CLINICAL INTRODUCTORY (DHYG 1260.7A1, DHYG 1260.7B1, DHYG 1260.7C1, DHYG 1260.7D1)

CREDIT
2 Semester Credit Hours (0 hours lecture, 8 hours lab)

MODE OF INSTRUCTION
Face to Face

PREREQUISITE/CO-REQUISITE:

Pre-requisite: Admittance to the dental hygiene program and DHYG 1301, DHYG 1431, DHYG 1304, DHYG 1227
Co-Requisite: DHYG 2301, DHYG 1219, DHYG 1235, DHYG 1207

COURSE DESCRIPTION
A health-related work-based learning experience that enables the student to apply specialized occupational theory, skills, and concepts. Direct supervision is provided by the clinical professional.

COURSE OBJECTIVES
As outlined in the learning plan, apply the theory, concepts, and skills involving specialized materials, tools, equipment, procedures, regulations, laws, and interactions within and among political, economic, environmental, social, and legal systems associated with the occupation and the business/industry and will demonstrate legal and ethical behavior, safety practices, interpersonal and teamwork skills, and appropriate written and verbal communication skills using the terminology of the occupation and the business/industry.

In addition to the above, upon completion of this course the student will be able to:

- Demonstrate the ability to provide therapeutic dental hygiene care directed towards the treatment of oral disease at Introductory Clinic competency levels as noted in this manual.
- Demonstrate modifications in dental hygiene care for patients with special needs.
- Apply clinical, communication and patient management skills and didactic knowledge to assess needs, formulate, plan and evaluate a comprehensive dental hygiene treatment plan directed towards attaining and maintaining healthy periodontal tissues for individuals with normal gingiva to those with slight periodontal disease as measured by successful completion of two care plans.
- Demonstrate the ability to use professional dental terminology in verbal and written communications.
- Demonstrate the ability to maintain dental healthcare records according to industry and HIPAA standards.
- React appropriately when confronted with a specific medical/dental emergency.

- Function as a member of a dental health delivery team within the dental hygiene clinic.
- Demonstrate observable behavior in clinic indicating personal knowledge of the concepts that are necessary to develop a professional and ethical value system for their personal practice of dental hygiene, with specific emphasis on patient rights, access to care and the legal responsibilities of the dental hygienist.

INSTRUCTOR CONTACT INFORMATION

Clinic Coordinator	Lori Rogers, RDH, BS
Email:	larogers@lit.edu
Office Phone	409-247-5159
Office Location	MPC 210
Office Hours	Monday 1-3, Wednesday 1-3, Friday 8-9 am (or by appointment)

DDS/Instructors	**RDH/Instructors**
Dave Carpenter DDS	Jaimie Bruno RDH, BAAS
Kristina Mendoza DDS	Courtney Campbell RDH, BS
William Middleton DDS	Leslie Carpenter RDH, BS
William Nantz DDS	Renee Sandusky, RDH, BS
Robert Smith DDS	Cynthia Thompson RDH, BS
	Joy Warwick RDH, BS

REQUIRED TEXTBOOKS

Wilkins' Clinical Practice of the Dental Hygienist, 14th Edition, Linda D. Boyd and Lisa F. Mallonee.Digital Premier Access- eBook and workbook ISBN: 9781284255997
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Fundamentals of Periodontal Instrumentation, 9th Edition, Jill S. Gehrig, Rebecca Sroda, Darlene Saccuzzo, ISBN: 9781284019339, Publisher: Jones and Bartlett Learning

Mosby's Dental Drug Reference, 13th Edition, Arthur H. Jeske. (Or 14th Edition- either ed. is okay for this book only)
ISBN: 9780323779364 (**paperback/print required for this book**)
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REQUIRED MATERIALS and SUPPLIES

Students are required to have all the instruments and supplies listed in the Student Handbook. It is your responsibility to make sure you do not run out of gloves, masks and any other student purchased supplies. You are required to have a physical appointment book.

COURSE CALENDAR Spring 2026

Clinic sections: M-W or T-TH

M-W	1st day	Last day
	W 1-21-26	W 4-29-26
T-TH	1st day	Last day
	T 1-20-26	T 4-30-26

IMPORTANT DATES:

DATE	TOPIC	READINGS	ASSIGNMENTS
1-19-26	MLK DAY/ CAMPUS CLOSED		
1-20-26	Screening day for T-TH clinic 1st Clinic Day for T-TH	Syllabus	You can schedule up to 4 patients per clinic session
1-21-26	Screening day for M-W clinic 1st Clinic Day for M-W	Syllabus	You can schedule up to 4 patients per clinic session
2-2-26 to 4-23-26	Students are allowed to sign up for screening patients/taking x-rays outside of their assigned clinic time.		You must sign up in the appointment book. Space is limited
2-11-26	NO CLINIC Fl Varnish Program		
2-26-26	NO CLINIC TDHA Convention		
3-2-26 to 3-6-26	Mid Semester Clinical Counseling	See syllabus for instructions	Make an appointment with your advisor
TBA	Radiographic Evaluation Test		Online

3-9-26 to 3-13-26	SPRING BREAK		
4-23-26	***All radiographic requirements are due.**		
4-28-26	NO CLINIC X-ray Grading Day		
4-29-26	Last Clinic Day for MW clinic		All Requirements Due
4-30-26	Last Clinic Day for T-TH clinic		All Requirements Due
5-4-26 to 5-6-26	End of Semester Clinical Counseling	See syllabus for instructions	Make an Appointment with your advisor
TBA	Clinic Cleanup		See posted schedule

ATTENDANCE POLICY:
Absenteeism In order to ensure the students in the dental hygiene program achieve the necessary clinical competencies outlined in the curriculum, it is necessary that the student complete all assigned clinical hours. It is the responsibility of the student, and expected by the instructors, that each student be present, and on time, at each clinic session. It is expected that students will take their clinical and radiographic exams at the scheduled examination time, unless arranged with the clinic coordinator. Make-up examinations will be given only if the absence is due to illness (confirmed by a physicians' excuse), a death in the immediate family, or at the discretion of the instructor. If students are unable to attend clinic, it is mandatory that you contact the appropriate instructor prior to the scheduled clinic time.

An absence will be considered unexcused if the student fails to notify the clinic faculty prior to the start of clinic. If a student is too ill to attend class, this will require an absence in clinic on the same day unless the student has Dr. permission to be on campus. Any other absence in clinic will be dealt with on an individual basis and must be discussed with the 2nd year clinic coordinator. Extenuating circumstances will be considered to determine if the absence is excused. Extenuating circumstances might include but are not limited to funeral of immediate family member, maternity, hospitalization, etc. If the student has surgery, a debilitating injury,

or an extended illness, a doctor's release will be required before returning to clinic. A Request to be Absent form should be filled out and submitted to the Clinic Coordinator.

- Dental hygiene students are required to makeup all excused absence clinic sessions and must be scheduled with the clinic coordinator.
- If a student has an unexcused absence, they will receive a written disciplinary action form which will be placed in the student's permanent record and a Professional Judgement and Ethical Behavior form will be given which may affect the students overall Professional Judgement and Ethical Behavior average.
- Any unexcused absence will be added to Cancellation time Clinical Evaluation Record (CER) and the student will lose that clinic time.

NOTE: If a clinic session is missed, it must be rescheduled within two weeks of the student's return to ensure all clinical requirements are met in a timely manner. The make-up session will be scheduled on a set clinic day, and students must coordinate with the clinic coordinator to confirm the new date. Additionally, students cannot cancel the rescheduled session if the patient cancels, as it is their responsibility to fulfill the clinic requirements. This policy helps maintain the integrity of the clinical training schedule and ensures that students have sufficient time to complete their required hands-on practice before graduation. Tardiness Punctuality is an important aspect of professionalism in the field of dental hygiene. Punctuality is not only a reflection of personal commitment but also an essential quality that contributes to a positive and efficient learning environment. Dental hygiene students are expected to be punctual in order to demonstrate their dedication to their education, respect for instructors and peers, and preparation for clinical settings where timely patient care is important.

TARDY:
Tardiness can affect the students time spent in Introductory Clinic (DHYG 1260) Spring 2026. A student is considered tardy if not present and ready to seat their patient at the start of clinic. It is expected that students will arrive on time for clinic, and remain until dismissed by the instructor. If a student knows they will be tardy, they must contact the appropriate instructor prior to the schedule clinic time.

- When a student is tardy, they will receive a written disciplinary action form which will be placed in the student's permanent record and a Professional Judgement and Ethical Behavior form will be given which may affect the students overall Professional Judgement and Ethical Behavior average. Students should plan on all clinic sessions as assigned throughout the semester. Family outings, vacations and personal business should be scheduled when school is not in session and will not be considered excuses for missing assignments, examinations or clinic time.

DROP POLICY :
If you wish to drop a course, you are responsible for initiating and completing the drop process by the specified drop date as listed on the Academic Calendar. If you stop coming to class and fail to drop the course, you will earn an "F" in the course.

STUDENT EXPECTED TIME REQUIREMENT:
For every hour in class, students should expect to spend at least two to three hours per week studying and completing assignments. For a 3-credit-hour class, students should prepare to allocate approximately six to nine hours per week outside of class in a 16- week session OR approximately twelve to eighteen hours in an 8-week session. Online/Hybrid students should expect to spend at least as much time in this course as in the traditional, face-to-face class.

ACADEMIC DISHONESTY:
Students found to be committing academic dishonesty (cheating, plagiarism, or collusion) may receive disciplinary action. Students need to familiarize themselves with the institution's Academic Dishonesty Policy available in the Student Catalog & Handbook at: http://catalog.lit.edu/content.php?catoid=3&navoid=80#academic-dishonesty.

TECHNICAL REQUIREMENTS:
The latest technical requirements, including hardware, compatible browsers, operating systems, etc. can be online at https://lit.edu/online-learning/online-learning-minimum-computer-requirements. A functional broadband internet connection, such as DSL, cable, or WiFi is necessary to maximize the use of online technology and resources.

DISABILITIES STATEMENT : The Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973 are federal anti-discrimination statutes that provide comprehensive civil rights for persons with disabilities. LIT provides reasonable accommodations as defined in the Rehabilitation Act of 1973, Section 504 and the Americans with Disabilities Act of 1990, to students with a diagnosed disability. The Special Populations Office is located in the Eagles' Nest Room 129 and helps foster a supportive and inclusive educational environment by maintaining partnerships with faculty and staff, as well as promoting awareness among all members of the Lamar Institute of Technology community. If you believe you have a disability requiring an accommodation, please contact the Special Populations Coordinator at (409)-951-5708 or email specialpopulations@lit.edu. You may also visit the online resource at Special Populations - Lamar Institute of Technology (lit.edu).

CLINICAL ACCOMMODATIONS POLICY:
Due to the structure and demands of the dental hygiene clinical setting, accommodations that alter essential clinical functions, time requirements, or performance standards cannot be made. The clinical environment is intentionally designed to reflect the realities of professional dental practice, where time management, procedural accuracy, and patient care are critical. All students are expected to meet established clinical competencies without modifications that would compromise the integrity of instruction or patient safety. This policy ensures that students are adequately prepared for the expectations and responsibilities of real-world dental practice.

STUDENT CODE OF CONDUCT STATEMENT:
It is the responsibility of all registered Lamar Institute of Technology students to access, read, understand and abide by all published policies, regulations, and procedures listed in the LIT

Catalog and Student Handbook. The LIT Catalog and Student Handbook may be accessed at www.lit.edu. Please note that the online version of the LIT Catalog and Student Handbook supersedes all other versions of the same document.

ARTIFICIAL INTELLIGENCE STATEMENT:

Lamar Institute of Technology (LIT) recognizes the recent advances in Artificial Intelligence (AI), such as ChatGPT, have changed the landscape of many career disciplines and will impact many students in and out of the classroom. To prepare students for their selected careers, LIT desires to guide students in the ethical use of these technologies and incorporate AI into classroom instruction and assignments appropriately. Appropriate use of these technologies is at the discretion of the instructor. Students are reminded that all submitted work must be their own original work unless otherwise specified. Students should contact their instructor with any questions as to the acceptable use of AI/ChatGPT in their courses.

STARFISH:

LIT utilizes an early alert system called Starfish. Throughout the semester, you may receive emails from Starfish regarding your course grades, attendance, or academic performance. Faculty members record student attendance, raise flags and kudos to express concern or give praise, and you can make an appointment with faculty and staff all through the Starfish home page. You can also login to Blackboard or MyLIT and click on the Starfish link to view academic alerts and detailed information. It is the responsibility of the student to pay attention to these emails and information in Starfish and consider taking the recommended actions. Starfish is used to help you be a successful student at LIT.

ADDITIONAL COURSE POLICIES/INFORMATION:

Assignment and Examination Policy

The Radiographic Evaluation Examination will be based on periapical, bitewing, and panoramic landmarks, lesions, anomalies and restorations. The exam will be multiple choice. Students are expected to the complete examination as scheduled. Make-up examinations will be given ONLY if the absence is due to illness (confirmed by a physician's excuse), a death in the immediate family, or at the discretion of the Instructor. All make-up examinations must be taken within two weeks from the scheduled exam date. Students may have access to the examination by appointment during the Instructor's office hours. Exams may be reviewed up to two (2) weeks following the exam date. You may not copy, reproduce, distribute or publish any exam questions. This action may result to dismissal from the program. A grade of "0" will be recorded for the examination on the day of the exam unless prior arrangements have been made with the Instructor.

Students must use their personal equipment, such as computer, MacBook, laptop, iPad, to take their exams and must not use their classmates'. School computers may be used if personal equipment is not available. Respondus Lockdown Browser and Respondus Monitor will be used for examinations therefore, a webcam is required to take the exam. The student is required to show the testing environment at the beginning of the exam to assure the instructor that it is

clear of any study materials. Failure to do so will result in a 10-point exam grade deduction. If you need online assistance while taking the test, please call Online Support Desk at 409-951-5701 or send an email to litbbsupport@lit.edu.

It shall be considered a breach of academic integrity (cheating) to use or possess on your body any of the following devices during any examination unless it is required for that examination and approved by the instructor: cell phone, smart watch/watch phone, electronic communication devices (including optical), and earphones connected to or used as electronic communication devices. It may also include the following: plagiarism, falsification and fabrication, use of A.I., abuse of academic materials, complicity in academic dishonesty, and personal misrepresentation. Use of such devices during an examination will be considered academic dishonesty. The examination will be considered over, the student will receive a zero for the exam and will receive disciplinary action. This policy applies to assignments and quizzes. Students with special needs and/or medical emergencies or situations should communicate with their instructor regarding individual exceptions/provisions. It is the student's responsibility to communicate such needs to the instructor

COURSE REQUIREMENTS

Course Requirements	**Attempts allowed**	**Letter Grade**	**Letter Grade**	**Letter Grade**	**Incomplete**
Competencies		**A**	**B**	**C**	**F**
Instrument Recirculation (Sterilization)	3	Complete	Complete	Complete	
*Patient Assessment (To achieve an A in clinic, this competency must be successfully completed on the first attempt)	3	Complete 1st attempt	Complete	Complete	
Pedodontic Patient	3	Complete	Complete	Complete	
Radiographic Evaluation	2	Complete	Complete	Complete	
Skill Evaluations		Complete	Complete	Complete	
Mid-Term Skills Assessment Use of the Mirror, Explorer for Calculus Detection	2	Complete	Complete	Complete	
Sickle Scaler	3	Complete	Complete	Complete	
Universal Curet	3	Complete	Complete	Complete	
Periodontal Debridement	3	Complete	Complete	Complete	
Slow Speed Handpiece	3	Complete	Complete	Complete	
Patient Education Sessions (3)	3	Complete	Complete	Complete	

Patient Points	**A**	**B**	**C**	
Total points in prophy class 1 and 2 patients	**12**	**10**	**10**	
Total points in prophy class 3 patients	**9**	**9**	**6**	
Periodontal Classification				
Gingivitis	**2**	**1**	**1**	
Periodontitis Stage 1 or 2	**4**	**3**	**3**	

Satisfactory Assessments	**Letter Grade**	**Letter Grade**	**Letter Grade**	**Incomplete**
	A	**B**	**C**	**F**
Med/Dent Hx	**8**	**7**	**6**	
Oral Exams	**8**	**7**	**6**	
Perio Assessment	**8**	**7**	**6**	
Dental Charting	**8**	**7**	**6**	
Plaque Free	**8**	**7**	**6**	
Satisfactory Radiographs				
FMX (1 using sensor)	**3**	**3**	**3**	
BWX (1 sensor, 1 plate, 1 using the Nomad)	**3**	**3**	**3**	
Pedo FMX (allowed to use Dexter for 1 pedo survey)	**1**	**1**	**1**	
Pedo BWX	**1**	**1**	**1**	
Panoramic	**1**	**1**	**1**	
Care Plans	**3**	**2**	**2**	
Sealant Patient	**1**	**1**	**1**	
Community Service Hours	**5**	**4**	**3**	
FL Varnish Program **This event covers your 3 hour minimum for the semester**	**3**	**3**	**3**	
Professional Judgement and Ethical Behavior Average Score	**40**	**39**	**38**	

**All requirements must be completed according to the above table. Any student considered incomplete will receive the grade F.*

COURSE EVALUATION

Final Clinic Grade will be calculated according to completion of the following criteria:

Skill Evaluations and Competencies	Mid-Term Skills Assessment	Care Plans	Radiographic Evaluation	Professional Judgement and Ethical Behavior
Complete	Complete	Score 75%	Score 80%	Average Score 38%

Skill Evaluations and Competencies are graded as Acceptable (A) or Not Acceptable (U). Mid-Term Skills Assessment is graded as A or U.

ADDITONAL CLINIC INFORMATION

Patient Selection:

Patient selection is very important; therefore, it is required to select a variety of patients to enhance clinical experience. In DHYG 1260 a prophy class 3 is the most difficult patient you can treat. All class 3 patients must have a calculus detection chart.

Screening:

Students may screen patients outside of their clinic time as well as take radiographs. Everyone must use the calendar in Mrs. Byrds office. Space is limited. Students must reserve a clinic chair prior to the date you want to screen. You may screen one patient per day to allow everyone access to the calendar. At 5:00pm the day before, you may add another patient if there is a space available. *Dental hygiene students may treat ONE hygiene student or faculty/staff member per semester for requirements. DH students, faculty and staff who are patients are not exempt from payment of customary charges. THESE PATIENTS WILL ONLY BE USED TO COUNT FOR POINTS, X-RAY REQUIREMENTS, OR SEALANT REQUIREMENTS.

*Each student may choose to waive the fee for one patient per semester. Services rendered to a patient will count for only one student. (i.e., Mary cannot start a patient and later give to Susie) There will be no sharing of patients for points.

Clinical Teaching Using the Pod System:

The Pod System will be utilized in the clinic setting to enhance student learning. The Pod system requires each clinical instructor be assigned to specific cubicles in order to create smaller groups within the clinic. Working in pods emphasizes one-on-one teaching, continuity of instruction and closer monitoring of student progression.

Comprehensive Care Grade:

Students are expected to perform comprehensive care on all patients. Not taking retakes, not critiquing surveys and submitting for a final grade by the end of the second appointment, prewriting charts, not doing the plaque or bleeding score, not doing diagnosed sealants, not completing dental shading before scaling, not having informed consent signed before scaling, not having drug cards by the second appointment are some examples of behaviors that will result in an unacceptable grade in this area. Three or more Us in Comprehensive Care on clinic CERs will result in a one-point deduction from the student's Professional Behavior and Ethical Judgement semester average. Four Us will result in a second one-point deduction, and additional Us will continue to result in further deductions. Faculty has the authority to modify the above policies if unusual circumstances mandate a change. Please refer to the Student Handbook for a complete listing of program policies.

TEACHING METHODS:

1. Faculty demonstrations
2. Individual assignments and instruction
3. Observation and feedback

DENTAL HYGIENE STUDENT CER POLICY:

- CERs can only be pulled by Clinic Admin or Clinic counselor.
- CERs are to remain in clinic office, unless in active use.
- If an instructor/counselor or student wishes to remove CERs from the clinic office, they must check them out from the clinic admin.
- Patient CERs will be pulled daily by clinic admin for all patients listed in appointment book and distributed to the students scheduled in clinic; therefore, patients must be in the appointment book prior to the beginning of clinic.
- Patient CERs must be turned back into clinic admin, by the student, at the end of each clinic session for grade entry. Any CER with a new entry must be placed in the designated CER holding area.

INFORMED CONSENT:

All patients must sign an informed consent for treatment. This form is used to educate the patient on procedures to be performed, risks involved with or without treatment, benefits from obtaining treatment, and any referrals made for the patient.

Any referrals should be noted at the end of dental charting with the D.D.S. and have the D.D.S. sign for the referrals. Referrals should also be noted in the patients' progress notes when the dental charting is checked. When a patient initially comes to the clinic for radiographs, an

Informed Consent must be filled out for that patient. If the patient returns for further treatment during the same semester, a new (2nd) Informed Consent will be filled out for that patient during the appointment. If your patient comes in for full treatment, which includes x-rays on the same day, 1 informed consent will be required which includes the radiographs taken, as well as the additional treatment that will be given.

RISK ASSESSMENT:

An oral pathology, a periodontal disease, and a caries risk assessment will be done on every patient. The student will complete these risk assessments when completing the informed consent. The student will present the completed risk assessment form and the informed consent to a faculty for review and signing after, the student and patient have signed. A grade will be assigned for the risk assessment on the CER.

GRADING OF DATA COLLECTION:

All data collection will be graded individually. Example: complete the extra/intra oral exam then get it checked. Follow the order of the CER form. The student must have radiographs displayed before any data is graded. Students may begin scaling after all assessments have been graded. It is expected you will give the patient oral hygiene education before you begin quadrant scaling.

Note: All data must be evaluated and informed consent signed before scaling can begin. You are allowed to sign up for a check then, return to your patient and continue treatment.

Example: Susie signed up to have her dental charting checked. She began the periodontal assessment while she was waiting. When in doubt, ask an instructor.

EVALUATION OF PERIODONTAL DEBRIDEMENT (SCALING):

Evaluation criteria for scaling includes calculus removal, stain removal, and tissue trauma. Prophy class 3 requires a calculus detection chart. Significant tissue trauma will be noted on the CER and may be reflected in the patient grade. Errors will be recorded under comments on the CER. Errors documented for scaling must be re-scaled by the student and re-checked by one instructor. An instructor must sign in the appropriate box on the CER indicating that the areas have been rechecked to receive credit for patient points. It is the responsibility of the student to see that all procedures are appropriately signed off by an instructor.

- Areas identified by faculty as remaining after the rescale will be counted as additional errors against the student and will be reflected in the CER grade.

  Example: Areas 29D, 30M and 25L were found on initial checking of scaling which makes 3 errors. When the instructor checks after spot removal, the area on 29D is still present. This student would then have 4 errors on this patient.)

CLINIC TIME:

If students feel that they are spending an excessive amount of time scaling per quadrant on a specific patient, then it is advisable to have the patient prophy class re-evaluated by an instructor. This must be done during or after the completion of one quadrant. Patient classification will not be changed if more than one quadrant has been scaled.

Patient Dismissal Patients must be evaluated by an instructor before dismissal at each appointment. An instructor must see the patient even if no clinical procedures were completed. Students must sign up for checks by 11:30 AM, 4:30 PM. Signing up does not guarantee that an instructor will be available. Availability depends on how many students have signed up before you. Patients must be dismissed no later than 11:45 AM, 4:45 PM. Repeated late dismissals of patients may result in disciplinary action.

Cancellation time is a good time to take radiographs on a manikin.

CHART AUDITS:

Chart audits will be randomized for students this semester. Faculty advisors will complete random chart audits on all students throughout the semester. Students are still required to complete a chart audit checklist and have each chart ready for potential audit within one week of completing the patient.

After patient completion and student self-audit, **students must submit a digital copy of the CER into the DHYG 1260 Blackboard submission link.** This must be done within one week of completing the patient, for the faculty advisor to monitor patient. When a chart audit is found with errors, the student will receive an “unacceptable” on the CER.

Receiving unacceptable grades on CER will affect the patients' overall CER grade. This may determine whether the student will get credit for the patient.

Three or more U's in chart audits will result in a one-point deduction from the student's Professional Behavior and Ethical Judgement semester average. A student with three or more "unacceptable" chart audits will need to schedule a time with their clinical advisor to have all patient files audited. The student will remain with the instructor while the charts are audited.

- CHARTS THAT ARE NOT AUDITED AND/OR CER UPLOADED INTO BLACKBOARD BY THE STUDENT WITHIN ONE WEEK OF COMPLETION OF PATIENT CARE MAY RESULT IN PENALTIES.
- These penalties could mean that the student may not use that patient toward meeting requirements for DHYG 1260.

STERILIZATION DUTY:
Each student is assigned **4 clinic sessions of sterilization**. Students are expected to arrive **30 minutes before the clinic session begins** to help assist in getting clinic ready. Upon arrival, students on sterilization duty must sign in at the clinic front office and in Trajecsys.

The penalty for arriving later than 15 minutes prior to the beginning of clinic will result in an **additional sterilization duty done outside of the students assigned clinic day**. This will be scheduled with the 1st year clinic coordinator.

Students are not to use assigned sterilization time for personal business, such as auditing charts, studying, sharpening instruments, or computer/phone use. The penalty for conducting personal business during sterilization duty is an extra 4 hours of sterilization duty outside of the student's regular clinic day.

END OF CLINIC PROCEDURES:
At the end of clinic, each student will remain in their cubicle until dismissed. CERs and progress notes will be checked for completion of information, time entries, signatures, and signed by the pod instructor. All students are expected to assist others at the end of clinic prior to removing PPE. No one will be dismissed until all students' CERs and progress notes have been checked for completeness and all students have performed postop procedures.

BLACKBOARD SYSTEM FOR RECORDKEEPING:
Blackboard is a powerful tool for organizing student information, ensuring that both students and instructors stay on track with course requirements being met. By setting clear deadlines for assignments and uploads, Blackboard promotes accountability, encouraging students to manage their record keeping and time effectively. The platform allows instructors to track submissions, monitor participation, and easily find course materials in one centralized location.

With time limits for uploading assignments or completing assessments, students are prompted to meet deadlines, fostering a sense of responsibility. Additionally, the ability to quickly access

course resources, announcements, grades, and feedback streamlines communication and enhances the overall learning experience. This structure not only helps students stay organized but also allows instructors to maintain an efficient and transparent course environment. Please note all the due dates for submissions such as CERs, clinical competencies, course requirements.

Not submitting CERs on time could prohibit a student from receiving points from that patient. Entering CER information in Trajecsys must be done also.

TRAJECSYS UTILIZATION POLICY

Students are required to properly utilize Trajecsys during all clinic and lab sessions. All Clinical Evaluation Record (CER) entries must be completed before patient check-in, and all patient information must be fully and accurately entered prior to beginning treatment. If the student plans to complete any competencies during the appointment, the appropriate skill evaluation form or required competency form must be initiated in Trajecsys prior to performing the procedure. Consistent, timely, and accurate use of Trajecsys is a required component of clinic and lab performance.

TRAJECSYS TIME KEEPING:

Students are required to use Trajecsys to clock in at the start of every clinical session and clock out at the end of each session. Each missed clock-in or clock-out counts as one missed use.

If a student misses three or more times during the term, a 1-point deduction will be applied to the final Professional Judgment and Ethical Behavior grade. In rare cases where Trajecsys is not working due to verified technical problems, the student must notify the instructor within 24 hours and provide documentation (such as a screenshot).

SKILL EVALUATIONS

Skill Evaluations

- Instructions for the Skill Evaluations are located with the evaluation forms in this appendix.
- Skill evaluations cannot be done during any make-up clinic time unless approved by the clinic coordinator
- Skill Evaluation forms should always be available to instructors during clinic.
- All Skill Evaluations must be successfully completed to complete DHYG 1260**.**

Time Allotment for Skill Evaluations

1.	Mid-term Skills Assessment*	30 minutes
2.	Sickle Scalers*	30 minutes
3.	Universal Curet*	30 minutes
4.	Use of the Slow Speed Handpiece	30 minutes
5.	Patient Education	15-20 minutes
6.	Periodontal Debridement (two quadrants)	2 and 1/2hours

Important!!

*The following skill evaluations MUST be passed prior to attempting the Periodontal Debridement Skill Evaluation

1. Mid-term Skills Assessment
2. Sickle Scalers
3. Universal Curet

Anterior and Posterior Sickle Scalers

Patient Requirements

- Adults (age 18 or over) or at the discretion of the instructor.
- Prophy Class II with supragingival calculus
- An instructor must approve a patient for this evaluation.

Student Instructions

- Inform your instructor if you think your patient will be suitable for this skill evaluation.
- Plan for the evaluation and sign up for it on the clinic sign-up sheet.
- Review the following information:

Initial Use of the Sickle Scalers

General Management

- Utilizes time effectively and efficiently
- Utilizes mirror effectively
- Maintains correct patient/operator positioning.
- Adjust the dental light for maximum illumination.
- Uses current infection control procedures.
- Use air and evacuation equipment effectively.
- Preparation of operatory is appropriate for procedure.
- Selects appropriate instruments and maintains sharpness.
- Professional judgment and ethical behavior demonstrated by:
- Providing patient comfort
- Providing proper patient communication
- Accepting constructive criticism
- Adapting to new situations
- Instilling confidence in the patient
- Explaining procedures to the patient
- Exhibiting the self-confidence necessary to perform the procedure

***Grasp**

- Holds with index finger and thumb pads opposite each other
- Stabilizes instrument with pad of middle finger.
- Maintains contact between index, middle and ring (fulcrum) fingers.
- Maintains contact with fingers when adjusting finger positions for optimal instrument adaptation.
- Always maintains the handle distal to the second knuckle of the index finger and proximal to the “V” of the hand.
- Use a light grasp with all exploratory strokes.

***Fulcrum:**

- Establishes and maintains a high stable fulcrum to avoid hand collapse.
- Establishes on occlusal or incisal surfaces, embrasure area, and/or extra-oral
- Positions as close to work area as possible.
- Uses constant, equal pressure.

***Instrument Positioning:**

- Determines the correct working end and cutting edge.
- Adapts the side of the tip 1/3 flush with the tooth surface at the gingival margin or under supragingival calculus deposit.
- Insertion to the CEJ, if necessary. Close the face of the blade (flat) against the tooth surface and insert until the side of the tip 1/3 is positioned under the ledge of the calculus deposit.

***Instrument Activation:**

- Angulate the cutting edge correctly and lock the tip into the tooth.
- Tighten grasp and increase lateral pressure using thumb, index and/or middle finger.
- Initiate short, powerful 2 mm stroke in a coronal direction to remove deposit.
- Relax grasp, close blade, if necessary, and reposition blade to continue removing deposit in each scaling zone.
- Use correct wrist/arm/hand motion to produce vertical, oblique and/or horizontal strokes
- Use no independent finger motion.
- Pivot on fulcrum finger to adapt to facial or lingual surfaces.
- Roll the instrument between index finger and thumb to maintain instrument adaptation when entering the interproximal areas.
- Maintain the lower shank as close to parallel as possible with the long axis of the tooth.
- Move the instrument in the direction the tip faces.

Instructor Instructions

- Identify patients that meet the criteria for this skill evaluation.
    - Class II
    - Adequate supragingival calculus to evaluate debridement technique
- Observe the student's technique in both anterior and posterior areas
- The student removes enough deposit to pass the quadrant
- Record any feedback on the Skill Evaluation form

*Denotes basic principles of dental hygiene skills

Patient Education Skill Evaluation (Three Sessions)

Patient Requirements

- An RDH instructor MUST designate and/or approve your choice of patient for this evaluation.
- Adult (age 18 or over) (Or a patient approved by the clinic coordinator)
- At least 16 teeth (An Instructor may approve a patient with fewer teeth if deemed appropriate).
- Any prophy or periodontal classification is acceptable
- The patient must present with educational needs that exceed homecare instructions consisting of brushing and flossing techniques. Some examples of this would be the need for instruction with auxiliary aids to clean fixed bridges, extensive caries involvement, active periodontal disease and multiple small problems combined with a major lack of dental awareness, etc.

Student Instructions

- A formal written care plan is required for this patient.
- The skill evaluation consists of successful completion of three patient educations sessions observed by a DH faculty member.
- Sign up for your education sessions in the skill evaluation book
- Refer to information from Preventive Dentistry to plan and organize your sessions.

Instructor Instructions

- Identify a patient whose educational needs <u>exceed</u> home care instructions consisting of brushing and flossing techniques.
    - Some examples include: The need for instruction with auxiliary aids to clean fixed bridges,
    - extensive caries involvement, periodontal disease, fixed orthodontic appliances, multiple
    - small problems combined with a major lack of dental awareness, etc.
    - patient has diabetes
- Observe the patient education sessions and provide feedback on the skill evaluation form.

Mid-Term Skills Assessment

Use of the Mirror and Explorer for Calculus Detection

Requirements

- This skill evaluation will be done on a typodont. The student must demonstrate acceptable skills in the use of the mirror and explorer for calculus detection.

Student Instructions

- Sign up in the skill evaluation calendar prior to the day you plan to attempt. No pre-op is performed prior to the evaluation.
- At the beginning of clinic inform your pod instructor that you will be attempting the skill evaluation
- Your instructor will give you a typodont to use.
- You will need the calculus detection worksheet.
- Your instructor is allowed to remind you to check the working end of the explorer once if you are using the incorrect end. The second time you are told you will have failed the evaluation.
- Review the following prior to the evaluation:

***Mirror**

- Demonstrate proper grasp.
- Demonstrate proper fulcrum area.
- Demonstrate proper use of mirror in area.
- Avoid resting mirror on attached gingiva and hitting teeth with mirror

Explorer

***Grasp**

- Holds with index finger and thumb pads opposite each other
- Stabilizes instrument with pad of middle finger.
- Maintains contact between index, middle and ring (fulcrum) fingers.
- Maintains contact with fingers when adjusting finger positions for optimal instrument adaptation.
- Always maintains the handle distal to the second knuckle of the index finger and proximal to the "V" of the hand.
- Uses a light grasp with all assessment strokes.

***Fulcrum**

- Establishes and maintains a high stable fulcrum to avoid hand collapse.
- Establishes on occlusal or incisal surfaces, embrasure area, and/or extraoral.
- Positions as close to work area as possible.

***Instrument Positioning**

- Determines the correct working end.
- Prepares for explorer insertion by positioning the side of the tip at the gingival margin at an oblique angle to the epithelial attachment.

***Instrument Activation**

- Initiate vertical, oblique or horizontal strokes to the base of the sulcus/pocket from the stable fulcrum.
- Uses no independent finger motion.
- Rolls instrument between thumb and index finger to move the explorer obliquely/vertically along the buccal/labial or lingual surfaces.
- Rolls the instrument between index finger and thumb to maintain instrument adaptation when entering the interproximal areas.
- Uses correct wrist/arm/hand motion to produce vertical, oblique and/or horizontal strokes.
- Maintains the lower shank as close to parallel and possible to the long axis of the tooth.
- Instrument adaptation is maintained throughout exploring procedure (side of tip adapted to the tooth surface).
- Moves the instrument in the direction the tip faces.
- Uses short 2 mm overlapping strokes to explore the entire sulcus from the marginal gingiva to the epithelial attachment.
- Keeps explorer strokes within the sulcus.

Instructor Instructions

- Give the student a prepared typodont.
- Make sure they have a calculus detection sheet.
- Observe the students as they explore all areas of the two quadrants identified for the skill evaluation and then compare the students' charting to the charting in the key. You may inform the students one time only to check their working end. You will tell them this when they have completed an entire surface (either towards or away) without self-correcting. The second time you have to tell them to check their working end after they have completed an entire surface (either towards or away) without self-correcting, they have failed the evaluation.
- The students' technique must be satisfactory according to the criteria stated and they must have identified at least 70% of the agreed upon areas of calculus. The student may find 100% of the deposits but use an inappropriate technique and still fail the evaluation. The student may inaccurately note calculus on calculus free surfaces up to a maximum of 50%. After this, for every surface incorrectly identified with calculus one surface correctly identified will be dropped.
- Record any feedback on the evaluation form.

***Denotes basic principles of dental hygiene instrumentation**

Manikin Skills Assessment: Use of the mirror and explorer for calculus detection

Purpose:

The purpose of this assessment is to evaluate the dental hygiene students' proficiency in assessment instrumentation skills and calculus detection using a manikin, simulating real-world scenarios encountered in clinical practice.

Components:

Calculus Detection:

1. Subgingival Calculus Detection -Students will use the mirror and explorer to locate and assess subgingival calculus. Emphasis on correct instrument technique and accurate detection of calculus deposits below the gumline.

Evaluation Criteria:

Technique and Instrumentation:

1. Proper use of the mirror and explorer.

   Correct angulation and movement during instrumentation.

   Ability to detect subgingival calculus with a score of 75% accuracy.

   Proper ergonomic clinician and patient positioning.

Professionalism:

1. Adherence to infection control protocols.
2. Efficient use of time and resources.

Scoring:

Feedback and Remediation:

After the assessment, students will receive constructive feedback on their performance, highlighting areas of strength and areas needing improvement. Students who do not pass the assessment at mid semester will not be allowed to continue in the program. Options will be discussed with the student by the program director and clinic coordinator.

This manikin skills assessment aims to ensure the dental hygiene students have developed the necessary skills in instrument use and calculus detection preparing them for the next level of patient therapy. At the mid semester time frame all students must demonstrate competence with their assessment instruments.

Periodontal Debridement Skill Evaluation

Patient Requirements

- Adult (age 18 or over)
- At least 24 teeth/ Perio stage 1 or 2
- Rarely a Perio stage 3 may be approved
- At least eight (8) subgingival easily discernible calculus deposits in two (2) quadrants
- See instructor instructions

Student Instructions

- Have an instructor identify an appropriate patient for this evaluation
- Usually, the patient you used for the calculus detection evaluation is appropriate
- Have an instructor identify the two quadrants you will be treating
- Make sure you have successfully completed the following:
- Using the Mirror and Explorer for Calculus Detection
- Anterior and Posterior Sickle Scalers
- Universal Curet
- Sign up for the evaluation on the clinic sign-up sheet
- Determine the amount of time you will need to sign up for with the instructor who will be
- working with you
- You have two (2) hours to complete the evaluation, but the instructor will not be watching
- you for the entire time
- Two (2) instructors must chart your designated quadrants for calculus if not already completed
- Get a start time from your instructor before you start and inform the instructor if you or your patient must have a "break" during the treatment
- *You will be given a copy of the chart showing the specific calculus deposits to be removed for this evaluation. If you are not given the chart, ASK for it.*
- Use all basic skills of dental hygiene instrumentation

Instructor Instructions

- Identify an appropriate patient for the evaluation
- The deposits may or may not be "clickable", but should be distinct and easily detectable
- The calculus deposits must have been agreed upon by two (2) instructors
- Two (2) instructors will calculus chart the indicated quadrants and produce a guide for the student showing the location of each agreed upon deposit
- There should be eight to no more than 10 deposits that the student will be required to remove <u>completely</u> for this evaluation
- Use your professional judgment to determine which deposits will be counted while making

up the guide form

- Observe the student's scaling technique
- Two (2) instructions will check scaling (all surfaces of both quadrants); remaining deposits agreed upon by both instructors will count as errors for this evaluation
- All deposits not removed during the evaluation will count for the quadrant grade on the CER
- Record any feedback on the evaluation form.

Universal Curet Skill Evaluation

Patient Requirements

- Adult (age 18 or over)
- Prophy Class III and instructor approval
- Perio classification G or I
- Adequate calculus to observe both anterior and posterior instrumentation techniques

Student Instructions

- Have an instructor identify an appropriate patient
- Sign up for the skill evaluation on the clinic sign-up sheet
- Perform periodontal debridement with the universal curet in both anterior and posterior areas
- Review the following prior to the evaluation:

***Grasp**

- Holds with index finger and thumb pads opposite each other
- Stabilizes instrument with pad of middle finger.
- Maintains contact between index, middle and ring (fulcrum) fingers.
- Maintains contact with fingers when adjusting finger positions for optimal instrument adaptation.
- Maintains the handle distal to the second knuckle of the index finger and proximal to the "V" of the hand at all times.
- Uses a light grasp with all exploratory strokes.

***Fulcrum**

- Establishes and maintains a high stable fulcrum to avoid hand collapse.
- Establishes on occlusal or incisal surfaces, embrasure area, and/or extraoral.
- Positions as close to work area as possible.
- Uses constant, equal pressure.

***Instrument Positioning**

- Determine the correct working end and cutting edge.
- Adapt the side of the tip 1/3 flush with the tooth surface at the gingival margin or under supragingival calculus deposit.
- Insertion. Close the face of the blade (flat) against the tooth surface and insert until the side of the tip 1/3 is positioned under the ledge of the calculus deposit.

***Instrument Activation**

- Angulate the cutting edge correctly and lock the toe into the tooth.
- Tighten grasp and increases lateral pressure using thumb, index and/or middle finger.
- Initiate short, powerful 2 mm stroke in a coronal direction to remove deposit.

- Relax grasp, close blade, if necessary, and reposition blade to continue removing deposit with channel scaling strokes.
- Use correct wrist/arm/hand motion to produce vertical, oblique and/or horizontal strokes
- Use no independent finger motion.
- Pivot on fulcrum finger to adapt to facial or lingual surfaces.
- Roll the instrument between index finger and thumb to maintain instrument adaptation when entering the interproximal areas.
- Maintain the lower shank as close to parallel as possible with the long axis of the tooth.
- Move the instrument in the direction the tip faces.

Instructor Instructions

- Identify an appropriate patient with accessible calculus in the anterior and posterior areas.
- Observe the student's technique and check the area for acceptable (student removes enough calculus to pass the quadrant) removal of deposits.
- Record any feedback on the evaluation form.

***Denotes basic principles of dental hygiene instrumentation**

Slow Speed Handpiece Use

Patient Requirements

- Adult (age 18 or over)
- Any Prophy Class or Perio classification

Student Instructions

- Select a patient who has no contraindications for use of the slow speed handpiece
- Sign up on the clinic sign-up sheet
- This evaluation may be done without signing up if an instructor is available
- Explain selective polishing to your patient
- Determine if you will need to use fine prophy paste to remove residual stain or if toothpaste will be sufficient for biofilm removal
- Review the following prior to the evaluation
  - Set up all equipment and check instrument operation prior to seating the patient.
  - Use a systematic procedure.
  - Use mirror effectively.
  - Use air and evacuation equipment effectively.
  - Utilize light effectively to aid instrumentation.
  - Maintain correct patient/operator positioning.
  - Maintain proper infection control procedures.

***GRASP:**

- Hold hand piece with the pads of the index finger, thumb and middle finger.
- Support the weight of the hand piece proximal to the "V" of the hand or distal to the third knuckle of the index finger.
- Maintain contact between the elements of the grasp as much as possible to avoid operator fatigue.
- Use as relaxed a grasp as possible.

***FULCRUM:**

- Establish on stable area, extended, cross arch and extra oral may be necessary to provide access and operator comfort.
- Maintain stable, constant pressure.

***INSTRUMENT POSITIONING AND ACTIVATION:**

- Obtain correct paste and apply to teeth.
- Direct cup occlusally to flare edge of cup into sulcular and proximal areas (especially on lingual surfaces).
- Maintain constant slow speed of angle.
- Continually moves cup on tooth.
- Use combination or roll/sweep stroke.
- Adapt edge of cup in anterior (fossae).

- Use overlapping strokes and light to medium pressure to effectively remove entire deposit.
- Use correct wrist/arm/hand motion to produce the desired stroke.
- Debride polishing cup of saliva before refilling.

***USE OF AUXILIARY POLISHING INSTRUMENTS:**

- Adapt toothbrush to occlusal pits and planes when indicated.
- Adapt finishing strips to interproximal areas if indicated.
- Adapt tape/floss to proximal surfaces.

- Make sure you floss completely after you have used this instrument

Instructor Instructions

- Determine if the patient is appropriate
- Witness the students' explanation of selective polishing and any further discussion between the student and patient.
- Observe the student's technique
- Record any feedback on the evaluation form.

***Denotes basic principles of dental hygiene instrumentation.**

COMPETENCY EVALUATIONS

Competency Evaluations

A. Instructions for the competency evaluations are located with the evaluation forms in this Appendix.
B. Competency evaluations may be attempted twice
C. Your competency evaluation forms must be on a clipboard & should always be available to the instructors during clinic.
D. All competency evaluations MUST be successfully completed to complete DHYG 1260**.**

Time Allotment for Competency Evaluations

1. Patient Assessment	2 and ½ hours
2. Pedodontic Patient	2 and ½ hours
3. Instrument Re-circulation and Clinic Readiness	Inform instructors you will be doing the competency that day. You will be observed the entire clinic session. (4 hours)

***Skill evaluations and Competency evaluations cannot be performed on any student enrolled in a dental hygiene program, RDH, DDS, or instructor.**

Instrument Re-Circulation and Clinic Readiness Competency Evaluation

Students are required to arrive 30 minutes prior to the start of clinic when reporting for sterilization duty. Sign in with the clinic Administrative Assistant (Mrs. Byrd) upon arrival.

- This evaluation is to be completed during a scheduled "Sterilization" day during your clinic time not when you are working outside of your clinic time.
- Inform the instructor you are performing the evaluation that day.
- Be aware of the following objectives which should be achieved during "Sterilization Duty"
- The student will demonstrate knowledge of the types of supplies used for DH care in the clinic and radiology areas, and the preparation of these supplies for use by performing the following during scheduled sterilization time:
- Determine which supplies need to be re-stocked and request an instructor/staff person obtain them for you if they are not available in the sterilization area.
- Prepare supplies for use by setting out in specific areas/containers or by packaging and sterilizing if necessary.
- The student will demonstrate knowledge of personal protective equipment while working in the instrument recirculation area by wearing uniform, lab coat, mask, glasses/shield, and exam and nitrile gloves when needed.
- The student will determine which method of sterilization/disinfection is appropriate for specific instruments and materials by following instructions given in the manual and in class.
- The student will demonstrate a working knowledge of instrument recirculation and storage procedures by performing the following during scheduled sterilization time:
- Instrument decontamination
- Preparation for sterilization and packaging, including lubricating the RDH handpieces
- Preparation of sterilization equipment
- Operation of sterilization equipment
- Preparation of chemical solutions for disinfection and/or cleaning
- The student will demonstrate knowledge of daily maintenance procedures for dental equipment by performing the following during scheduled sterilization time:
- Prepare and distribute solutions for cleaning and maintaining the evacuation system.
- Prepare solutions for and perform the procedures to clean the autoclaves, when requested to do so by an instructor.
- The student will demonstrate knowledge of surface classifications by determining which decontamination/disinfection techniques are appropriate for the clinic, radiology area, reception room and patient education rooms and by performing these techniques where necessary.
- The student will demonstrate an understanding of the effect orderliness and cleanliness has on the confidence and trust the patient has in the dental professional by keeping the reception and patient education rooms clean and orderly.

The student will demonstrate knowledge of proper biohazardous waste handling.

The student will demonstrate effectiveness as a team member by performing the following for peers and faculty during scheduled sterilization time:

- Assistant
- Messenger
- Supply retrieval

Instructor Instructions

1. Acknowledge the student is performing the competency.
2. Watch the student throughout the session and record any feedback on the competency rubric.
3. Review the evaluation with the student prior to recording the grade and placing a copy in their folder.
4. Enter the completed competency in Trajecsys

***Students are required to sign in with Mrs. Byrd when they arrive for sterilization duty. The arrival time is 30 minutes prior to the start of that clinic.**

Patient Assessment Competency Evaluation

Patient Requirements

- Male or female adult age 18 or over or at instructor's discretion
- At least 24 teeth
- Uncomplicated medical history
- Must be able to stay for a 3–4-hour appointment
- Must have recent BWs or FMX available at time of evaluation
- Be careful in choosing this patient. A difficult patient will decrease your chances of successfully completing this competency in the allotted time. There are no provisions for modifying the grading of this competency to account for a more difficult patient.

Student Instructions

- Must be scheduled in the skill evaluation book in the clinic with your Pod instructor.
- **You MUST have an instructor present before you review the patient's health history and obtain vital signs.** Time will start as soon as you begin reviewing the patient's health history. The instructor will sign the history and other documents**. No other procedures will be checked or signed until check out.**
- Make sure you have all the necessary paperwork or forms at your unit.
- Radiographs, if necessary, will be taken during the appointment but will be excluded from the time limit. Ask for a stop time and restart time. Radiographs may be taken prior to the appointment also.
- Complete all the assessment examinations in the required examination period. This will include:
    - **Medical/dental history and vital signs (BP must be taken 2 times)**
    - **Head and Neck and Intraoral Examination**
    - **Periodontal Assessment (including plaque score and home care regimen)**
    - **Initial Dental Charting (shading will be done after you are checked.)**
    - **Complete the Informed Consent Document (student and patient will sign) (other signatures will be done at check time.)**
- Notify your instructor when you have completed the assessment competency or if you need to take a break for any reason. **You must get a stop and start time**.

Instructor Instructions

- Record a start time for the student as soon as the patient is seated in the chair and the student is ready to review the medical history.
- Make sure you are available to observe the student during each of the required elements of the competency; including review of medical history and taking vital signs (**teaching**

stethoscope is required). Students are expected to obtain the blood pressure 2 times. Sign the medical history after the student has completed the review.

- Give the student time out for radiographs. Write the stop and start times on the evaluation form.
- Record the time the student is finished.
- Begin evaluation of the assessments.
- Record any feedback on the competency evaluation form and review it with the student.

Pedodontic Patient Competency Evaluation

Patient Requirements:

- 5 to 10 years of age, no exceptions.
- No complicated medical history problems
- One parent/legal guardian **MUST** accompany the patient. Students may not see their own children. You may see another student's child if the student is not in the same clinic. It is preferable for parents to wait in the reception area if the child is compliant.

Student Instructions:

- Must be scheduled in the skill evaluation book in the clinic.
- **You have 2 and ½ hours to complete the competency. Your Instructor MUST be present before you review the medical history for this patient**. Most of the time the Dentist on duty will be assigned to you for this competency. Review the medical history with the parent present. Direct questions to the parent when necessary. Take vital signs using the chart for children's values to evaluate. The instructor will use the teaching stethoscope while you are obtaining the blood pressure. The instructor will sign the health history, and other documents. Have an instructor sign your informed consent prior to proceeding. No other documents or procedures will be checked or signed until you complete the patient to the point of plaque free (after polish and floss). You will have everything checked and signed before you give the fluoride treatment. Fluoride treatment is not included in the time.
- Obtain the correct paperwork for the child patient. Any necessary radiographs may be taken during the appointment or a prior appointment. A stop and restart time will be given.
- The informed consent will be signed by the student and the parent before presenting to an instructor to sign.
- Complete the initial dental charting. (Shading will be done after you have been checked.)
- Follow the assessment plan from the Pedodontic Patient PowerPoint. It is not the same as an adult patient.
- Record detailed patient education information and recommendations made to the parents in the progress notes. This is part of the grading on the rubric. (not in the timed portion)
- If you have questions, you must ask them prior to the start of the competency.

Instructor Instructions:

- Check the patient age is correct. (5-10 yrs old). Observe the student reviewing the medical/dental history and vital signs and sign the appropriate paperwork. (teaching stethoscopes are available) No other procedures or paperwork will be checked or signed until the student has completed the patient to the point of plaque free.
- Observe the student at intervals noting the criteria on the evaluation.
- Make sure you record stop and start times for radiographs.
- When the student states they are finished, give them a stop time. Check all paperwork and evaluate all procedures using the criteria for a child patient.

- Complete the written competency evaluation rubric. You will sign the progress notes making sure the student gave a detailed description of parent involvement and patient education topics.

LIT Dental Hygiene Program

Skill Evaluation

Periodontal Debridement (Two Quadrants Class 3 Patient)

LIT Competency Statements	12. Provide specialized treatment that includes preventive and therapeutic services designed to achieve and maintain oral health. a. Perform dental hygiene interventions to eliminate and/or control local etiologic factors to prevent and control caries, periodontal disease, and other oral conditions. b. Control pain and anxiety during treatment through the use of accepted clinical and behavioral techniques. 13. Evaluate the effectiveness of the implemented clinical, preventive, and educational services and modify as needed. a. Determine the outcomes of dental hygiene interventions using indices, instruments, examination techniques, and patient self-report.		
Student		Date:	
Instructor		Periodontal Stage	G I II III IV
Patient		Prophy Class	0 1 2 3 4 5 6 7 8
	Start Time: End Time:	Grade	A= Acceptable U= Unacceptable

	The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.	Critical Error	Yes	No
1	Utilize accepted infection control procedures	Yes		
2	Apply basic principles of dental hygiene instrumentation	Yes		
3	Maintain patient records as instructed	No		
4	Obtain informed consent prior to treatment	Yes		
5	Maintain student records as instructed	No		
6	Appropriate application of professional knowledge, judgment and skills by the student while providing patient care	Yes		
7	Demonstrate the ability to communicate professional knowledge verbally and in writing	No		
8	Removes indicated calculus from specified teeth leaving no more than 3 deposits	Yes		
9	Completes in a two-hour time period	Yes		

Comment:

LIT Dental Hygiene Program

Skill Evaluation

Universal Curet

LIT Competency Statements	12. Provide specialized treatment that includes preventive and therapeutic services designed to achieve and maintain oral health. a. Perform dental hygiene interventions to eliminate and/or control local etiologic factors to prevent and control caries, periodontal disease, and other oral conditions. b. Control pain and anxiety during treatment through the use of accepted clinical and behavioral techniques.		
Student		Date:	
Instructor		Periodontal Stage	G I II III IV
Patient		Prophy Class	0 1 2 3 4 5 6 7 8
		Grade	A= Acceptable U= Unacceptable

	The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.	Critical Error	Yes	No
1	Utilize accepted infetion control procedures	Yes		
2	Apply basic principles of dental hygiene instrumentation	Yes		
3	Maintain patient records as instructed	No		
4	Obtain informed consent prior to treatment	Yes		
5	Maintain student records as instructed	No		
6	Appropriate application of professional knowledge, judgment and skills by the student while providing patient care	Yes		
7	Demonstrate the ability to communicate professional knowledge verbally and in writing	No		
8	Maintain sharp well contoured instruments	No		
9	Successfully removes deposits (passes quadrant)	Yes		

Comment:

LIT Dental Hygiene Program

Skill Evaluation

Sickle Scalers

LIT Competency Statement	P12. Provide specialized treatment that includes preventive and therapeutic services designed to achieve and maintain oral health. a. Perform dental hygiene interventions to eliminate and/or control local etiologic factors to prevent and control caries, periodontal disease, and other oral conditions. b. Control pain and anxiety during treatment using accepted clinical and behavioral techniques.		
Student		**Date**	
Instructor		**Periodontal Stage**	**G I II III IV**
Patient		**Prophy Class**	**1 2 3 4 5 6 7 8**
		Grade	**A= Acceptable** **U= Unacceptable**

The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.		Critical Error	Yes	No
1	Utilize accepted infection control procedures	Yes		
2	Apply basic principles of dental hygiene instrumentation	Yes		
3	Maintain patient records as instructed	No		
4	Obtains informed consent prior to treatment	Yes		
5	Maintain student records as instructed	No		
6	Appropriate application of professional knowledge, judgment and skills by the student while providing patient care	Yes		
7	Demonstrate the ability to communicate professional knowledge verbally and in writing	No		
8	Maintain sharp well contoured instruments	No		
9	Successfully removes deposits (passes quadrant)	Yes		

Comments:

LIT Dental Hygiene Program

Skill Evaluation

Patient Education First Session

LIT Competency Statements	P2. Assume responsibility for dental hygiene actions and care based on accepted scientific theories and research as well as the accepted standard of care. P4. Communicate effectively with individuals and groups from diverse populations both verbally and in writing. PC10 Diagnosis - Use critical decision-making skills to reach conclusions about the patient's dental hygiene needs based on all available assessment data. PC11 Planning-Collaborate with the patient, and/or other health professionals, to formulate a comprehensive dental hygiene care plan that is patient centered and based on current scientific evidence c. Establish a collaborative relationship with the patient in the planned care to include etiology, prognosis, and treatment alternatives. PC12 Implementation - Provide specialized treatment that includes preventive and therapeutic services designed to achieve and maintain oral health. a. Perform dental hygiene interventions to eliminate and/or control local etiologic factors to prevent and control caries, periodontal disease, and other oral conditions. PC13 Evaluation - Evaluate the effectiveness of the implemented clinical, preventive, and educational services and modify as needed. a. Determine the outcomes of dental hygiene interventions using indices, instruments, examination techniques, and patient self-report.

Student		Date:	
Instructor		Periodontal Stage	G I II III IV
Patient		Prophy Class	0 1 2 3 4 5 6 7 8
		Grade	A= Acceptable U= Unacceptable

	The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.	Critical Error	Yes	No
1	Utilize accepted infection control procedures	Yes		
2	Apply basic and advanced principles of dental hygiene instrumentation	No		
3	Maintain patient records as instructed	No		
4	Obtain informed consent prior to treatment	Yes		
5	Record <u>detailed</u> description of education session in progress notes	Yes		
6	Maintain student records as instructed			
7	Appropriate application of professional knowledge, judgment and skills by the student while providing patient care	Yes		
8	Demonstrate the ability to communicate professional knowledge verbally and in writing	Yes		
9	Assess the needs of the patient and help the patient determine dental health goals	Yes		
10	Prepare an individualized patient education plan	Yes		
11	Assist the patient in assessing their own level of home care proficiency	No		
12	Emphasize patient responsibility in health care partnership	No		
13	Involve patients and provide positive reinforcement	No		
14	Review the session, evaluate any skill performance, preview the next session	No		

Comment:

LIT Dental Hygiene Program

Skill Evaluation

Patient Education Second Session

LIT Competency Statements	P2 Assume responsibility for dental hygiene actions and care based on accepted scientific theories and research as well as the accepted standard of care. P4 Communicate effectively with individuals and groups from diverse populations both verbally and in writing. PC10 Diagnosis - Use critical decision-making skills to reach conclusions about the patient's dental hygiene needs based on all available assessment data. PC11 Planning-Collaborate with the patient, and/or other health professionals, to formulate a comprehensive dental hygiene care plan that is patient centered and based on current scientific evidence c. Establish a collaborative relationship with the patient in the planned care to include etiology, prognosis, and treatment alternatives. PC12 Implementation - Provide specialized treatment that includes preventive and therapeutic services designed to achieve and maintain oral health. a. Perform dental hygiene interventions to eliminate and/or control local etiologic factors to prevent and control caries, periodontal disease, and other oral conditions. PC13 Evaluation - Evaluate the effectiveness of the implemented clinical, preventive, and educational services and modify as needed. a. Determine the outcomes of dental hygiene interventions using indices, instruments, examination techniques, and patient self-report.

Student		Date:	
Instructor		Periodontal Stage	G I II III IV
Patient		Prophy Class	0 1 2 3 4 5 6 7 8
		Grade	A= Acceptable U= Unacceptable

	The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.	Critical Error	Yes	No
1	Utilize accepted infection control procedures	Yes		
2	Apply basic and advanced principles of dental hygiene instrumentation	No		
3	Maintain patient records as instructed	No		
4	Record <u>detailed</u> description of education session in progress notes	Yes		
5	Maintain student records as instructed			
6	Appropriate application of professional knowledge, judgment and skills by the student while providing patient care	Yes		
7	Demonstrate the ability to communicate professional knowledge verbally and in writing	Yes		
8	Review goals and progress towards meeting goals	Yes		
9	Assist the patient in assessing their own level of home care proficiency	No		
10	Emphasize patient responsibility in health care partnership	No		
11	Involve patient and provide positive reinforcement	No		
12	Review the session, evaluate any skill performance, preview the next session	No		

Comment:

LIT Dental Hygiene Program

Skill Evaluation

Patient Education Third Session

LIT Competency Statements	P2 Assume responsibility for dental hygiene actions and care based on accepted scientific theories and research as well as the accepted standard of care. P4 Communicate effectively with individuals and groups from diverse populations both verbally and in writing. PC10 Diagnosis - Use critical decision-making skills to reach conclusions about the patient's dental hygiene needs based on all available assessment data. PC11 Planning-Collaborate with the patient, and/or other health professional, to formulate a comprehensive dental hygiene care plan that is patient centered and based on current scientific evidence c. Establish a collaborative relationship with the patient in the planned care to include etiology, prognosis, and treatment alternatives. PC12 Implementation - Provide specialized treatment that includes preventive and therapeutic services designed to achieve and maintain oral health. a. Perform dental hygiene interventions to eliminate and/or control local etiologic factors to prevent and control caries, periodontal disease, and other oral conditions. PC13 Evaluation - Evaluate the effectiveness of the implemented clinical, preventive, and educational services and modify as needed. a. Determine the outcomes of dental hygiene interventions using indices, instruments, examination techniques, and patient self-report.		
Student		Date:	
Instructor		Periodontal Stage	G I II III IV
Patient		Prophy Class	0 1 2 3 4 5 6 7 8
		Grade	A= Acceptable U= Unacceptable

The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.		Critical Error	Yes	No
1	Utilize accepted infection control procedures	Yes		
2	Apply basic and advanced principles of dental hygiene instrumentation	No		
3	Maintain patient records as instructed	No		
4	Record detailed description of education session in progress notes	Yes		
5	Maintain student records as instructed			
6	Appropriate application of professional knowledge, judgment and skills by the student while providing patient care	Yes		
7	Demonstrate the ability to communicate professional knowledge verbally and in writing	Yes		
8	Review goals and progress towards meeting goals	Yes		
9	Assist the patient in assessing their own level of home care proficiency	No		
10	Emphasize patient responsibility in health care partnership	No		
11	Involve patient and provide positive reinforcement	No		
12	Review all sessions, evaluate skill performance, review referrals, goals and progress towards achieving both and set up recare schedule	Yes		

Comment:

LIT Dental Hygiene Program

Mid Term Skill Evaluation

Using the Mirror and Explorer for Calculus Detection

LIT Competency Statements	9. Systematically collect, analyze, and record data on the general, oral, and psychosocial health status of a variety of patients. a. Select, obtain, and interpret diagnostic information recognizing its advantages and limitations. b. Recognize predisposing and etiologic risk factors that require intervention to prevent disease. f. Perform a comprehensive examination using clinical, radiographic, periodontal, dental charting, and other data collection procedures to assess the patient's needs. 13. Evaluate the effectiveness of the implemented clinical, preventive, and educational services and modify as needed. a. Determine the outcomes of dental hygiene interventions using indices, instruments, examination techniques, and patient self-report.		
Student		Date:	
Instructor		Periodontal Stage	G I II III IV
Patient		Prophy Class	0 1 2 3 4 5 6 7 8
		Grade	A= Acceptable U= Unacceptable

	The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.	Critical Error	Yes	No
1	Utilize accepted infection control procedures	Yes		
2	Apply basic principles of dental hygiene instrumentation	Yes		
3	Maintain patient records as instructed	No		
4	Demonstrate the ability to communicate professional knowledge verbally and in writing	No		
5	Choose the correct working end of the EXD 11/12 explorer	Yes		
6	Keep the lower shank as parallel as possible with the long axis of the tooth	No		
7	Use rotary motion and a walking stroke	No		
8	Effectively roll the instrument into the interproximal area and under the contact	Yes		
9	Maintain the tip one third of the instrument adapted to the tooth surface	Yes		
10	Use an effective mirror fulcrum	Yes		
11	Avoid resting the mirror on the attached gingiva	No		
12	Inaccurately identifies calculus free surfaces as having calculus 50%_____ # over_____ Total penalty _____	Yes		
13	Detect 70% of the calculus in the two quadrants	Yes		

Comment:

LIT Dental Hygiene Program

Skill Evaluation

Slow Speed Handpiece

LIT Competency Statements	2. Assume responsibility for dental hygiene actions and care based on accepted scientific theories and research as well as the accepted standard of care. 11. Planning - Collaborate with the patient, and/or other health professionals, to formulate a comprehensive dental hygiene care plan that is patient-centered and based on current scientific evidence. c. Establish a collaborative relationship with the patient in the planned care to include etiology, prognosis, and treatment alternatives. 13. Evaluate the effectiveness of the implemented clinical, preventive, and educational services and modify as needed. b. Evaluate the patient's satisfaction with the oral health care received and the oral health status achieved.

Student		Date:	
Instructor		Periodontal Stage	G I II III IV
Patient		Prophy Class	0 1 2 3 4 5 6 7 8
		Grade	A= Acceptable U= Unacceptable

	The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.	Critical Error	Yes	No
1	Utilize accepted infection control procedures	Yes		
2	Apply basic principles of dental hygiene instrumentation	Yes		
3	Maintain patient records as instructed	No		
4	Obtain informed consent prior to treatment	Yes		
5	Maintain student records as instructed	No		
6	Appropriate application of professional knowledge, judgment and skills by the student while providing patient care	Yes		
7	Demonstrate the ability to communicate professional knowledge by explaining the concept of selective polishing to the patient. The instructor MUST witness this discussion.	Yes		
8	Apply the principles of selective polishing	Yes		
9	Floss the entire mouth after completing the procedure	Yes		
10	Leave no more than 4 surfaces with stain or biofilm	Yes		

Comment:

LIT Dental Hygiene Program

Competency Evaluation

Instrument Recirculation and Clinic Readiness

LIT Competency Statements	1. Apply a professional code of ethics in all endeavors. 6. Evaluate and utilize methods to ensure the health and safety of the patient and the dental hygienist in the delivery of dental hygiene		
Student		Date:	
Instructor		Periodontal Stage	N/A
Patient		Prophy Class	N/A
		Grade	A= Acceptable U= Unacceptable

	The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.	Critical Error	Yes	No
1	Utilize accepted infection control procedures	Yes		
2	Maintain clinic and laboratory records as instructed	No		
3	Prepare the clinic for the session	Yes		
4	Restock clinic supplies	No		
5	Prepare patient education area for the session	Yes		
6	Prepare the reception area for the session	Yes		
7	Prepare all solutions for the day if indicated	Yes		
8	Choose the correct cleaning and sterilization/disinfection process for equipment and instruments	Yes		
9	Operate sterilization equipment properly	Yes		
10	Wear appropriate PPE	Yes		
11	Assist faculty and peers as requested	Yes		
12	Properly dispose of biohazardous material	No		

Comment:

LIT Dental Hygiene Program

Competency Evaluation

Pedodontic Patient

LIT Competency Statements	9. Systematically collect, analyze, and record data on the general, oral, and psychosocial health status of a variety of patients. 10. Use critical decision-making skills to reach conclusions about the patient's dental hygiene needs based on all available assessment data. 11. Collaborate with the patient, and/or other health professionals, to formulate a comprehensive dental hygiene care plan that is patient-centered and based on current scientific evidence. e. Obtain the patient's informed consent based on a thorough case presentation. 12. Provide specialized treatment that includes preventive and therapeutic services designed to achieve and maintain oral health. a. Perform dental hygiene interventions to eliminate and/or control local etiologic factors to prevent and control caries, periodontal disease, and other oral conditions. 13. Evaluate the effectiveness of the implemented clinical, preventive, and educational services and modify as needed.

Student		Date:	
Instructor		Periodontal Stage	0 I II III IV
Patient		Prophy Class	0 1 2 3 4 5 6 7 8
		Grade	A= Acceptable U= Unacceptable

	The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.	Critical Error	Yes	No
1	Utilize accepted infection control procedures	Yes		
2	Maintain patient records as instructed	No		
3	Maintain student records as instructed	No		
4	Obtain a complete medical and dental history	Yes		
5	Perform an adequate oral assessment and record the information properly	Yes		
6	Expose radiographs as necessary	No		
7	Present the parent/guardian/instructor with an appropriate informed consent which the parent/guardian signs before treatment starts	Yes		
8	Provide individualized education for the child AND the parent/guardian	Yes		
9	Apply basic and advanced principles of dental hygiene instrumentation	No		
10	Includes <u>detailed description</u> of education *topics* and *recommendations* to parent in the progress notes	Yes		
11	Complete all identified procedures in two (2) hours.	Yes		

Start Time: Stop Time:	Start Time: Stop Time:	Start Time: Stop Time:	Total Time:

Comments:

LIT Dental Hygiene Program

Competency Evaluation
Patient Assessment

LIT Competency Statements	9. Assessment – Systematically collect, analyze, and record data on the general, oral, and psychosocial health status of a variety of patients. a. Select, obtain, and interpret diagnostic information recognizing its advantages and limitations. b. Recognize predisposing and etiologic risk factors that require intervention to prevent disease. c. Obtain, review, and update a complete medical, family, social, and dental history. d. Recognize health conditions and medications that impact overall patient care. e. Identify patients at risk for a medical emergency and manage the patient care in a manner that prevents an emergency. f. Perform a comprehensive examination using clinical, radiographic, periodontal, dental charting, and other data collection procedures to assess the patient's needs.

Student		Date:	
Instructor		Periodontal Stage	0 I II III IV
Patient		Prophy Class	0 1 2 3 4 5 6 7 8
		Grade	A= Acceptable U= Unacceptable

	The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.	Critical Error	Yes	No
1	Utilize accepted infection control procedures	Yes		
2	Maintain patient records as instructed	No		
3	Maintain student records as instructed	No		
4	Obtain a complete medical and dental history	Yes		
5	Recognize medical conditions that require special precautions or considerations prior to or during dental hygiene treatment	Yes		
6	Identify the patient at risk for a medical emergency and be prepared to handle the emergency	Yes		
7	Assess vital signs accurately and discuss with patient (BP is taken twice and averaged)	Yes		
8	Perform a head and neck and intraoral examination and accurately record the findings	Yes		
9	Perform an examination of the teeth and accurately record the results	Yes		
10	Evaluate the periodontium and identify conditions that compromise periodontal health and function	Yes		
11	Distinguish normal from abnormal radiographic conditions	Yes		
12	Obtain informed consent	Yes		
13	Demonstrate the ability to communicate professional knowledge verbally and in writing	No		
14	Complete the patient assessment, excluding time for radiographs and instructor evaluation, in two (2) hours	Yes		

Start Time: Stop Time:	Start Time: Stop Time:	Start Time: Stop Time:	Total Time:

Comments:

Clinical Introductory Tracking Sheet
SPRING 2026

Student Name: _____

Requirements: List only the satisfactory assessments.

Satisfactory Assessments:	A=8	B=7	C=6	Incomplete

Medical/Dental History (Patient #)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Head and Neck/Intraoral Exams (Patient #)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Periodontal Assessment (Patient #)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Initial Dental Charting (Patient #)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Plaque Free (Patient #)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)

Satisfactory Radiographs: List only the satisfactory radiographic surveys.

FMX (Patient #)	A=3	B=3	C=3	Incomplete
(1) (sensor)	(2)		(3)	

Pedo FMX	A=1	B=1	C=1	Incomplete
(Patient #) (1)				

BWX (Patient #)	A=3	B=3	C=3	Incomplete
(sensor)	(2) (plates)		(3) (NOMAD)	

Pedo BWX	A=1	B=1	C=1	Incomplete
(Patient #) (1)				

Panoramic (Patient #)	A=1	B=1	C=1	Incomplete
(1)				

Care Plans: Score 75%			
A=3	B=2	C=2	Incomplete

(Patient #) (1)	(Patient #) (2)	(Patient #) (3)

Sealant Patients			
A=1	B=1	C=1	Incomplete
(Patient #) (1)			

Professional Judgement: (Write scores)						
A=40		B=39		C=38		Incomplete
(1)	(2)	(3)	(4)	(5)	(6)	Total

Community Service Hours (Fluoride Varnish)			
A=3	B=3	C=3	Incomplete
(1)	(2)	(3)	

Competencies:	1st Attempt	2nd Attempt	3rd Attempt
Instrument Recirculation (1st attempt must be acceptable for an A)			
Patient Assessment (Patient #)			
Pedodontic Patient (Patient #)			

Radiographic Evaluation: Score 80%	1st Attempt	2nd Attempt
(score)		

Mid-Term Skills Assessment	1 Attempt
(Typodont)	

Skill Evaluations (Patient #)	1st Attempt	2nd Attempt	3rd Attempt
Sickle Scaler			
Universal Curet			
Periodontal Debridement			
Slow Speed Handpiece			

Patient Education (Patient #)	1st Attempt	2nd Attempt	3rd Attempt
Session 1			
Session 2			
Session 3			

Patient Points: **(Patient #)**

Class 1 and 2 (combined)	**A=12**	**B=10**	**C=10**	**Incomplete**								**TOTAL**
Class 1 Started	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	
Class 1 Finished													

						TOTAL
Class 2 Started	(1)	(2)	(3)	(4)	(5)	(6)	
Class 2 Finished							

Class 3	**A=9**	**B=9**	**C=6**	**Incomplete**		**TOTAL**
Class 3 Started	(1)			(2)	(3)	
Class 3 Finished						

Periodontal Classification: **(Patient #)**

Gingivitis Stage 1 or 2	**A=2 A=4**	**B=1 B=3**	**C=1 C=3**	**Incomplete Incomplete**			**TOTAL**
Gingivitis	(1)			(2)			
Stage 1 or 2	(1)			(2)	(3)		

Comments:

X-ray Completion Tracking Sheet

Patient #	Type of Survey	Date Submitted	# of Retakes Needed	Graded (S or U)

RADIOGRAPHIC GUIDELINES

All surveys must be critiqued using the designated form available in **Trajecsys**. Please select the correct form. Technique and evaluation will be graded, and a minimum score of **75%** is required to pass.

After completing the critique on Trajecsys, email **dhcritique@lit.edu** with the following:

- **Subject line**: Your clinical counselor's name
  - **Example**: Dr. Mendoza
- **Email body**: Type of survey, patient ID number, and patient code
  - **Example:** "FMX using sensor completed on patient #09999, patient code 1A"

Completed Surveys must be turned in within 1 week after the initial films have been taken or they may not be graded (i.e., Survey taken on Tuesday morning = due by the following Monday).

You will be notified of any required retakes after grading. Retakes on all surveys must be completed on the 2nd appointment. Incomplete surveys will not be counted towards your requirements and will affect your Professional Judgment grade. Retakes must be completed regardless of the initial survey's acceptability. Only take radiographs that are clinically necessary and appropriate for the patient.

Incomplete entry of patient information in Eaglesoft will result in an automatic unsatisfactory ('U') grade.

Full Mouth Survey – Grading Criteria

Full Mouth Surveys will be evaluated according to the standards outlined in **DHYG 1304**. Each survey begins with a perfect score of **100 points**.

- **Retakes**: **5 points** will be deducted for each required retake or circled retake.
- **Improvable**: For each area marked as improvable, **1.68 points** will be deducted.
- **Insufficient Findings/Incomplete Evaluations**: May be classified as either improvable or retake, depending on the nature of the deficiency.

***5 Retakes** or **15 Improvable images/evaluations**

BWX Survey – Grading Criteria

Bitewing surveys will be evaluated according to the standards outlined in **DHYG 1304**. Each survey begins with a perfect score of **100 points**.

- **Retakes**: **16.34 points** will be deducted for each required retake or circled retake.
- **Improvable**: For each area marked as improvable, **4.33 points** will be deducted.
- **Insufficient Findings/Incomplete Evaluations**: May be classified as either improvable or retake, depending on the nature of the deficiency.

***1 Retake plus 2 Improvable images/evaluations**

PANORAMIC Survey – Grading Criteria

Panoramic Surveys will be evaluated according to the standards outlined in **DHYG 1304**. Each survey begins with a perfect score of **100 points**.

- **Retakes**: **30 points** will be deducted for each required retake or circled retake.
- **Improvable**: For each area marked as improvable, **15 points** will be deducted.
- **Insufficient Findings/Incomplete Evaluations**: May be classified as either improvable or retake, depending on the nature of the deficiency.

***No retakes**

Radiographic Evaluation:

1 One Radiographic Evaluation is scheduled this semester.
2. It is scheduled to be completed online.
3. The Radiographic evaluation is considered to be a Competency Evaluation and must be successfully passed by achieving an **80%** or better.
4. Only 1 repeat evaluation will be given later in the semester for students whose first attempt was not successful. Remediation is mandatory.
5. A student that has not successfully completed the Radiographic Evaluation will not progress in the program.

INTRODUCTORY CLINIC INFORMATION

Introductory Clinic Information

Students are advised to use an alternate cell phone # for contacting patients for clinic appointments. The faculty feels this will decrease the potential for patients to track and harass students. Harassment has not been a significant problem in the past; however, the faculty is constantly trying to make sure it remains that way.

I. Appointment book control-All students are required to have a paperback planner.

1. You must write all appointments in the appointment book. Failure to record appointments will result in disciplinary action or an incident report in the student's permanent record.
2. The appointments in your personal book and the clinic book should always match.
3. Record the patient's name in the appropriate spot in the appointment book.
4. **Be very careful when making appointments or changing them, an error may cost you valuable clinical time or you may have two patients at the same time and waste someone else's time.**

II. Cancellation Time (Non-productive Time)

1. It is your responsibility to explain the necessity of keeping scheduled appointments and of notifying you at least 24 hours in advance if your patient cannot keep the appointment. The maximum time allowed is 20 hours. After 20 hours the final grade drops by one letter grade.
2. Patients should be told they can leave messages for you by calling the Dental Hygiene Clinic number.
3. Check your folder and the bulletin board regularly to receive messages.
4. Confirm all appointments 24 hours prior to the scheduled appointment time.
5. You should record any cancellations or missed appointments in the patient's progress notes and call log. The Dental hygiene program cannot be accused of abandoning a patient if there is a record of the missed or cancelled appointments. This patient will also be identified as non-compliant if they ever desire treatment at the LIT Dental Hygiene Clinic again.
6. Communication forms will be made for all patients and an entry of student/patient communication will be recorded for each contact. Contact with new patients who have no record yet will still be recorded on a communication form which will be kept in the student's file area in a folder especially labeled for that purpose. When the patient comes in for their first appointment this form will be placed in their patient folder.
7. Students are responsible for monitoring the arrival of their patients. No one is allowed to hang out in the reception office. Have your patient notify you when they arrive. If you have a cancellation, you may opt to go recruit a patient from the building. You must inform your Pod instructor. When you return you need to inform the same instructor of your return. If you have no patient you must

use your clinic time constructively and document it on the back of the cancellation CER. An instructor must sign it.

III. Patient Fees

1. See Table below

Patient Category	Cost
General Public	$25.00
Senior Citizens (65 plus)	$15.00
Public Assistance*	$10.00
LU and LIT Students and Faculty	$15.00
Radiographs Only	$10.00

1. Paymentmust be shown by written receipt before instructors sign the patient's health history, unless other arrangements have been made with the receptionist.
2. Inform your patients they will be required to show a form of identification. You will make a copy of the identification, and an instructor will initial it when the health history is signed. The same applies to student ID 's and proof of public assistance. No discounts will be given without proof.

IV. Planning

You may not be able to complete each patient you begin to treat this semester (i.e. the patient may elect to discontinue treatment or lack of time at the end of the semester may necessitate completing the patient during the next semester). You should plan to complete more than the required minimum. Good planning and organization will ensure the completion of clinical requirements.

V. Patient education, plaque and bleeding scores

Plaque and bleeding scores will be obtained at every patient appointment and recorded in the progress notes. Patient education will be performed at chairside during every appointment. The best time for education is after determining the patient's plaque and bleeding score. Patient education may include intraoral demonstration of homecare techniques by the patient at every appointment.

VI. Dismissing patients at the end of an appointment

Every patient **MUST** be checked by an instructor prior to dismissal at every appointment even if the patient had NO procedures done. An instructor must sign your progress notes, and we need to at least talk to your patient in order to do this.

VII. Children/Minors (under the age of 18)

You are allowed to see two children ages 5-10 yrs of age this semester. Youth aged patients are not limited. Children must be accompanied by a parent or legal guardian, no one else is allowed to sign the informed consent unless a legal document providing permission is used. The form is available on Blackboard under DHYG 1260. See the clinic coordinator if you have questions.

VIII. LIT Appointment Policy

The LIT Appointment Policy form should be explained to each patient before they sign it. This form is to be placed in the patient's record.

IX. Sterilization Duty

Each student will be assigned to work in Sterilization approximately 4 times during the semester. This assignment is not optional. Students who schedule patients during their scheduled in-session assignment will be required to reschedule their patients. Students who miss any part of their assignments will be required to make up that session and an additional 4-hour session outside of your clinic time. You must arrive 30 minutes prior to the start of clinic. DO NOT BE LATE.

X. Patient Transportation and Parking:

Patients must arrange for transportation to and from the clinical facility. Students must not transport patients unless they are immediate family members (parent, sibling, or offspring).

Patient parking is provided in the front/back of and adjacent to the LIT Multi-Purpose Center. Patients are required to obtain an official parking permit from the receptionist in the dental hygiene clinic. The parking permit must be placed on the front dash of the patient's locked car. It is the dental hygiene students' responsibility to ensure their patients are legally parked in the patient parking area. **Under NO circumstances are students allowed to park in the Patient Parking Area. Violators in the patient parking area will be ticketed and/or towed.**

XI. Patient Records:

All patient records are the property of the LIT Dental Hygiene Program. No patient records may leave the dental hygiene clinic. Students must use the out-card system to retrieve patient charts.

XII. Patient Confidentiality:

All patients have the right to expect the strictest confidentiality of their records. Students violating this policy will receive point deductions from their grade or dismissal from the program.

XIII. Instruments:

The students are expected to care for and monitor their instruments. Students on sterilization duty have specific duties; they are not there to be your assistant. If you are taking radiographs outside of your normal clinical time, you are solely responsible for

anything used. LIT and the faculty are not responsible for missing instruments and/or instrument breakage.

XIV. Patient Rights:

Students and faculty alike are expected to consider the rights of patients. The rights of patients include:

1. Considerate, respectful and confidential treatment.
2. Continuity and completion of treatment.
3. Access to complete and current information about their condition.
4. Advance knowledge of the cost of treatment.
5. Informed consent to include the explanation of recommended treatment, treatment alternatives, the option to refuse treatment, the risk of no treatment and expected outcomes of various treatments.
6. Postoperative instructions.
7. Treatment that meets the standard of care in the profession.

XV. **Medically Compromised Patients**:

Patients may have a medical or drug history that would compromise their health if dental treatment is rendered. Certain patients who have a complicated medical/drug history must obtain a medical release from their physician. The release must be received prior to dental treatment. A new/updated medical release is required every 3 years.

XVI. **Hepatitis and HIV Positive Patients**:

Hepatitis and HIV Positive patients will be treated in the Dental Hygiene Clinic. Patients who have symptoms beyond the scope of training of dental hygiene students will be referred to an appropriate health care professional.

XVII. **Herpes Simplex Infection**:

Proper infection control should prevent cross-contamination with the Herpes virus. However, auto-inoculation can occur. It is in the best interest of the patient to delay routine treatment until the herpetic lesion is considered non-infective or until the lesion has completely crusted over.

XVIII. **Professional Judgement and Ethical Behavior:**

Students are required to display attitudes and behaviors consistent with accepted standards of professional conduct. Therefore, evaluation of professional behavior occurs continuously throughout the curriculum. There will be six opportunities for faculty to observe the students and complete a Professional judgement and Ethical Behavior scoring rubric. If accepted standards are not met, a student may have points deducted from the professional judgement and ethical behavior score. A minimal score of 38% must be met to progress in the program. For repetitive breaches of professional standards, a student may be administratively withdrawn from the Program without the opportunity for re-admission. The following professional characteristics are among those encouraged, observed, and evaluated

throughout the dental hygiene curriculum: clinic readiness, professional appearance, professional judgement, professional instrumentation skills, infection control, time management, organization skills, documentation, and patient rapport. Students are expected to demonstrate these characteristics, both in their academic and clinical pursuits.

Professionalism in the patient-care environment reflects the principles described above and is further defined by expectations in the following areas: protocol, skill maintenance, instrumentation skills, documentation, time management, infection control, equipment maintenance, decision making, ethics, conduct and communication.

XIX. **Clinical Teaching Using the Pod System:**

- The pod system will be utilized in the clinic setting to enhance student learning.
- The Pod system requires each clinical instructor to be assigned to specific cubicles to create smaller groups within the clinic. Working in pods emphasizes one-on-one teaching, continuity of instruction and closer monitoring of student progression.

APPOINTMENT PLANNING

APPOINTMENT PLANNING

This section of the manual is provided to the student for use as a guide in appointment management. It should be emphasized that this is a guide only and should not be used as an alternative to creative individual appointment planning. Use this guide as a reference before and during your appointments.

I. Appointments

A. Appointments are usually made over intervals of 2 or 4 hours.

B. Appointments **must be** recorded in the office appointment book. Failure to record the appointment under other than extraordinary circumstances will result in an error under professional judgment and ethical behavior.

C. Appointment cards are available through the Dental Hygiene Clinic Receptionist. When you are making the initial appointment over the phone, it is an excellent idea to review the medical history. If the medical history contains questionable elements, you will be able to obtain a medical release prior to the initial appointment. Examples would be heart disease, history of latex allergy, uncontrolled high blood pressure or diabetes. It would also be a good idea to email the patient an appointment card with the time and date of their appointment and your name so that they know whom they have an appointment with. You can also send out medical history and treatment release forms to be completed by the patient.

D. Appointments **must be** confirmed 24 hours prior to the appointment time. We have had problems in the past with patients who cancel at short notice or just do not show up at all - even when confirmed. It is very helpful if you can have a few stand-by patients you can call on short notice. It is also very important your patients know how important they are to you; without them you will not become a hygienist. Take an interest in them. Please do not harass your patients by calling numerous times at all hours of the day and night. Every year at least several patients object to overzealous confirmation tactics.

E. Communications Log

Note every contact with your patient on the Communication Log in the record. This log is required and may prove to be very helpful when trying to sort out misunderstandings between patients, students and the clinic. Fill this out as completely as possible. Communication logs for patients who have not yet been in the clinic should be kept in a folder labeled “Communication Logs” and filed at the front of the student’s file area in the file room.

F. You should locate your patient’s chart prior to the day of the appointment.

II. Pre-appointment preparation

A. Carry out all pre-appointment infection control procedures.

B. Pick up your patient's chart from the file cabinet.

C. Set up only those items necessary for the procedures to be performed during the appointment. You must plan!

D. Your patient will check in with the clinic receptionist.

E. Greet your patient and seat on time. If you are running behind schedule, please notify the patient and the clinic receptionist. She will need to know how long you will be delayed - be honest do not underestimate. If more than 15 minutes are required, you should stop where you are with your current patient and start where you left off at their next appointment. Remember, it will take about 15 minutes to post and pre-op before you are able to seat your next patient.

III. Fill out the CER/Deploy in Trajecsys

A. Account for clinical time by filling in the appropriate box in the top left corner of the CER. You will have a separate CER for each patient. You will also have a CER for the following occurrences. CER's must remain in the reception office. They must be checked out by an instructor or the administrative assistant. Students are not allowed to take CER's without assistance.

Cancellation CER

When a patient cancels or does not show up for his appointment you must use a Cancellation CER to record clinic time use.

Sterilization CER

You will have one CER to record time spent on sterilization duty.

Student Illness CER

A student illness CER will be executed only when a clinic absence is not excused or when an excused clinic absence is not made up prior to clinic counseling dates. See your clinic counselor or clinic coordinator for instructions on how to record your time in this situation.

Screening CER

Students are encouraged to have their patients screened prior to setting up appointments for them if has been a long time since their last dental check up. Patients are not charged for screening alone but will be charged the appropriate fee if radiographs are taken.

IV. Initial paperwork and Histories

A. The student is reminded that it is good practice to obtain at least some of the medical history over the phone when making the first appointment for the patient. If a medical consultation or release is necessary, you can obtain it prior to the actual appointment. The following forms must be filled out at the initial appointment.

1. Medical/Dental History
    a. Make sure this is filled out completely - vital signs, etc.
    b. Have patient sign and date
    c. Student signature

d. If medications (prescriptions, OTC or Herbal medications) are listed follow this procedure:
   (1) At the initial appointment look up the drug in the PDR or other drug reference (don't forget the internet for herbal medications) and record any treatment modifications or contraindications for dental treatment on the second sheet of the medical history.
   (2) By the second appointment have a drug card for each prescription the patient is taking. You do not have to write a drug card for OTC medication or herbal medications or supplements (herbal or others).
   (3) Drug cards accompany the medical/dental history on the second patient visit and will be reviewed by the instructor. The instructor will note the cards have been done by initialing the drug card space on the second sheet of the medical history.

e. If medical history indicates a consultation with an MD is required, the student will attempt to reach the MD by phone and FAX a Medical Release form to the MD for completion before the student can proceed with patient treatment.
   (1) At the discretion of the instructors and depending on the reason for the medical release the student may perform some limited procedures prior to receiving a medical release. An instructor will evaluate each patient and inform you what can be done.
   (2) The best way to avoid wasted time is to obtain a preliminary medical history over the phone when making the initial appointment.

2. Patient Application for Treatment and Release Form. Have your patient read, sign and date this form. Your instructor will initial this form at the first appointment when the Medical/Dental history is reviewed. No other signatures are required during the semester in which the patient begins treatment. If seen in subsequent semesters, a new signature and initials must be obtained.
3. LIT Appointment Policy form. Have your patient read and sign this form. Please ask if they have any questions, if so, clarify the policy for them. Your instructor will initial the form. This form is signed once and does not have to be signed in subsequent semesters
4. Fill out and explain all HIPAA Forms to the patient
   a. Have the patient sign and give the patient a copy of the policy at LIT.
5. The CER. The CER must be filled out and an entry in Trajecsys must be made.

B. The first appointment

When the patient has completed the forms, you will take their vital signs and record your findings. Ask an instructor to come to your chair to review the patient's medical/dental history and vital signs. The instructor may comment or question you regarding any information contained or not contained on the form before placing the grade on the CER. The instructor will check and initial the patient ID, payment receipt, release forms, and HIPAA forms. The need for x-rays will be determined at this time.

C. For second and subsequent appointments the student will update the Medical/Dental history, note any changes by recording the number of the line item next to the signature line (or N/C if there have been no changes). If additional drugs have been added the student will follow the procedures noted above. The updated Medical/Dental history and other necessary forms will be given to an instructor for signatures.

V. Oral Exam (Head and Neck and Intraoral exams)

The next section should be done as one exam before signing up for an instructor to check. Make sure you list atypical as well as pathological findings and the suspected etiologies.

A. Head and Neck Exam

Follow the procedures listed on the clinic Head and Neck and Intraoral exam form

B. Intraoral Exam

1. Before proceeding with the intra oral portion of the exam, have your patient rinse with antiseptic mouth rinse.
2. Proceed with the exam as listed on the exam form.

C. Have both exams checked by an instructor before proceeding.

****

A prophy class should be assigned to your patient at this time. An RDH instructor is responsible for determining a prophy class and for helping you decide if this patient would be appropriate for a skill evaluation or competency. It is your responsibility to alert the instructor that a prophy class is needed.

****

VI. Periodontal Assessment

It is often impossible to complete this examination during one appointment at the beginning of the semester. The examination has been divided into 4 sections which are graded by an instructor. The individual sections are added together to produce a grade for the examination.

A. Dental Biofilm associated gingival/periodontal disease related to:

Note the number of soft deposits, <u>without disclosing the patient and before the deposits have been disturbed by instrumentation.</u> Fill out the biofilm section. Some of this information may not be available until you complete other sections of the form.

1. Biofilm: Evaluate

2. Determine and check off biofilm retentive features using the dental chart, gingival description and any other source of information.
3. Use the medical history and any other information to determine the existence of other predisposing or contributing factors and check these off.

B. Soft Tissue Examination

Examine the free gingival tissues for clinical characteristics noting generalized as well as localized areas of change.

1. Probe all quadrants noting readings of four mm or more in the appropriate places and calculate the CAL. Note the presence of bleeding and record by placing a red dot above the area where the pocket depth reading should appear.
2. Note any areas of recession by measuring the distance between box and calculate the CAL.
3. Inadequate zones of attached gingiva will be noted.
4. Frenum involvement will be charted in the area in which it occurs.
5. Furcation involvement should be charted in the appropriate places.
6. Note mobility (indicate severity with 1, 2, or 3).
7. If any one of the above findings is present, the student must determine the CAL to correctly identify the periodontal stage and grade.

C. Radiographic Findings

Radiographs are needed at this point, although they can be taken at any time prior to this. The instructor/DDS will help determine which radiographs are necessary.

1. Bring your CER to your instructor and he/she will procure needed supplies and record the patient's name and number along with number and type of radiographic imaging in the clinic grade book. The instructor will also initial the CER next to the proper radiographic procedure and place a start date in the appropriate column.
2. Take the radiographs and process if necessary. Use the radiographs to fill in the radiographic findings portion of the periodontal assessment form and have this graded.
3. The type of radiograph and the justification for exposure must be recorded on the progress notes on the date the radiographs are taken.

D. Periodontal Condition

Determine the periodontal stage/grade and check off the appropriate box on the assessment form.

E. Calculus Detection

Class 3 patients. The student will explore all surfaces for hard deposits and chart on the calculus detection form for each Class 3 patient. You are not required to do calculus charting on Class 1 and 2 patients.

VII. Dental Charting

A. A complete dental charting will be accomplished for every patient. There are 2 forms. The initial dental charting and the shading portion. Information obtained from the chart will be used to determine biofilm retentive features and the predisposing factors on the periodontal assessment form. The initial dental charting form is completed by the student. The dentist will check your findings for accuracy. Only the DDS can grade this form. Corrections should be made immediately.The dentist must sign all areas assessed at the bottom of the form. Correct findings will then be recorded on the dental charting form using the red/blue pencil. (no ink) The dentist or an instructor can give your grade for dental shading on the CER.

B. Unless otherwise indicated radiographs must be utilized for dental charting. The radiographs may be taken at the clinic or may be requested from the patient's dentist of record. Mrs. Byrd can assist you in obtaining a digital record.

C. You can fill out the progress notes for this patient up to the point of dental charting before the dentist is asked to check the patient. One of the following entries should be used:

Dental charting with x-rays
Dental charting without x-rays

D. Referrals for dental treatment will be noted in the referral section on the informed consent document. The dentist must initial referrals or no referrals. It is your responsibility to write about the conditions the patient is being referred for.

E. It is your responsibility to ensure the dentist has the forms required and the proper signatures and grades are recorded. If these procedures are not completed correctly it will reflect on your professional judgment and ethical behavior grade.

VIII. Plaque/Bleeding Score and Home Care Regimen Form

A. Determine the plaque score by disclosing. The initial plaque score and bleeding will be determined for all patients during their first or second visit and at **each** subsequent visit. Record the plaque and bleeding scores on this format for each appointment. Bleeding score is evaluated as localized or generalized. A bleeding score of 30% or less is considered localized.

B. Each patient shall have an initial full mouth bleeding score recorded during the first or second visit and a partial score at every appointment thereafter using the 6 indicator teeth on the form.

1. Number of bleeding points / (number of teeth present (28) x 6 possible bleeding **points)**
26 bleeding points/168 possible = .15 or 15% bleeding score

2. Number of bleeding points / (number of teeth present (6) x 6 possible bleeding points)
12 bleeding points/36 possible = .33 0r 33% bleeding score

C. On the first or second patient visit, determine the patient's home care routine. Circle "baseline" under home care and record the information in the appropriate areas. At subsequent visits you can record your home care recommendations by circling "recommendations" and recording the information in the appropriate areas. Make sure you update this as necessary.

D. The plaque score and bleeding score should be noted in the progress notes on the dates they are done.

IX. Full Periodontal Charting will be used to determine the periodontal stage and grade if a patient presents certain abnormal findings. This includes one or more of the following: (pocket depths of 4mm or above, recession, furcation involvement, mobility, IZAG, and frenal attachment involvement).

A. The following information is assessed

1. Pocket depths (6 readings for each tooth)
2. Gingival margins (6 readings for each tooth)
3. Determination of clinical attachment level (CAL) (6 readings per tooth)
4. Mobility
5. Sensitivity to percussion
6. Suppuration
7. Frenal problems, furcation involvement and IZAG
8. Determination of the patient's periodontal stage and grade

B. RDH Instructors will check your periodontal assessment. The DDS can check the radiographic portion of the assessment. If you do not have an instructor's signature for this assessment you will receive a U on this portion of the CER.

X. Informed Consent / Care Plan and Risk Assessment Documents

A. Informed Consent / Care Plan

1. After completing and analyzing all baseline data the student will fill out an Informed Consent Document.
2. The student will present the document to an instructor after the student and patient have signed the form.
3. Fill out the referral section if any dental/medical referrals need to be made. Referrals are also recorded in the patient's progress notes. The dentist on duty must sign any referrals.
4. The instructor will sign the plan in the designated area and place a grade on the CER after the student has verbally presented and explained the plan to the patient. The student and the patient's signature must be present.
5. Give the patient the original and keep the yellow copy in the file.

XI. Dental Hygiene Care Plans

A. Dental hygiene care planning and patient education will be accomplished on every patient during treatment; written plans are required for the following:

1. The patient you are using for the patient education skill evaluation
2. Another patient approved by an instructor (preferably a class 3)
3. If you are working towards a grade of "A" in this course, a third treatment plan needs to be done on another patient approved by an instructor.

B. Data collection ends with the completion of all assessment forms. Submit care plans on Blackboard. Give the patient file to your clinical advisor for grading. ***You have 1 week from the date of the last assessment appointment to submit the written care plan to your clinical advisor. Late submissions will not count for requirements.***

XII. Patient Education

A. Patient education will precede any scaling. Patient education WILL be done at EVERY appointment following determination of the plaque score. If appropriate patient education is not done the student will receive an "unsatisfactory" rating for Professional Behavior and Ethical Judgment.

B. Record the patient's plaque score, bleeding score, level of learning in the progress notes in association with each patient education topic.

XIII. Scaling Procedures

When all examination procedures and assessments are graded. You proceed with patient education. Next you may begin therapeutic treatment (the removal of all hard deposits without unnecessary tissue trauma).

A. Start in one quadrant and use a systematic approach. Make sure you feel the deposits before you try to remove them. If you do not feel the deposits, you cannot remove them. Get help from your instructor to identify deposits, if necessary. Trying to remove something you cannot feel is only going to cause tissue trauma and waste time.

B. At the beginning of the semester or when you have a difficult patient, you may ask an instructor to check your progress without grading you. We are here to help you learn, do not assume we know if you are having trouble or not. It is your responsibility to ask for assistance.

C. When scaling in one quadrant is complete, ask for a scale check from an instructor. Dentists are not allowed to grade scaling except for Dr. Mendoza.

D. The instructor will check the areas scaled and indicate which areas still have deposits or which areas have tissue trauma. Record these areas in the comments area on the CER for that quadrant. The student is graded on the amount of deposit left and the presence of tissue trauma at this evaluation. Proceed to remove the remaining deposits identified by the instructor.

E. Ask for a re-evaluation from an instructor and if the deposits have been removed the instructor will sign the re-evaluation column and the grade for the quadrant will be recorded. Continuing with the next quadrant.

F. Instructors may be occupied when you need a quadrant checked. Never sit and do nothing unless necessary. Ask the instructor if you can go on and remember you can always perform patient education.

XIV. Polishing/Plaque Free

Determine the procedure your patient needs. If polishing is necessary, determine which surfaces need to be polished. Explain selective polishing to your patient.

A. Plaque Free (without prophy paste) *

1. You will disclose your patient and proceed to remove all biofilm deposits. Use a slow speed handpiece with a cleanser such as non-abrasive toothpaste. Follow with flossing.
2. Re-disclose the patient and remove any remaining biofilm before you sign up for an instructor to check.
3. The instructor will indicate any remaining areas. You will record these on the CER and remove them before asking for a re-evaluation.

B. Polishing (using a prophy paste)
1. Disclose the patient and remove all soft deposits and stain. Use a slow speed handpiece and appropriate prophy paste. Follow with flossing.
2. Disclose again and when you have determined the patient to be biofilm free, have your instructor check.
3. The instructor will indicate any areas that remain, and you will remove these before asking for a re-evaluation.

C. Children

One option is the use of a toothbrush with toothpaste when there is minimal plaque. Polishing is acceptable if there is stain or heavy plaque. Care must be used with regard to the speed of the prophy angle to avoid exposing the pulp chamber to heat.

XV. Fluoride Treatment

After the patient is plaque free, provide a fluoride treatment.

A. Follow the procedures regarding patient education and be sure to give your patient a fluoride fact sheet. (Put one in their record when you start treatment)
B. Don't forget to have an instructor check your patient.
C. Never leave your patient during fluoride treatments
D. Fluoride Varnish. Fluoride varnish will be done for all children with primary dentition. Patients who have excessive recession will also be offered fluoride varnish. Follow the manufacturer's instructions. Be sure to give appropriate instructions to your patient and one of the patient handouts to take home. You will be given a limited number of Varnish applications. You may ask for extra.

XVI. The Last Appointment

Make sure all the following are done before you dismiss your patient for the last time.

A. Treatment is complete. The patient will scan the QR code and take a survey. Check your CER for grades and signatures. Information is entered in Trajecsys.
B. The last entry on the progress notes contains the following.
1. Description of the patient's gingival/periodontal condition upon leaving.
2. Current learning level
3. Referrals needed
4. Maintenance schedule (recall schedule) example: 6 month recall, June 2026
5. Patient's receipt number and payment information, if not recorded previously

C. Have an instructor check your patient before he or she leaves.

XVII. Comprehensive Care Grade

The following information must be recorded and procedures performed before your patient will be identified as complete.

A. Comprehensive Care Grade-meaning all required treatment has been completed.

B. The patient record must be complete

1. All forms present in the correct order
2. Radiographs must be saved on the computer. The progress notes should state where the radiographs were sent if a patient requests them.

C. Completed CER

D. Payment receipt number, type (cash or credit card) and amount on CER

E. Have the chart audited

1. All charts must be organized according to the audit form, including those seen for radiographs only.
2. Charts must be audited within one week of completion of treatment or receipt of a grade on the radiographs.

XVIII. Consumer Survey

A. Have patients scan the QR code located in each unit to complete the survey. The patient will show your instructor the completed survey before being dismissed from the clinic.

XIX. Patient Records

A. **<u>Patient records are NOT to leave the building.</u>**

B. Follow the Chart Audit Form for record organization and writing progress notes

XX. Chart Audit

A. Random charts will be audited by your clinic advisor.

B. Charts are to be audited as soon as you have finished all procedures and have received a grade on any radiographs taken. You have 1 week to complete the audit. Give completed patient charts to your clinical advisor.

C. Patient charts must be filed when returned to you.

DHYG 1260 Introductory Clinic
GRADING CRITERIA

Clinic Procedure	Satisfactory
1. Medical/Dental History	2 errors
2. Oral Examination	3 errors
3. Periodontal Assessment	3 errors
4. Periodontal Charting	8 errors
5. Radiographic Evaluation	3 errors
6. Informed Consent	4 errors
7. Initial Dental Charting	4 errors
8. Dental Shading	3 errors
8. Scaling (per quadrant)	
A. Class I	2 errors
B. Class II	3 errors
C. Class III	4 errors
Tissue Trauma	*Counted as a scaling error
9. Polishing/Plaque Free	4 errors
10. Fluoride Treatment	2 errors

Radiographs (3 improvable=1 retake)	
1. Adult FMX	4 retakes + 2 improvable
Primary/Mixed FMX	2 retakes + 2 improvable
2. Adult BWX	1 retake + 2 improvable
Primary/Mixed BWX	1 retake
3.Panoramic	2 errors
Chart Audit	2 errors per chart

HARD DEPOSIT AND PERIODONTAL CLASSIFICATIONS

HARD DEPOSIT CLASSIFICATION SYSTEM

Class I: Any condition less than Class II.

Class II: Slight to moderate generalized supramarginal calculus and/or subgingival calculus on at least 10 teeth.

Class III: Easily detectable subgingival calculus deposits on at least 10 teeth.

PERIODONTAL CLASSIFICATION SYSTEM

Periodontal Staging:

Periodontitis	Stage I	Stage II	Stage III	Stage IV
Interdental CAL	1-2mm	3-4mm	5mm or +	5mm or+
RBL	Coronal 1/3 <15%	Coronal 1/3 15-33%	Middle third of root +	Middle third of root +
Tooth Loss	None	None	<4 teeth	>5 teeth
Local or General	*Max probe depth 4or less *Mostly horizontal bone loss	*Max probe depth 5or less *Mostly horizontal bone loss	*Probe depths 6mm or + *vertical bone= loss 3mm or + *furcation involvement= II or III	Need for complex rehab due to: Masticatory dysfunction Tooth mobility 2+ Ridge defects Bite collapse,drift,flaring Less than 20 teeth

GRADING

Progression		Grade A Slow rate	Grade B Moderate rate	Grade C Rapid rate
Direct Evidence of progression	RBL or CAL	No loss over 5 years	<2mm over 5 years	2mm + over 5 years
Indirect Evidence	% bone loss/age	<0.25	0.25-1.0	>1.0
	Case phenotype	Heavy biofilm Low destruction	Biofilm commensurate with destruction	Destruction exceeds expectation from biofilm deposits Periods of rapid progression suggested and/or early onset disease
	Smoking	Non-smoker	<10 cigarettes/day	10+ cigarettes/day
Risk factors	Diabetes	No diabetes	HbA1c<7.0 in diabetics	HbAc1 7.0+ in diabetics

INSTRUCTIONS FOR MID AND FINAL CLINIC COUNSELING

INSTRUCTIONS FOR MID-SEMESTER CLINICAL COUNSELING

STUDENTS:

1. What to bring:
• Appointment book
• CERs
• Clinic Tracking Chart from syllabus (filled in where applicable)
• Clinic Syllabus (for reference or questions)
• Have all information organized so that finding specific information is easy for you.
• Make sure completed skill evaluations, competencies, radiographic critiques, and professional judgement forms have been submitted in Blackboard within one week of finish date
2. Check your entered time in Trajecsys.
3. At the end of each progress check/clinical counseling session, upload clinical tracking sheet into Blackboard.

FACULTY:

1. Check patient #'s and codes on the grade book in Trajecsys
2. Check computer grade book for the following:
a. Accuracy
• Check patients listed on the grade sheet in Trajecsys.
• Check accuracy of completed patients.
• Check to see if any clinic requirements were successfully completed.
b. Check accuracy of clinic time.
c. Check accuracy for special needs patients
d. Check accuracy for recall patients.
e. Corrections to CER's should be done in Trajecsys.
f. Check Blackboard for submissions
3. Fill out the clinical tracking spreadsheet in the 'R' drive under Gradebooks, Current.

INSTRUCTIONS FOR FINAL CLINIC COUNSELING

STUDENTS:

1. What to bring:
• Appointment book
• CER's
• Clinic Tracking Chart from syllabus (filled in where applicable)
• Clinic Syllabus (for reference or questions)
• Have all information organized so that finding specific information is easy for you.
• Make sure completed skill evaluations, competencies, radiographic critiques, and professional judgement forms have been submitted in Blackboard within one week of finish date
2.Check time in Tracjecsys. Be able to document any errors with CER's.

FACULTY:

1.Check and document patient #'s and codes in gradebook. Check accuracy of grades in Trajecsys.

2. Check computer grade book for the following:
a. Accuracy
- Check patients listed in Trajecsys.
- Check accuracy of completed patients.
- Check to see if clinic requirements were successfully completed.

b. Check accuracy of clinic time. Students should have a total of 104 hours (26 days) of clinic time. Students should have 16 hours of sterilization.
c. Check accuracy for special needs patients.
d. Check accuracy for recall patients.
e. Corrections to CER's should be done in Trajecsys.
f. Check Blackboard to make sure all skill evaluations, competencies, radiographic critiques, and professional judgement forms have been submitted.
3.Confirm students' final grade for semester.
4.Fill out the clinical tracking spreadsheet in the 'R' drive under Gradebooks
5.Record progress on Starfish.
6.Remind student to turn in locker and key from instrument locker.

CHART AUDIT PROCEDURE:

Students will complete a chart audit on each patient treated in the clinic. (including x-ray only) There is a chart audit checklist located with the other clinical paperwork. It lists all the paperwork to be included in the patient chart along with the order it should be in. Notations that should be in the progress notes (blue sheet) are listed also. You have one week after the patient is completed (this includes radiographs once they are graded) to complete a chart audit. When your patient is complete and you have audited the chart, return it to the file room. Instructors will audit your charts randomly to ensure the correct documentation procedures are being followed. You will receive an A or U on the CER to indicate which charts were audited by an instructor.
*You are allowed only 2 (U)-unsatisfactory chart audits for the semester. You will receive feedback on corrections. Beginning with the 3rd grade of (U) for the chart audit, one point will be deducted from the total of your Professional Judgement and Ethical Behavior scores. This will affect your overall average for this requirement and may lower your clinic grade. Documentation is an integral part of standard dental hygiene care. The documents are legally binding and must be properly processed by the student. It is the student's responsibility to ensure this is completed correctly according to LIT Dental Hygiene Program policies.

*Help is available. If you receive a U for a chart audit, consult with an instructor to correct errors.

Students,

Planning and being prepared is the best advice I can give you for Introductory clinic.
You have the necessary skills to begin this portion of the program. You will be astonished at how much you will improve. Be confident and optimistic. Remember you are still learning.

You've got this!

Mrs. Rogers

Approved: Initials/date