks or more <p><i>**Priority 3a patients should be given an appointment, and concurrently advised to consider seeking medical attention from a general practitioner if their condition deteriorates, or to re-contact the contact centre to be re-triaged.</i></p>	1 week
3b^	<ul style="list-style-type: none"> • Patients with pain of suspected dental origin during waking hours <p><i>^Priority 3b patients should be given an appointment or waitlisted, and concurrently advised to consider seeking medical attention from a general practitioner if their condition deteriorates, or to re-contact the contact centre to be re-triaged.</i></p>	1 month
3c	<ul style="list-style-type: none"> • Patients who have a denture request involving missing upper front teeth that is required because: <ul style="list-style-type: none"> ○ There is no existing denture, OR ○ The existing denture causes pain, OR ○ The existing denture falls out while talking • Patients who are pregnant 	3 months

Priority	Adult Triage Criteria	Recommended Maximum Waiting Time
4	<p>For adult patients who meet one or more of the criteria below:</p> <ul style="list-style-type: none"> • Has a serious medical condition AND: <ul style="list-style-type: none"> ○ Takes medication regularly for this medical condition, OR ○ Sees a doctor regularly for this medical condition, OR ○ Has been hospitalised in the last 12 months for this medical condition • Has a physical or intellectual disability • Uses a wheelchair or is unable to leave home • Patient has the following living conditions: <ul style="list-style-type: none"> ○ Homeless ○ Boarding house/refuge/rehabilitation facility ○ Institution/group home ○ Care facility (hospice/aged care facility) • Arrived as a refugee within the last 12 months • Identifies as an Aboriginal and/or Torres Strait Islander • Referred from a medical practitioner • Referred from an Aged Care Assessment Team (ACAT) • Meets the criteria for a LHD-specific referral pathway 	6 months
5	<p>For adult patients requesting a check-up with one of the following concerns:</p> <ul style="list-style-type: none"> • Extractions • Needs fillings or complains of a broken filling • Broken or chipped tooth • Bleeding or sore gums • Loose teeth • Other denture requests including broken plate or clasp • Ulcers for less than three weeks^^ • Crown and bridge • Scale and clean • Clicking/grating in jaw joint • Halitosis (bad breath) <p><i>^^these patients will be given an appointment or placed on a waitlist and at the same time advised to see their medical practitioner for symptomatic management and to assess for medical causes of mouth ulceration.</i></p>	12 months
6	For patients who request a check-up without any of the above concerns.	24 months

2.1.5 Child Triage Codes

Priority	Child Triage Criteria	Recommended Maximum Waiting Time
1*	<ul style="list-style-type: none"> • Dental trauma or injury • Symptoms of suspected dental origin that may include: <ul style="list-style-type: none"> ○ Swelling of the face or neck ○ Swelling in the mouth ○ Difficulty opening jaw and/or swallowing ○ Significant bleeding from the mouth ○ Fever and/or refusing food and fluids <p><i>* Priority 1 patients should be given the earliest possible appointment and concurrently advised to attend an emergency department if they experience an acute deterioration prior to their appointment, or to seek medical attention if otherwise concerned.</i></p>	24 hours
2	Referral from a specialist medical practitioner for patients who require specific life-saving medical care (e.g. radiotherapy, chemotherapy, organ transplant, heart surgery or urgent assessment for specialist service)	3 days
3a**	<ul style="list-style-type: none"> • Symptoms of suspected dental origin that may include: <ul style="list-style-type: none"> ○ Swelling in the mouth ○ Pain in the mouth causing disturbed sleep ○ Ulcers in the mouth <p><i>**Priority 3a patients should be given an appointment, and concurrently advised to consider seeking medical attention from a general practitioner if their condition deteriorates, or to re-contact the contact centre to be re-triaged.</i></p>	1 week
3b^	<ul style="list-style-type: none"> • Pain in the mouth during waking hours <p><i>^Priority 3b patients should be given an appointment or waitlisted, and concurrently advised to consider seeking medical attention from a general practitioner if their condition deteriorates, or to re-contact the contact centre to be re-triaged.</i></p>	1 month

Priority	Child Triage Criteria	Recommended Maximum Waiting Time
3c	<ul style="list-style-type: none"> • Children 0-5 years of age • Referral from the Department of Family and Community Services (FACS) or Agency providing services to children under temporary care (includes Out Of Home Care). • Symptoms of suspected dental origin that may include: <ul style="list-style-type: none"> ○ Decayed tooth (may need filling or extraction) ○ Minor bleeding or sore gums ○ Over-retained primary tooth ○ Severe crowding affecting speech/eating ○ Broken or chipped tooth ○ Broken or chipped filling 	3 months
4	<p>For child patients who meet one or more of the criteria below:</p> <ul style="list-style-type: none"> • Has a serious medical condition AND: <ul style="list-style-type: none"> ○ Takes medication regularly for this medical condition, OR ○ Sees a doctor regularly for this medical condition, OR ○ Has been hospitalised in the last 12 months for this medical condition. • Has a physical or intellectual disability. • Uses a wheelchair or is unable to leave home. • Patient reports one of the following living conditions: <ul style="list-style-type: none"> ○ Homeless or Out of Home Care ○ Refuge/rehabilitation facility ○ Institution/group home • Arrived as a refugee within the last 12 months. • Identifies as an Aboriginal and/or Torres Strait Islander. • Meets the criteria for a LHD-specific referral pathway. 	6 months
5	<ul style="list-style-type: none"> • For patients requesting a check-up with one of the following concerns: <ul style="list-style-type: none"> ○ Loose teeth ○ Crowded teeth ○ Halitosis (bad breath) ○ Scale and clean • Child has a referral letter from: <ul style="list-style-type: none"> ○ Aboriginal Health Services (e.g. LHD AHW) ○ Aboriginal Community Controlled Health Services ○ Child and Family Health Nurse ○ Medical Practitioner ○ Practice Nurse ○ Private Dentist ○ Public Health Service (e.g. Allied Health, Maternity, Public Hospital) 	12 months
6	For patients who request a check-up without any of the above concerns.	24 months

2.2 Clinical Assessment

A clinical assessment is performed by a dental practitioner to confirm the clinical care priority of the patient. When the clinical care requirements of the patient are confirmed by the practitioner, one of the following courses of actions can occur:

- a) An episodic course of care is provided, then the course of care is closed.
- b) An episodic course of care is provided, then the course of care is closed and the patient is placed on a waiting list for other treatment needs.
- c) The patient is placed on a treatment waiting list for their treatment needs.
- d) No treatment is required.

2.3 Treatment Pathways

2.3.1 Episodic Care

The scope of episodic care is to provide relief of pain, treatment of infection, or to address dental trauma only.

Episodic care is provided after clinical need has been confirmed at the clinical assessment appointment, either at a public dental clinic or through the Oral Health Fee for Service Scheme (OHFFSS). In some limited circumstances, such as when a dental practitioner is not available to provide a clinical assessment, an OHFFSS voucher may be issued. More information about the OHFFSS can be found in NSW Health Policy Directive [PD2016_018](#).

2.3.2 Comprehensive Care

The scope of comprehensive care is to address all treatment needs of the patient, as appropriate.

All adults should be offered a course of comprehensive care after coming off a treatment waiting list. Where possible, children should receive a full comprehensive course of care after being appointed from triage. LHD/SN's must use the definitions of the codes and clinical criteria outlined in the tables below.

2.3.3 Adult General Dental Treatment Waiting List Codes

Priority Code	Clinical Categorisation	Criteria	Recommended Maximum Waiting Time
A	Confirmed Medical Priority	<p>The patient has been referred from a medical practitioner who has requested a dental examination preceding treatment for a medical condition. The condition should be of equal significance to:</p> <ul style="list-style-type: none"> • Head and neck cancer • Other cancers that require radiotherapy, chemotherapy or significant immunosuppression • Transplant surgery • Cardiac surgery • Intravenous antiresorptive therapy 	2 weeks
B	Pregnancy	The patient presents with poor oral health during pregnancy.	3 months
C	Chronic Disease/ Medically Compromised*	<ul style="list-style-type: none"> • At risk of developing endocarditis • At risk of developing medication-related osteonecrosis of the jaw • Has a significant psychiatric illness (e.g. requiring recent hospitalisation) • Dementia • Degenerative diseases • Has coagulopathy • Is living with HIV • Patient has poorly controlled diabetes • Patient has Special Needs • Significant Salivary hypofunction • Organ transplants / immunosuppressed <p><i>*Other conditions of equal clinical significance may be considered in consultation with a Clinical Director.</i></p>	6 months

Priority Code	Clinical Categorisation	Criteria	Recommended Maximum Waiting Time
D	Urgent Denture Needs	The patient is confirmed to have urgent denture needs due to: <ul style="list-style-type: none"> No existing denture and missing maxillary anterior teeth Existing maxillary denture that is displaced whilst speaking No existing maxillary denture with social impairment, or where lack of denture will result in damage to supporting structures 	9 months
E	High Treatment Needs	<ul style="list-style-type: none"> Three or more teeth present with carious lesions Periodontal Screening & Recording Code 3 or greater All other denture needs not included in Code D 	12 months
F	Low Treatment Needs	<ul style="list-style-type: none"> All other assessed treatment needs 	24 months

2.3.4 Child General Dental Treatment Waiting List Codes

Priority Code	Clinical Categorisation	Criteria	Recommended Maximum Waiting Time
A	Confirmed Medical Priority	Situations where failure to provide dental treatment would delay the commencement or progress of urgent medical treatment.	2 weeks
B	Urgent Treatment Needs	<ul style="list-style-type: none"> Special need patients who have extensive treatment needs Dental anomalies are present that require management Dental anomalies are present in the permanent dentition 	3 months
C	High Treatment Needs	<ul style="list-style-type: none"> Carious lesions and/or periodontal disease are present 	6 months
D	Low Treatment Needs	<ul style="list-style-type: none"> All other assessed treatment needs 	12 months

3 SPECIALIST / SPECIALISED ORAL HEALTH SERVICES

LHD/SN's may operate specialist and/or specialised child and adult services that are prioritised according to the tables below. Specialist and specialised services are those identified in the *Oral Health Specialist Referral Protocols* Policy Directive ([PD2011_071](#)). The clinical priority categories in the tables below align with the [Australian National definitions for elective surgery urgency categories](#).

It is recognised that there may be slight variation in the waiting times for different specialties based on clinical staging.

3.1 Specialist/Specialised Dental Referral Waiting List Codes

Priority	Definition	Recommended Maximum Waiting Time
1	Assessment clinically indicated within 7 days	7 days
2	Assessment clinically indicated within 30 days	30 days
3	Assessment clinically indicated within 90 days	90 days
4	Assessment clinically indicated within 365 days	365 days

3.2 Specialist/Specialised Dental Treatment Waiting List Codes

Priority	Definition	Recommended Maximum Waiting Time
X	Procedures clinically indicated within 30 days	30 days
Y	Procedures clinically indicated within 90 days	90 days
Z	Procedures clinically indicated within 365 days	365 days

4 MANAGED CARE PROGRAMS

Managed care programs seek to improve health outcomes for particular patient groups. Adults and children who receive care under managed care programs may be placed on a recall list. Recall lists are only for patients that need review of a specific clinical need within a defined timeframe.

It is recommended that patients who require recall are allocated only by dental practitioners following a course of care, consultation or referral/review.

Local guidelines should be established to ensure a structured approach to managed care.

5 ADMINISTRATIVE PROCESSES

5.1 Movement of Patients between Local Health Districts

When a patient moves to a locality serviced by another LHD/SN:

- The previous LHD/SN oral health service must advise the receiving service of the patient's current waiting list status, if requested; and
- The transferred waiting list status must include the original listing date to avoid disadvantaging the patient.

Due to funding and reporting arrangements, oral health care will normally be provided by the LHD/SN in which a patient lives. However, LHD/SN's may have inter-district arrangements that allow for patients to receive care in a bordering district to facilitate accessibility to an appropriate service.

5.2 Management and Auditing Of Waiting Lists

Managing waiting lists is a key priority for the Government and NSW Health. LHD/SN's should have appropriate staff training programs, protocols and processes in place to ensure a high standard of data quality is maintained within oral health information systems.

Waiting list monitoring should be undertaken on a regular basis (at least monthly).

Measures should be put in place to ensure that documentation provides a clear audit trail that can identify:

- Any changes made to a patient's wait list status and type
- Patients who have completed their treatment and should be removed from the waiting list
- Duplicate list entries
- Whether waiting times are within timeframe

Any one patient should only be waiting on one type of treatment waiting list (the highest priority that they meet the clinical criteria for) at any point in time.

5.3 Missed or Cancelled Appointments.

1.	Type of Non-Attendance	2.	Definition
3. 4.	Failure to Attend (FTA)	5. a) b)	A patient has failed to attend a scheduled appointment when they: do not arrive prior to the appointment time; or do not ring to cancel the appointment (Refer to UTA)
6. 7.	Unable to Attend (UTA)	8.	A patient or carer has notified the service prior to the appointment time that the patient will not be able to attend for the appointment. The patient's reason for nonattendance should be documented.
9. 10.	Dental Organisation Cancelled Appointment (DOC)	11.	The oral health service cancels or reschedules an appointment. An apology and explanation should be given to the patient in these circumstances.

- Local processes should be implemented to minimise/manage non-attendance.
- Patients must be fully informed that a requirement for ongoing care is to inform the oral health service if they are unable to attend their scheduled appointment.
- A patient who has two (2) FTA appointments during a course of care may have their course of care discontinued. The LHD/SN should exercise discretion on a case by case basis to avoid disadvantaging patients in cases of a genuine hardship, misunderstanding and other unavoidable circumstances.
- LHD/SN's should have an active strategy to identify and assist vulnerable persons who regularly fail to attend (FTA) appointments without adequate prior notification, for example people with a mental illness, the frail and aged, and people experiencing homelessness.
- When the patient contacts the oral health contact centre after an FTA they may be required to re-register their oral health needs via a POHP triage. Local LHD/SN policies regarding patients who FTA their appointments should be complied with.

SMOKING CESSATION BRIEF INTERVENTION IN ORAL HEALTH SETTINGS (PD2021_016)

PD2021_016 rescinds PD2021_014 and PD2015_030

POLICY STATEMENT

Tobacco smoking is a leading cause of preventable chronic disease, including periodontitis and oral pharyngeal cancer, and premature death in Australia. Tobacco use is more prevalent in disadvantaged groups who are served in public oral health settings. Dental practitioners and dental assistants in NSW public oral health settings can play a pivotal role in engaging with patients and supporting them to modify their risk practices. Dental practitioners must consider providing brief advice and support to patients, through smoking cessation brief interventions as appropriate to the clinical situation.

SUMMARY OF POLICY REQUIREMENTS

Dental practitioners and dental assistants are expected to be appropriately trained in delivering smoking cessation brief interventions. Mandatory training is available via *My Health Learning*.

All patients aged 14 years and over are to have their use of tobacco or other similar substances assessed and recorded in the oral health record, unless doing so would be clinically inappropriate.

Where the setting is appropriate, all patients who smoke are to be approached in a nonjudgmental way about their smoking and be provided advice to quit. Dental practitioners must record the smoking cessation advice offered in the patient's oral health record.

Consenting patients are to be offered a referral to a smoking cessation support service. Oral health executives must ensure that supporting resources are available. Local health districts and the Ministry of Health are to monitor local smoking cessation brief intervention activities.

Go to https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=pd2021_016 to view the **Smoking Cessation Brief Intervention in Oral Health Settings Policy and Procedures**.

ORAL HEALTH: CLEANING, DISINFECTING AND STERILISING (PD2013_024)**PD2013_024 rescinds GL2005_037.**

The purpose of this policy directive is to provide minimum standards for cleaning, disinfecting and sterilizing in oral health care settings for the maintenance of a safe and healthy environment for patients, visitors and staff. This policy must be read in conjunction with NSW Health Infection Control Policy PD2007_036 and Hand Hygiene Policy PD2010_058.

MANDATORY REQUIREMENTS

NSW Health is committed to ensuring health and safety for patients in the oral health care setting and providing a healthy working environment for all oral health employees. This includes adopting and maintaining infection prevention processes that minimise the risk of oral health patients and oral health providers acquiring a health-care associated or occupational infection. For this to be achieved NSW Local Health Districts must implement the ‘Oral Health: cleaning, disinfecting and sterilizing standard operating procedures’, and:

- successfully promote and implement the Oral Health cleaning, disinfecting and sterilizing procedures through annual auditing processes;
- implement facility wide auditing of oral health practices, which is reported to the Local Health District Chief Executives; and
- set the example: Chief Executives, Health Service Executives, Directors of Clinical Governance, Oral Health Managers and Oral Health Clinical Directors implement and sustain infection prevention practices in all patient care activities.

All health care services and health care workers have a common law duty of care to take all reasonable steps to safeguard patients, staff and the general public from infection. The *Work Health and Safety Act 2011*¹⁷ (WH&S) prescribe the employer’s duty of care to provide a safe and healthy working environment for all employees and other persons on their premises.

The *WH&S Act* also prescribes responsibilities for managers (who manage WH&S within the areas they are responsible for) and employees (who must cooperate with the employer and not put anyone at risk by their acts or omissions). There is also a requirement for employers to provide the information, instruction, training and supervision necessary to ensure the health and safety of employees at work.

IMPLEMENTATION

The policy directive and standard operating procedures are to be used in the public dental services, as well as providing guidance to private oral health facilities, such as universities, TAFE and private practices. To implement the policy effectively the following roles and responsibilities are required.

Roles and Responsibilities*NSW Ministry of Health*

- Ensure the mandatory requirements and standards of this policy are monitored and acted on accordingly.

Chief Executives of Local Health District

- Assign responsibility and personnel to implement the cleaning, disinfecting and sterilization processes identified in Oral Health: cleaning, disinfecting and sterilizing standard operating procedures.

182(15/08/13)

¹⁷ http://www.comcare.gov.au/laws_and_regulations/ohs_act_regulations_and_code

Oral Health Clinical Directors and Oral Health Managers

- Provide oral health clinicians, patients and visitors with the means to perform infection control processes;
- Provide support to oral health line managers to implement and sustain infection control processes in oral health settings; and
- Manage oral health staff/s who doesn't comply with the policy, in accordance with NSW Health policy directives for staff performance management.

1. BACKGROUND

The Oral Health: cleaning, disinfection and sterilizing standard operating procedures' document has been developed in accordance with the NSW Health Infection Control Policy¹⁸; Acts and Regulations that define the registration requirements for Dentists, Dental Therapists, Dental Hygienists, Oral Health Therapists, Dental Prosthetists and Dental Technicians^{19,20}; available scientific evidence; and consultations with key stakeholders.

The standard operating procedures (SOP) was developed by the Centre for Oral Health Strategy NSW and State Oral Health Executive through a working group consisting of representatives from Department of Health, Local Health Districts and Infection Control Experts. The SOP was reviewed by the NSW Health Healthcare Associated Infections (HAI) Expert Advisory Group and the Clinical Excellence Commission for accuracy.

In this standard the term:

Must – indicates a mandatory action required that must be complied with.

Should – indicates a recommendation action that should be followed unless there are sound reasons for taking a different course of action.

The SOP is to be read in conjunction with the following NSW Health policies and programs:

- Environmental Cleaning²¹
- Hand Hygiene²²
- Hand Hygiene In Out Patient Care²³
- HIV, Hepatitis B and Hepatitis C – Management of Health Care Workers Potentially Exposed²⁴
- HIV, Hepatitis B or Hepatitis C – Health Care Workers Infected²⁵
- Incident Management²⁶
- Infection Control Management of Reportable Incidents²⁷
- Infection Control Policy²⁸
- Infection Control Policy: Animals as Patients in Health Organisations²⁹
- Infection Control Policy: Prevention & Management of Multi-Resistant Organisms (MRO)³⁰
- Infection Control Program Quality Monitoring³¹

182(15/08/13)

¹⁸ http://www.health.nsw.gov.au/policies/pd/2007/PD2007_036.html

¹⁹ <http://www.legislation.nsw.gov.au/maintop/view/inforce/subordleg+333+2010+cd+0+N>

²⁰ <http://www.legislation.nsw.gov.au/sessionalview/sessional/sr/2008-190.pdf>

²¹ http://www.health.nsw.gov.au/policies/pd/2012/PD2012_061.html

²² http://www.health.nsw.gov.au/policies/pd/2010/PD2010_058.html

²³ <http://www.hha.org.au/home.aspx>

²⁴ http://www.health.nsw.gov.au/policies/pd/2005/PD2005_311.html

²⁵ http://www.health.nsw.gov.au/policies/PD/2005/PD2005_162.html

²⁶ http://www.health.nsw.gov.au/policies/pd/2007/PD2007_061.html

²⁷ http://www.health.nsw.gov.au/policies/PD/2005/PD2005_203.html

²⁸ http://www.health.nsw.gov.au/policies/pd/2007/PD2007_036.html

²⁹ http://www.health.nsw.gov.au/policies/pd/2009/PD2009_030.html

³⁰ http://www.health.nsw.gov.au/policies/pd/2007/PD2007_084.html

³¹ http://www.health.nsw.gov.au/policies/PD/2005/PD2005_414.html

- Lookback Policy³²
- Occupational Assessment, Screening & Vaccination Against Specified Infection Diseases³³
- Sharps Injuries – Prevention in the NSW Public Health System³⁴
- Waste Management Guidelines for Health Care Facilities³⁵
- Work Health and Safety: Better Practice Procedures³⁶

2. GOAL

The goal of this standard operating procedure document is to identify processes that aim to provide a safe clinical environment that protects the health and wellbeing of all patients who access public dental services and all dental staff.

3. KEY DEFINITIONS

Anti-reflux valve	is a valve that only allows liquid to flow one direction. Previously known as Anti-retraction valve.
Cleaning	is the physical removal of soil and organic matter from surfaces and other objects using a detergent and water. Cleaning reduces the numbers of microbes on surfaces and prevents multiplication with the production of many organisms by removing organic matter. A clean dry surface is generally hostile to the reproduction of microorganisms. ³⁷
Clinical Area	is an area that is made of one or more collocated dental surgeries.
Clinical Waste	is waste which has the potential to cause sharps injury, infection or offence. When packaged and disposed of appropriately there is virtually no public health significance. Clinical waste contains the following types of waste: <ul style="list-style-type: none"> • sharps; • human tissue (excluding hair, teeth and nails); • bulk body fluids and blood; • visibly blood stained body fluids and visibly blood stained disposable material • and equipment; • laboratory specimens and cultures; • animal tissues, carcasses or other waste arising from laboratory investigation or for medical or veterinary research³⁸.
Decontamination	is a process that renders equipment, or environmental surfaces safe to handle by cleaning and disinfection or sterilization (PD2007_036).
Disinfection	means the destruction of pathogenic and other kinds of micro-organisms by thermal or chemical means. Disinfection is less lethal than sterilization, because it destroys the majority of recognised pathogenic micro-organisms, but not necessarily all microbial forms (eg bacterial spores). Disinfection does not ensure the degree of safety associated with sterilization processes. (PD2007_036 page iv).

³² http://www.health.nsw.gov.au/policies/pd/2007/PD2007_075.html

³³ http://www.health.nsw.gov.au/policies/pd/2011/PD2011_005.html

³⁴ http://www.health.nsw.gov.au/policies/pd/2007/PD2007_052.html

³⁵ http://www.health.nsw.gov.au/policies/pd/2005/PD2005_132.html

³⁶ http://www.health.nsw.gov.au/policies/pd/2013/PD2013_005.html

³⁷ http://www.health.nsw.gov.au/policies/pd/2012/PD2012_061.html

³⁸ http://www.health.nsw.gov.au/policies/PD/2005/PD2005_132.html

Four-handed dentistry	is the cooperative action of the treating clinician and assistant to significantly enhance overall productivity, efficiency and effectiveness.
NSW Health Services	consists of staff employed in all Local Health Districts, all statutory health corporations, the Ambulance Service of NSW, Institute of Medical Education and Training, Health Technology, Health Support and any declared affiliated health organisations.
Operating Area	is the area set aside as the primary working area includes patient's mouth, bracket table and dental assistant's kit.
Patient	includes (but is not limited to) a person who is accessing medical or health services or who is undergoing any medical or health procedure.
Sharp	is any object capable of inflicting a penetrating injury, which may or may not be contaminated with blood and/or body substances. This includes needles and any other sharp objects or instruments designed to perform penetrating procedures (PD2007_036 page v).
Sterile	is free from all living micro-organisms, usually described as a probability (eg the probability of a surviving microorganism being 1 in 1 million) (PD2007_036 page v).
Sterilization	is the destruction of all living organisms, including spores (PD2007_036 page v)
Surgery Zones	are developed to keep the surgery as clean as possible during the course of treating patients. The zones are clean, grey and dirty.
Technical Procedures	are those procedures carried out by dental technicians within the dental laboratory.

4. DENTAL AND CLINICAL PRACTICE

4.1 Surgery Zones

The surgery zones are designated as clean, grey and dirty and are to be identified in the clinical area (refer to picture below). Clean zones are where no contaminated items enter. The grey zone is centred on the patient's mouth and includes the clinician and assistant work surfaces. Dirty zones are where contaminated instruments are placed to start the cleaning and/or disinfection and/or sterilizing process. Dirty zones are not in the surgery.



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4.2 Placement of equipment

Equipment should be positioned as follows:

- primary work surface (grey zone), usually on top of the assistant's cart and on the bracket table, where instruments and equipment of direct relevance to the appointment should be placed;
- when using equipment that cannot be sterilized such as amalgamators and curing lights, barrier film/s and/or disinfection must be carried out as per manufacturer's instructions after each patient;
- all other items that are not involved in the procedure such as the clinical record, patient notes, radiographs, computer key board and mouse must remain in the clean zone. To access these items in the clean zone gloves must be removed and hand hygiene performed;
- if other items, equipment or consumables are required during the procedure they should be retrieved by the assistant by:
 - using transfer forceps that are cleaned and disinfected between patients, or single use only, and stored in the clean zone; or
 - removing gloves and performing hand hygiene before and after retrieving equipment.

Exemptions may occur depending on the design of the dental unit as some equipment may be attached to the unit, such as the curing light and would therefore remain in the grey zone. This equipment must be covered with a barrier film to minimize bacterial/microbial load. Decontamination of this equipment must be carried out as per the manufacturer's instructions.

4.3 Dental practice processes

Clinicians and assistants should be trained in four handed dentistry techniques to improve safety and performance as it is considered to be the ideal way to deliver of care^{40 41}.

4.3.1 Pre-plan, pre-set, pre-dispense, reprocessing, dispense

All instruments should be set up and materials dispensed prior to treatment commencing and remain in their sterile pack until the patient is seated in the dental chair. This reduces the need to enter drawers or cupboards during an appointment.

Adherence to the following guidelines is recommended:

- all materials should be pre-dispensed, where appropriate. (Some volatile materials deteriorate quickly in air, so should be prepared for dispensing, but not dispensed.);
- hand hygiene must be performed immediately prior to the procedure commencing and after finishing (refer to 5 moments for hand hygiene⁴²), and appropriate personal protective equipment shall be used. Please refer to NSW Health Hand Hygiene⁴³ and Infection Control Policy – Standard & Additional Precautions for personal protective equipment (PPE) requirements;
- materials that require hand mixing should be mixed on a single sheet of non-porous clean paper; and
- a bib, tray or paper towel should be used to define the work surface. Pre-set/pre-dispensed items should be placed on the primary work surface.

⁴⁰ Paul (1980) 'A Manual of Four Handed Dentistry'

⁴¹ Robinson and McLaughlin (1996) 'Annals Royal Australasian College of Dental Surgeons'

⁴² <http://www.hha.org.au/home.aspx>

⁴³ http://www.health.nsw.gov.au/policies/pd/2010/PD2010_058.html

4.4 Methods of Limiting Contamination

4.4.1 Dental dam

The use of dental dam is an effective measure in confining and limiting contamination.

Silicone dams must be used for patients who have a known sensitivity or allergy to latex.

4.4.2 Suctioning

Effective suctioning at the tooth site will markedly reduce contamination from aerosol. This is achieved by:

- using a four-handed technique with a trained dental assistant;
- utilising high speed evacuation suction tips that have a posterior and anterior end. Suction tips must not be reversed during a procedure. If the other end of the tip is required, a new tip must be used; and
- disposable single use low speed suction tips may be pre-bent to increase effectiveness.

Cleaning of suction is guided by the manufacturer's 'Instructions for Use'. Detergents and disinfectants must be registered with the Therapeutic Goods Administration (TGA) and listed on NSW State Contract.

5. DENTAL CLINIC EQUIPMENT

5.1 Chair controls

The chair should be pre-set at the commencement of treatment. Where possible the chair should be foot controlled allowing adjustment at any time, however if the chair is hand controlled then barrier film must be used.

The entire chair including the controls located on the back of the head rest or the side of the chair must be wiped clean with neutral detergent and water and/or detergent wipes at the conclusion of the appointment. Single use barrier film may be used in addition to this procedure, but must not be used instead of this procedure.

5.2 Lights

The patient light should be pre-set at the commencement of treatment. Only the handles of the overhead light should be touched, and these must be covered with barrier film where light sensor controls are not in place. The barrier film must be changed between patients. The light and handles must then be wiped clean with neutral detergent and water at the conclusion of the appointment and between patients (NSW Health Infection Control Policy).

5.3 Mouth rinsing

Spittoons must not be used. If mouth rinsing is required the mouth can be rinsed with a triplex and high-speed suction or a funnel connected to the high speed suction. Funnel attachments must be sterilized between patients or single use only. Following impressions, a two-cup technique may be used by patients to rinse their mouth. The used cups are to be disposed of into general waste whilst their contents can be discarded into a designated dirty sink in a utility/disposal room or by suction.

5.4 Hand Hygiene - Clinical Sinks⁴⁴

'Hand washing should be undertaken in dedicated (clean) sinks preferably fitted with non-touch taps (or done with a non-touch technique) and not in the (contaminated) sinks used for instrument cleaning. If touch taps are used the taps may be turned on and off with a paper towel' (ADA 2008a).

Hands must not be washed in a sink which is used for processes such as:

- instrument cleaning
- disposal of blood, body substances or chemicals
- cleaning of impressions and impression bowls
- flushing of lines
- where bleach or other antiseptic solutions are disposed

5.5 Air, water and suction lines

Air, water and suction lines^{45, 46} must be flushed for a minimum of **2 minutes** at the start of the day and for **30 seconds** after each patient.⁴⁷

5.5.1 Air

Triplex heads must be wiped clean with neutral detergent and water and covered with a barrier film after each use.

Triplex tips must be changed after each patient use and sterilized or if disposable these need to be discarded after each use.

5.5.2 Suction

Suction lines should be non-convoluted with a flat bore and not covered with woven fabric. Suction lines should be flushed thoroughly with water after each patient and at the end of the day using neutral detergent or following manufacture's 'Instructions for Use'.

5.5.3 Water

All dental equipment which supplies water to the oral cavity is to be fitted with anti-reflux valves. Routine maintenance of anti-reflux valves is necessary to ensure their effectiveness. Manufacturer's 'Instructions for Use' must be considered to establish an appropriate maintenance routine.

Australian Dental Association Inc. state that 'sterile irrigants such as sterile water or sterile saline as a coolant are required for surgical procedures such as dentoalveolar dental implant placement'.

Water for tooth irrigation during cavity preparation and for ultrasonic scaling should be of no less than potable standards as identified in the Australian Drinking Water Guidelines 2011.⁴⁸ When treating immunocompromised patients, it is recommended that water from dental unit waterlines contain less than 200 colony forming units per mL. Bacterial levels can be tested using commercially available test strips or through commercial microbiology laboratories.⁴⁹

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⁴⁴ <http://www.nhmrc.gov.au/node/30290>

⁴⁵ <http://shop.standards.co.nz/scope/ASNZS4187-2003.scope.scope.pdf>

⁴⁶ <http://www.saiglobal.com/PDFTemp/Previews/OSH/AS/AS4000/4800/4815-2006.pdf>

⁴⁷ <http://www.nhmrc.gov.au/node/30290>

⁴⁸ National Health and Medical Research Council (2011) National Water Quality Management Strategy : Australian Drinking Water Guidelines 6 http://www.nhmrc.gov.au/files_nhmrc/publications/attachments/eh52_aust_drinking_water_guidelines_120323_0.pdf

⁴⁹ Wirthlin, M.R., Marshall, G.W., Rowland, R.W. (2003) Formation and decontamination of biofilms in dental unit waterlines, J Periodontal 2003 Nov; 74 (11): 1595-609

5.6 Transportation of Instruments

Where dental care is provided in a location separate to the sterilization, all sterilized instruments and equipment must be transported in metal or rigid plastic (puncture proof) containers with secure lids to prevent damage and/or spillage. There are to be separate dedicated containers for sterile and contaminated instruments/equipment that are clearly labelled and in a different colour to identify its contents.

The labels must be worded 'clean' or 'dirty'. These containers should be cleaned with neutral detergent and water and are to be dedicated for this purpose only. All transport equipment shall be maintained in a clean, dry state, and in good working condition.

Public Dental Services must provide all staff with personal protective equipment to undertake this task.

The motor vehicles used to transport equipment should have adequate means of segregation between 'clean' and 'dirty' instruments.

6. DENTAL PROSTHETICS/LABORATORY**6.1 Clinical Area⁵⁰****6.1.1 Mixing of impressions**

For mixing of impressions, a flexible bowl and spatula are used. The flexible bowl and spatula must be cleaned with neutral detergent and water and dried after use.

6.1.2 Cleaning of Impressions/Prosthesis⁵¹

When taking an impression either single use trays or sterilized metal trays must be used. All impressions must be rinsed clean with neutral detergent and running water to remove all debris. A neutral detergent must be used according to the manufacturer's instructions for the cleaning of impressions and dental prostheses. This process must occur prior to transportation from the clinical area. If a designated sink is not available in the clinical area an alternative location must be provided.

Public Dental Services must consider the DOHA guideline statement; *'Although the efficacy of disinfection of dental materials is still undetermined, standard precautions must be applied whenever people handle dental material. The most important step is the thorough cleaning of material that has contacted oral tissue (e.g. impressions). Thorough rinsing with tepid running water, followed by the application of a neutral detergent and further rinsing, should continue until all visible contamination is removed'*⁵².

6.1.3 Transportation of Dental Prosthesis Impressions

Transportation to the laboratory of any items is to be placed in a designated container with a lid or single use sealable plastic bag. Such containers and lids or bags must be single use or cleaned and decontaminated before and after use. The container/s or bag/s must be marked identifying the disinfecting procedure for the impression or dental prostheses that has been undertaken.

⁵⁰ <http://www.nhmrc.gov.au/node/30290>

⁵¹ <http://www.health.gov.au/internet/main/publishing.nsf/content/icg-guidelines-index.htm>

⁵² <http://www.health.gov.au/internet/main/publishing.nsf/content/icg-guidelines-index.htm>

6.1.4 Polishing

For all items and appliances it is recommended that:

- fresh pumice must be used to polish each patient's dental prostheses and must be discarded after use;
- the pumice tray must be cleaned after each use;⁵³
- denture polishing brushes and denture mops should be cleaned as per the manufacturer's 'Instructions for Use', and
- detergents and disinfectants must be registered with the Therapeutic Goods Administration (TGA) and listed on NSW State Contract.

6.1.5 Minor Adjustments

Where possible, denture adjustments are to be done in the laboratory. Dentures and dental prostheses are to be cleaned with a neutral detergent and water before extra oral adjustments.⁵⁴ Minor adjustments may be performed at the chair side in the surgery over a bin. Reusable burs used for adjustments must be cleaned and sterilised after use in accordance with manufacture's 'Instructions for Use'. Single use burs must be discarded at the chair-side in the sharps container.

6.1.6 Return to the Clinic⁵⁵

Dental prostheses and appliances must be cleaned with neutral detergent and water before leaving the laboratory for patient areas.

Items must be transferred in sealed containers or in single use sealable plastic bags with appropriate identification. If disposable containers are not used and reusable containers are used, they must be cleaned between uses.

6.2 Radiographs

Between patients the head of the x-ray tube must be wiped down with neutral detergent and water after each use. Single use barriers must be used on parts that come into contact with non-intact skin or mucous membrane. All parts including lead aprons must be thoroughly cleaned with neutral detergent and water after each use and stored dry.⁵⁶

Radiographic films should be covered by single use barrier envelopes or be single use films, which are wiped over with neutral detergent prior to processing.⁵⁷

6.3 Extra-Oral Radiological Equipment

Single use barrier film must be used for extra-oral radiological equipment,⁵⁸ such as bite piece for OPG, chin rests, head frames, cephalostat earpieces and extra-oral cassettes and are to be thoroughly cleaned with neutral detergent and water after each use.

6.4 Use of Covers or Sheaths on Radiological Equipment

Single use barrier film designed to protect the equipment must be disposed of between patients. Barrier film use does not negate the need to clean the equipment after each patient.⁵⁹ Manufacture's 'Instructions for Use' must be followed.

⁵³ <http://www.health.gov.au/internet/main/publishing.nsf/content/icg-guidelines-index.htm>

⁵⁴ <http://www.health.gov.au/internet/main/publishing.nsf/content/icg-guidelines-index.htm>

⁵⁵ <http://www.nhmrc.gov.au/node/30290>

⁵⁶ http://www.health.nsw.gov.au/policies/pd/2007/PD2007_036.html

⁵⁷ http://www.health.nsw.gov.au/policies/pd/2007/PD2007_036.html

⁵⁸ http://www.health.nsw.gov.au/policies/pd/2007/PD2007_036.html

⁵⁹ http://www.health.nsw.gov.au/policies/pd/2007/PD2007_036.html

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GROWTH ASSESSMENT AND DIETARY ADVICE IN PUBLIC ORAL HEALTH SERVICES (GL2019_001)

PURPOSE

This document introduces routine measurement of height and weight of patients in public oral health services, as part of addressing the NSW Premier's priority on Tackling Childhood Obesity to reduce childhood overweight and obesity by 5% by 2025.

This document complements the NSW Health Guideline *Growth Assessment in Children and Weight Status Assessment in Adults* (GL2017_021). It provides specific directions on the implementation of growth assessment and dietary advice for children in public oral health services.

KEY PRINCIPLES

A strategic direction under the NSW Premier's priority on Tackling Childhood Obesity is the routine collection of height and weight across NSW Health Services. Routine weight status assessment and management by public oral health services, including the provision of brief advice and referral pathways to healthy lifestyle programs, is important for inter-professional collaboration to address the issue of childhood obesity.

This Guideline provides the recommended approach for public oral health services to implement routine growth assessment and advice into clinical care. This includes:

- Professional development for staff (Section 2);
- Processes for growth and dietary assessments (Section 3);
- Provision of brief intervention for children above a healthy weight (Section 4.1);
- Provision of dietary and physical activity advice to address both oral health and obesity risk (Section 4.2), and;
- Referral pathways and processes for children identified as being outside of a healthy weight status (Section 5).

Successful implementation of this Guideline will require oral health service to establish partnerships with other key health services in their Local Health District, such as Health Promotion, to obtain additional support for staff and patients.

USE OF THE GUIDELINE

Public oral health staff should be aware of the recommended professional development (Section 2), and the processes for:

- Measuring and recording height and weight of patients (Section 3);
- Providing an appropriate brief intervention (Section 4); and
- Providing referrals to other health services (Section 5).

Public oral health service managers and clinical directors should support staff in completing recommended professional development, and in the implementation of the measurement of height and weight, brief interventions, and referrals as part of standard clinical practice.

The Growth Assessment and Dietary Advice in Public Oral Health Services guideline can be downloaded from: https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2019_001

TELEDENTISTRY (GL2020_019)**GUIDELINE SUMMARY**

This Guideline provides a framework for the use of teledentistry-enabled models of care by NSW Health Districts. Specifically, this Guideline is designed to provide information for live patient – provider teledentistry interactions and store-and-forward episodes and to establish standard item codes for teledentistry services.

KEY PRINCIPLES

- Provide a framework for teledentistry utilisation in NSW public dental services for:
 - Live patient and provider teledentistry services
 - Store and forward teledentistry services
- Establish standard item codes for teledentistry services
- Establish a consistent approach to recording and reporting of teledentistry episodes

USE OF THE GUIDELINE

This Guideline is intended for use by NSW Health public dental and medical organisations which provide teledentistry services.

- Support public dental services to use teledentistry to improve access to oral healthcare
- Clinicians should follow these guidelines when providing teledentistry-enabled services
- Standardise the use of item codes for recording teledentistry utilisation
- Dental clinicians should use the described, standard teledentistry item codes when providing treatment
- Teledentistry services should be monitored, evaluated and improved

The Teledentistry guideline can be downloaded from:

https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2020_019