SURGICAL ASSISTANT PROTOCOLS

CONSULT PROTOCOLS

Consult appointment Setup (Max time: 3-5mins.)
The operatory must be setup BEFORE patient is brought back with close attention to details.

- **Exam set up includes:**
  - A clean (visible, non-scratched) dental exam mirror
  - A clearly marked Perio probe (3,6,9,12 perio probe)
  - 2x2 gauzes (x5 pieces)
  - Patient bib/chain
  - Saliva ejector
  - Chlorhexidine/Listerine rinse in a small cup for patient to rinse
  - Radiographs (FMX/Pano/CBCT scan) pulled up and ready for doctor review
    - If radiographs are older than 6mos, ask if the doctor wants a new set prior to seating the patient
  - Mask and gloves on the tray for the doctor

- **For Implant consults also include:**
  - Implant models
  - The doctor's patient education iPad

- **For Perio consults also include:**
  - *"Perio-care"* form
  - New-patient toothbrush
  - A string of floss
  - A clean hand-mirror for Oral Hygiene Instructions (OHI)
  - The doctor's patient education iPad
  - Be prepared to go over OHI with the patient

- **Present the following to the doctor BEFORE seating the patient:**
  - *"Health History"* form (Completed & signed by the patient)
    - Please make sure the patient completes the second page
  - *"Treatment Plan Template"* forms (Put patients name, date of birth and today's date on top)

    - *“Pre-anesthesia Evaluation”* form (Put patients name and today’s date on top)
    - *“Pre/Post Anesthesia Instructions” form*
    - *“Medical Clearance”* form (Put patients name and today’s date on top)
        - If patient has more than one doctor, please print multiple medical clearance forms for each doctor
            - **If patient has any history of hear disease, diabetes, is on a blood thinner, etc. must have a medical clearance from their physician(s) prior to surgery**

- **Seat the patient for consult and complete the following BEFORE the doctor comes to the room (Max time: 5-10mins. includes taking new X-rays/CBCT scan)**
    - Have the patient rinse with Chlorhexidine or Listerine for 30 secs.
    - Select the appropriate “consult note template” and enter it into the patient’s chart
        - If you are not sure which note template to select, Ask the doctor or look at the route slip and find out what exactly is the patient here for (Implant consult, Periodontal consult, etc.)
    - In note template fill in the following:
        - BP(blood pressure), HR(heart rate), SpO2(oxygen saturation), temperature
        - Enter “Chief Complaint”
            - You may ask the patient *“What Brings You in Today?”*
            - Chief complaint should be verbatim
            - After chief complaint you can also write a short summary of why the patient is here
        - Physician’s name, specialty and phone/fax (If multiple doctors then copy/past the physician info template and add all the doctors)
        - Smoking/E-cigarette(vaping) history
        - For Periodontal consult patients ONLY
            - In addition to entering the above, fill out “Periodontal therapy History” and “Oral Hygiene History” section
            - Open a new patient Perio chart and mark the existing dentition/implants to the best of your knowledge
- **During consults**
    - Assistant must be in the room the entire time. The lead assistant by default is always that person. If backup assistant has been arranged by the lead assistant to help during a consult (only if the lead assistant is preparing for the next procedure/consult), it is the lead assistant’s responsibility to educate and communicate all the above guidelines to the backup assistant to make sure they fully understand what needs to be completed for a smooth experience.

PRE-OP PROTOCOLS

2-3 weeks prior to surgery:

- Make sure all STL (IO scanning) and DICOM (CBCT) files have been received by the appropriate lab
    - This is for Surgical guides (such as Bone fixation, Bone reduction and Implant guide)
- Make sure all clinical impressions have been received by the appropriate lab
    - This is for immediate Compete Denture(s) ("ICDs") or a semi-rigid Essex tray

1-2 weeks prior to surgery:

- Make sure the following has been received:
    - Surgical guides
    - Right size implants for the case
    - ICDs or semi-rigid Essex tray (if applicable)
- Place everything in a box with a clear label showing patient's name, DOB, and surgery date
- Make sure you have all the necessary
    - Medical Clearance from ALL physicians (if applicable)
    - Consent forms, etc

1-2 days prior to surgery:

- Confirm that you have all the followings:
    - Medical Clearance from ALL physicians (if applicable)
    - Consent forms, etc
    - Surgical guides
    - Right size implants for the case
    - ICDs or semi-rigid Essex tray (if applicable)
    - Bone graft and membranes
- Call the patient to go over Pre/Post-Anesthesia Instructions
    - **Emphasize the importance of not eating 8 hours prior to surgery or will have to cancel the surgery**
    - Use the "Pre-Anesthesia instruction" form as a guide when you call the patient and review everything with them.

SURGERY PROTOCOLS

Surgical Appointment Forms: (Max time: 5mins)

- **Print or show the following to the doctor BEFORE seating the patient:**
    - *"Health History"* form (Completed & signed by the patient)
        - A recent (less than 6mos old) copy from previous consult appt. is acceptable.
    - *"Medical Clearance"* form (if it was requested)
    - *"Consent"* form(s) (Examples: Anesthesia, Extraction, Implant, Sinus Graft, Bone Graft, etc.)
        - Make sure patient initials EVERY line (check marks ✓ NOT accepted)
        - Make sure patient signs and dates on the bottom of the last page

            - Make sure you (the witness) sign and date on the bottom of the last page
    - *"Prescription"* form
        - Ask patient if they have picked up all their prescriptions from the pharmacy
    - Anesthesia forms- present all 3 forms below in a bundle (if doing IV sedation)
        - *"Pre-Anesthesia Evaluation"* form – Print the one completed by the Dr/RDA at the consult visit
        - *"Anesthesia Record"* (provide a blank copy to the doctor)
        - "Post-Anesthesia Recover & Dismissal" (provide a blank copy to the doctor)

Surgical Set-up: (Max time: 15mins)

THIS IS A STERILE FIELD, YOU CAN NOT SET-UP WITH BARE HANDS (WASH YOUR HANDS AND USE CLEAN GLOVES BEFORE AND AFTER EACH SETUP/SURGERY). DO NOT COMPROMISE THE STERILE AREA WITH NON-STERILE THINGS SUCHS AS: STICKIE NOTES, PENS, PAPER, ETC. ALL THESE MEASURES WILL DECREASE THE RISK OF INFECTION AND IMPROVE OUR PATIENT CARE. REMEMBER TREAT THE PATIENT HOW YOU WANT TO BE TREATED!

- Make sure you have all your necessary hand pieces, cassettes and instruments for the planned surgery
- Have plenty of 2x2 gauzes, 4x4 gauzes and C-sponges
- Have all your suctions (high volume suction, white and green surgical, Yanker suction)
- Run the air hand-piece line for one full minute (60 seconds) to flush the bacteria out of the lines prior to surgery
- Seat the patient and make them comfortable
    - Ask if they need to use the bathroom before starting
    - Put a blanket by their legs
- Give patient appropriate pre-op meds such as antibiotics, pain meds etc
    - Before giving any meds, confirm with the doctor and make sure patient has no allergies
    - We usually pre-load the patient with antibiotics
        - 2 grams (4x500mg capsules) of Amoxicillin
        - if allergic to Amoxicillin, 600mg of Clindamycin (4x150mg capsules)
- Have the patient rinse with Chlorhexidine for 30 seconds
- Select the appropriate surgical *"note template"* (ex: implant surgery) and enter it into the patient's chart
    - If you are not sure which template to select, ask the doctor
- Connect the vital monitor BP cuff, Pulse Ox, and EKG (if doing sedation) to the patient
    - Get the patient's temperature
    - Use the appropriate size BP cuff (Adult regular, small and large)
        - **VERY IMPORTANT: If patient's BP is 170/100 or greater, notify the doctor immediately**
    - Make sure the Pulse Ox reader is attached on the opposite arm of the BP cuff
    - EKG placement tip:
        - White right, smoke over fire: The white lead goes over the right subclavian, the black (smoke colored) goes over the left subclavian, and smoke is above fire, so the red lead (fire colored) goes on the left lower rib area.

- After initials vital (BP, HR, SpO2,EKG) have been taken, press PRINT on the monitor to get a print out
- Enter the first set of pre-op vitals (BP, HR, SpO2,Temp) into the patient's chart in the designated area
- Make sure to press PRINT again at the end of the procedure to get a final reading of the patients vitals

- Grab a blank piece of paper, write patient's name, date of birth and surgery date on the top and tape it to the wall
    - Make sure to document and place all implant, bone graft and membrane stickers (with Ref/Lot #'s) on the above piece of paper.
    - **It is your responsibility to make sure this document is scanned into the patients chart at the end of the surgery**
- Load the CBCT scan onto the surgical operatory monitor and have it ready for the doctor's review during the procedure.
- Once surgery is completed present the following to the doctor for final review and sign off:
    - Patients Intra-op vital printing from the monitor
    - All anesthesia paperwork
    - Implant, bone graft, membrane (ref/lot#) document
- **It is your responsibility to make sure above documents are scanned into the patient's chart after Dr Hamidi signs off.**

<u>Post-Surgery Patient Packet/Folder</u>
Should include the following:

1. Pre & Post-op instruction forms
    - *"Pre/Post Anesthesia Instructions"*
    - *"Surgical Post-op Instructions"*
    - *"Sinus Post-op Instructions"*
2. Ice pack (cold compress) x1
3. Pre-made pouch consist of 10 pieces of 2x2 gauzes
4. **Starter basket (*All on Four / Snap-On patients only)***

(Includes: a WaterPik, variety of protein shakes, juices, apple sauce, custard, etc)

<u>Giving Post Op Instructions: (Max time: 5mins)</u>

- Please understand and memorize the Post Op Instructions so that you do a great job explaining it to your patients or their caregiver. Be precise. Be clear. Be specific.
- **Do NOT go over Post Op instructions with a sedated patient!!**
    - They're sedated and will not understand nor remember anything you tell them. Go over the Post op instructions with their caregiver and make sure they fully understand it.

STERILIZATION PROTOCOLS

Instrument Sterilization

- Staying late hours or coming early to sterilize instruments should **NOT** be a routine practice. With **effective communication** and **team utilization**, most if not all the instruments should be sterilized and ready to go for the next day by no later than end of the day. This requires running unsterilized instruments in-between patients throughout the day with the exception of the last surgical procedure for the day.

- Remember you're the **LEAD** assistant in every office so get into the mentality of being **PROACTIVE** and **DELEGATING** tasks i.e. delegate Wiping down and setting up the operatory. Lead assistant should be the only person dealing with instrument set up, unless you're guiding and delegating the task appropriately to the 2nd and 3rd surgical assistants. Otherwise, everything around instruments setup that includes disposables can be done by the backup surgical assistant(s). You may refer to the laminated setup images.

- Please be gentle with all instruments. **Instruments are very expensive and in some cases very fragile and costly to repair/replace.** Damaging instruments will only delay surgery and cause more work on your end, so take your time with setting up and or when breaking down the room after surgery.

End of The Day

- Before leaving each office a **THOROUGH Op by Op and STERILIZATION AREA** check must be completed to make sure everything has been placed back in the surgical cabinet and locked up
- Examples include but not limited to:
  - Bone graft bottles
  - Membrane
  - Implants and Healing abutments
  - Blades
  - Burs
  - Sutures
  - Single instruments
  - Surgical cassettes
  - Hand piece or Couplers
  - BP cuffs, thermometer, etc.
  - IV sedation equipment and disposables
  - Leaving materials behind adds up to an increases cost of operation over time. It also means more traveling, time lost and toll/gas cost for the assistant to get those materials back to the right office. By having a thorough paper checklist and paying close attention to collecting all the surgical team belongings, we can wrap up the day without wasting unnecessary time and energy.

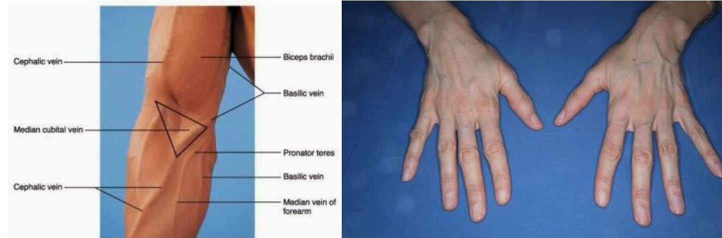
Remember to be **PROACTIVE** and **ATTENTIVE** at all times! For example, if you know you have multiple patients back to back plan your day with all the team members including the doctor to

allow things go smoothly and efficiently. During consults, be attentive and take notes as dictated by the doctor and write up the proposed treatment with the help of the doctor.

Ask the doctor at any point if you have questions. The doctor should not have to constantly keep looking for the assistant or calling assistant's name for multiple things that should be available during a routine consult. Assistant should not have to keep getting out of the room in the middle of the consult or procedure. If you're proactive, minimum interruptions should take place during any consult or procedure. **If you were the patient, you would want the same quality attention from both the doctor and the surgical team!**

<u>Some IV sedation tips during consult appointment:</u>

- Ask the patient "do medical professionals have a hard time starting an iv on you or drawing blood?" if yes, ask where to they usual start an iv or draw blood from?
- Perform a visual exam of patient's hands and arms: ask the patient to pump their fist and hang their arm down as low as possible and look for obvious veins. using a tourniquet may be helpful to visualize the veins.
- Reassure patients that if for whatever reason iv can not be established by the doctor, oral & nitrous sedation combination may be provided or will provide the patient with an option of dental anesthesiologist (at an additional cost and patient will pay the dental anesthesiologist directly) to provide the patient with sedation and be anxiety free.



I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE SURGICAL ASSISTANT PROTOCOLS AND THAT I HAVE BEEN GIVEN AN APPROPRIATE ORIENTATION. I AM QUALIFIED, CAPABLE, AND PREPARED TO FULFILL THE DUTIES AS ASSIGNED.

Surgical Assistant: ______________________________ Date: _______________________

Print Name

Surgical Assistant : ____________________________________

Signature