CLINICAL ADVANCED (DHYG 2262.7A1, DHYG 2262.7B1, DHYG 2262.7C1, DHYG 2262.7D1, DHYG 2262.7E1)

LAMAR INSTITUTE OF TECHNOLOGY

CREDIT
2 Semester Credit Hours (0 hours lecture, 12 hours lab)

MODE OF INSTRUCTION
Face to Face

PREREQUISITE/CO-REQUISITE:
Prerequisite: DHYG 1301, DHYG 1431, DHYG 1304, DHYG 1227, DHYG 1235, DHYG 1219, DHYG 1339, DHYG 1207, DHYG 1260, DHYG 1311, DHYG 2261, DHYG 2331
Co-Requisite: DHYG 2153, DHYG 1315

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
Upon completion of this course, the student will be able to

- 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.
- 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.

INSTRUCTOR CONTACT INFORMATION

Instructor: Ronni Cruz, RDH, BS

Clinic faculty:

Michelle DeMoss, RDH, MS	Joy Warwick, RDH, BS
Kristina Mendoza, RDH, DDS	
Renee Sandusky, RDH, BS	Harriett Armstrong, DDS
Cynthia Thompson, RDH, BS	Charisse Colbert, DDS
Lacey Blalock, RDH, BS	Travis Miller, DDS
Courtney Campbell, RDH, BS	William Nantz, DDS
Leslie Carpenter, RDH, BS	Robert Smith, DDS
Rebecca Ebarb, RDH, BS	Robert Wiggins, DDS
Michelle Hidalgo, RDH	Roland Williams, DDS

Email: rcruz@lit.edu
Office Phone: (409) 247- 4884
Office Location: MPC 206
Office Hours: Mondays 12:00 pm – 4:00 pm; Tuesdays 9:00-12:00pm; Wednesdays 12:00pm-1:00pm, Thursdays & Fridays- 7:00 am – 8:00am

REQUIRED TEXTBOOK AND MATERIALS
Student instruments, gloves, glasses, masks, lab coats, clinic syllabus

COURSE CALENDAR

DATE		ADDITIONAL INFORMATION
JANUARY		
Week 1	First Day of Clinic	1/20/26
FEBRUARY		
Week 4	Progress Check Week	Check in with clinical advisor
Week 5	Radiographic Evaluation	Testing on Blackboard
Week 6	TDHA/SCADHA Conference	San Marcos, TX- NO Clinic on 2/27/26
MARCH		
Week 8	SPRING BREAK	NO CLINIC OR CLASSES - 3/9/26 - 3/13/26
Week 9	Clinical Evaluation Testing Mid-Semester Clinical Counseling	Test Patient Only - 3/18/26 & 3/19/26 Check in with clinical advisor
	ADEX Registration Deadline	**3/18/26**
APRIL		
Week 11	No Clinic	Good Friday –Campus Closed 4/3/26
Week 12	MANIKIN TESTING BEGINS Progress Check Week	Check schedule for assigned day Check in with clinical advisor
Week 13	**NATIONAL BOARD EXAM – ALL STUDENTS**	**Pearson Vue Professional Center Houston NW Center - 4/18/26**
Week 14	Last Tuesday Clinic	4/21/26
	Last Wednesday Clinic	4/22/26
	Last Thursday Clinic	4/23/26
Week 15	Last Monday Clinic	4/27/26
	Friday Clinic Make Up for 2/27/26	Tuesday 4/28/26 (Friday students only)
	Last Friday Clinic (make up for 4/3/26) **All requirements due by 4/30 at 5:00PM**	Wednesday 4/29/26 (Friday students only) **All requirements include all radiographic critiques, retakes, and chart audits.**
	ADEX Information Meeting for Students	4/30/26 (Time TBD)
MAY		
5/1/26	**ADEX Clinical Testing Exam**	**LIT Clinic**
Week 16	Final Clinic Counseling Week	Check in with clinical advisor
Week 17	Clinic Clean Up and Check out	Duties and instructions TBD

YAY!!! You did it!!! We are so Proud of you!!!

Approved: Initials/date

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. Tardiness can affect the students time spent

providing patient care. 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 (or unit of credit), 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 (2)

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 lit-bbsupport@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.

Electronic Devices
Electronic devices are a part of many individual's lives today. Students must receive the instructor's permission to operate electronic devices in the clinic. Texting on cell phones will not be allowed during clinic.

Late coursework
Assignments and Tests must be completed by the due date. Late submissions or completion will not be accepted and will result in a zero for that assignment/test. This also applies to required Blackboard submissions at the end of the semester.

Remediation
Clinic remediation is offered according to the information provided in the Student Handbook.

*** 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.**

COURSE REQUIREMENTS
See grading rubric on following page

COURSE EVALUATION

Each student must meet minimal competency for all requirements in order to pass DHYG 2262. Criteria for achieving a grade of "A", "B", "C", "D" or "F" can be found on page 7 and 8 of this syllabus. All criteria must be met in each grading category in order to achieve the desired grade. (EXAMPLE: If all criteria, except one, are met for a grade of "B" then the student would receive a grade of "C".) These criteria place the responsibility for learning in the hands of the student and are meant to identify those who strive for excellence in the clinical setting.

The student must achieve successful completion of patients at a minimal competency of **85%**. If the student does not meet minimal competency on a patient, he/she will be responsible for successfully completing another patient at a minimal competency level of **85%**, in order to satisfy requirements for the course. All clinical requirements must be met in order to pass this course.

All course work must be successfully completed and turned in by April 30 at 5:00 PM, **this includes radiographic critiques and initial chart audits.** Failure to complete chart audits by due date could result in receiving no credit for the patient. Failure to successfully complete all course requirements will result in receiving an "F" in DHYG 2262 and dismissal from the DH program. Exclusions from this policy will be dealt with at the discretion of the program faculty.

See grading rubric on the following page.

GRADING SCALE

	A	B	C	D/F
Grading Scale Requirements (GSR)			Minimal Competency	
Total Patient Points (GSR 1)	48 Total points 22 points in Class III and above	45 Total points 19 points in Class III and above	42 Total points 16 points in Class III and above	Does not meet all requirements for a grade of "C".
Adult Patients (A) (GSR 2)	8	8	8	
Geriatric Patients (G) (GSR 3)	2	2	2	
Assessment Data: Med/dent history, oral exams, periodontal assessment, dental charting, polishing/plaque free (GSR 4)	12	11	10	

Full Periodontal Charting (GSR 5)	1	1	1	
Special Needs Patients (GSR 6)	3	2	2	
Periodontal Stage Category (GSR 7)	Stage I & II = 4 patients			
	Stage III & IV = 3 patients			
Perio Grade Category (GSR 8)	Grade A & B = 4 patients			
	Grade C = 1 patient			
Radiographic Surveys = Total # (GSR 9)	4 FMX, 4 BWX, 1 PNX	4 FMX, 4 BWX, 1 PNX	4 FMX, 4 BWX, 1 PNX	
	*3 FMX & 3 BWX with Sensor *1 BWX w/NOMAD using bisecting angle	*3 FMX & 3 BWX with Sensor *1 BWX w/NOMAD using bisecting angle	*3 FMX & 3 BWX with Sensor *1 BWX w/NOMAD using bisecting angle	
	A	**B**	**C**	**D/F**
Calculus detection (GSR 10)	1 patient/IV or V Pass 1st attempt	1 patient/IV or V Pass 2nd attempt	1 patient/IV or V Pass 2nd attempt	
Eagle Soft Full Perio Chart (GSR 11)	1 Perio chart Pass 1st attempt	1 Perio chart Pass 2nd attempt	1 Perio chart Pass 2nd attempt	
Private practice patients (GSR 12)	6 patients	5 patients	4 patients	
Sealants (GSR 13)	4 patients	3 patients	2 patients	
Ultrasonic quadrants (GSR 14)	12 quadrants	10 quadrants	8 quadrants	
Professional Judgment & Ethical Behavior (GSR 15)	Average of 40	Average of 39	Average of 38	Average of below 38

Community service (GSR 16)		5 hours	4 hours	3 hours	
Cancellation (GSR 17)		Over 20 hours of cancellation will lower Clinic grade by one letter grade			
Treatment plans					
Nutritional Counseling (GSR 18)		Passing on initial attempt (75% or higher)	Passing on second attempt	Passing on second attempt	
Periodontal Maintenance Patient (GSR 19)		90 and above	86 – 89	75-85	
Radiographic evaluation					
Radiographic Evaluation (GSR 20)	90%	Passing evaluation on initial attempt	Passing evaluation on second attempt	Passing evaluation on third attempt	Does not meet all requirements for a grade of "C".
Clinical Competency*		Meet minimal competency on any all evaluations on initial try.	Meet minimal competency on any 4 evaluations on initial try.	Meet minimal competency – must pass all evaluations	Does not meet all requirements for a grade of "C".
Clinical Evaluation (GSR 21)		See above	See above	See above	
Root Debridement (GSR 21)		See above	See above	See above	
Geriatric Patient (GSR 21)		See above	See above	See above	
Patient Education (GSR 21)		See above	See above	See above	
Manikin Mock Board (GSR 21)		See above	See above	See above	

***Students will have two attempts at successfully completing each clinical competency. Failure to successfully complete the competency on the second try will result in a meeting with the clinic coordinator to discuss progress in the program.**

DH STUDENTS, FACULTY/STAFF, DENTISTS, OR HYGIENISTS' MAY NOT BE USED FOR ANY REQUIREMENTS, SUCH AS SKILL EVALUATIONS OR COMPETENCIES FOR THE COURSE. ONE OF THESE IDENTIFIED PATIENTS MAY BE USED FOR REQUIREMENTS SUCH AS POINTS, SEALANTS, PRIVATE PRACTICE PATIENTS, AND/OR RADIOGRAPHS.

Grading Scale Requirements (GSR) Defined:

GSR 1: Total Patient Points

The total points required for each grade category are defined in the previous table. Total patient points will be dependent on the grade the student is striving to attain. Each student must ensure that they are obtaining the total points required, as well as the number of points designated for Class 3 and higher patients. The remainder of the points can be obtained in any prophy classification points that the student desires. For the student to be awarded the points for the patient, the patient must be completed at a competency level of **85%** or higher on the Clinical Evaluation Record (CER).
A minimum of two (2) quadrants must be satisfactorily scaled and graded (all spot checks done) to receive partial point credit for incomplete patients. **ALL PATIENTS ARE EXPECTED TO BE COMPLETED**. Incomplete patients will adversely affect the final clinic grade of the student by receiving an Unsatisfactory in the Comprehensive Care grade on the CER. Cases of incomplete patients will be addressed on an individual basis and action on these cases will be at the discretion of the faculty.

Patient Point Value

Class	I = 1 points	Class	V = 5 points
Class	II = 2 points	Class	VI = 6 points
Class	III = 3 points	Class	VII = 7 points
Class	IV = 4 points	Class	VIII = 8 points

GSR 2: Adult Patients

Each student is required to see a minimum of 8 adult patients this semester. An adult patient is defined as a patient between the ages of 18 – 59. For the student to be awarded credit for an adult patient, the patient must be completed at a competency level of 85% or higher on the Clinical Evaluation Record (CER) (see criteria under GSR 1).

GSR 3: Geriatric Patients

Each student is required to see a minimum of 2 geriatric patients this semester. A geriatric patient is defined as a patient that is aged 60 and older. For the student to be awarded credit for a geriatric patient, the patient must be completed at a competency level of 85% or higher on the Clinical Evaluation Record (CER) (see criteria under GSR 1).

GSR 4: Assessment Data

Medical/Dental History

A thorough medical and dental history is a foundational aspect of dental hygiene practice. It enables dental hygiene students to provide safe and effective care, tailor treatments to individual needs, and contribute to overall patient well-being. A thorough review of the patient's medical and dental history is to be completed on every patient at every appointment. Any positive finding should receive follow-up documentation to support the positive finding. Listing of medications and the dental implications must be noted in the follow-up notes.

Vital Signs

The student will take blood pressure, pulse, respiration, and temperature on every patient and evaluate it at every appointment. The patients ASA classification will be determined and documented. This will be recorded on the vital sheet form.

Extra Oral and Intra Oral Examination

Examine and palpate the head, face and neck for any lesions, asymmetry, swelling, infected facial piercings or palpable nodules, which may include raised nevi. Examine and palpate the oral mucosa/alveolar ridge/lips and all supporting structures for any lesions, chemical or physical irritations, exostosis, tattoos, swellings, intraoral piercings, hematomas, or palpable nodules. Examine and palpate the palate and examine the oral pharynx (including the tonsillar pillars) for the presence of torus, and lesions. Examine and palpate the tongue for symptoms of hairy tongue, fissured tongue, loss of papilla, geographic tongue, glossitis, piercings, palpable nodules or lesions. Examine the floor of the mouth for ankyloglossia, tori, hematomas, lesions and tattoos.

Periodontal Assessment

Record findings on Periodontal Assessment form as indicated. The student will conduct a periodontal assessment of all patients during data collection. Students are to record tissue architecture, color, consistency, margins, papillae shape, surface texture, suppuration and all radiographic findings. The patient's pockets depths of 4mm and higher will be recorded, any recession will be recorded, and the CAL will be calculated, furcation, and mobility. Upon completion of the Periodontal Assessment data collection, a Periodontal Stage and Grade should be assigned to the patient. The patients' periodontal classification should be determined by using clinical attachment loss (CAL) as the first indicator, radiographic bone loss is used second; this will help determine the most accurate periodontal diagnosis.

- Plaque scores are a part of the Periodontal Assessment. Plaque scores are to be performed on each patient at every appointment. The patient should only brush prior to a plaque score being taken if they have not brushed within 4 hours prior to the appointment. After the plaque score is taken, this gives the student the opportunity to provide education to the patient using a toothbrush and interdental aids. Plaque scores will be randomly checked by faculty in clinic or during chart audits.

- Bleeding scores are a part of the Periodontal Assessment. Bleeding scores are to be obtained on each patient at every appointment. On the initial appointment, a bleeding score should be charted and calculated during the probing of the tissues. On subsequent appointments, the 6 indicator teeth may be used to calculate the bleeding score. The bleeding score gives the student the opportunity to provide education to the patient. Calculation of bleeding scores will be randomly checked by faculty in clinic or during chart audits.

Dental Charting

A thorough dental charting is an integral part of the dental hygiene education process. It not only supports clinical decision-making but also contributes to effective communication, legal documentation, and ongoing patient care. Developing proficiency in dental charting is essential for dental hygiene students to provide quality oral health care and contribute to overall patient well-being. The student is expected to use the radiographs and do a visual examination of the patients' dentition. The student is to chart using the Initial Dental Charting Form. List all of the radiographic findings (missing teeth, restorations, suspicious areas, periapical pathologies) and all the clinical findings (missing teeth, restorations, sealants, suspicious areas, rotations, abfractions, attrition, overhangs)

A dentist must evaluate the initial dental charting first. Once the initial dental charting has been checked by the dentist, the student must use the Dental/Periodontal Chart form to shade in the dental charting. Any dental hygiene faculty can check the dental charting shading in clinic. The shading must be done prior to scaling.

- Any sealant designation must be done during the dental charting check with the DDS. If sealants have not been designated for the patient at dental charting grading, a DDS will not come later to designate sealants.
- Have your progress notes and Informed Consent, with any referrals included, ready for the DDS to sign at the time the DDS is checking your patient.

** Once all assessments are complete, sign up for periodontal assessment with assigned pod instructor and Extra Oral/ Intra Oral Examination and Initial Dental Charting with the Doctor **AT THE SAME TIME.**

Plaque Free/polishing

Complete biofilm removal is to be done on every patient after scaling of all quadrants is complete. The student is expected to disclose the patient after polishing/plaque free to check the dentition for any remaining deposits. Plaque free removal will be graded by an instructor prior to fluoride application. The disclosing agent must be available when an instructor comes to check the plaque free. The instructor may choose to re-disclose the patient during the checkout process.

GSR 5: Full Periodontal Charting

A complete periodontal charting must be done on the Periodontal Maintenance patient which includes 6-point pocket depths, 6-point gingival margin measurements, clinical attachment loss calculations, mobility, furcation involvement and bleeding points. This charting will allow for a complete evaluation of the periodontal patients' progress toward optimal oral health.

GSR 6: Special Needs Patients

Special Needs patients are defined as patients whose medical, physical, psychological, or social situations may make it necessary to modify procedures to provide dental hygiene treatment for that individual. Special needs patients may have mobility issues, be mentally disabled, immunocompromised, have a complex medical problem, or be a child with behavioral or emotional conditions. (See *Clinical Practice of the Dental Hygienist* by Wilkins for a list of special needs patients). The Special Needs Patient Evaluation will be completed after the appointment and turned into the clinical advisor. Each student is required to complete a minimum of 2 Special Needs Patient Evaluations this semester. However, if the student is striving for an 'A' in clinic, then they will need to complete a minimum of 3 Special Needs Patient Evaluations this semester. For the student to be awarded credit for a Special Needs patient, the patient needs to have all services complete, including post calc (if applicable), and must be completed at a competency level of 85% or higher on the Clinical Evaluation Record (CER).

If the patient was used as a Special Needs Patient Evaluation patient previously, they cannot be used again. Be thorough in your assessment of the patient and their condition(s) they present. The Special Needs Patient Evaluation directions and form are included in the Appendix section of this syllabus on pages 55-56.

GSR 7: Periodontal Staging Category

Each student must see a minimum of 4 patients in the Periodontal Staging Category 1 & 2. Each student

must also see a minimum of 3 patients in the Periodontal Staging Category 3 & 4. For the student to be awarded credit for a Periodontal Stage category, the patient must be completed at a competency level of 85% or higher on the Clinical Evaluation Record (CER).

GSR 8: Periodontal Grading Category

Each student must see a minimum of 4 patients in the Periodontal Grading Category A & B. Each student must also see a minimum of 1 patient in the Periodontal Grading Category C. For the student to be awarded credit for a Periodontal Grade category, the patient must be completed at a competency level of 85% or higher on the Clinical Evaluation Record (CER).

GSR 9: Radiographic Surveys

A student must demonstrate minimal competency by exposing acceptable quality radiographic surveys. Regardless of requirements, the student will take all necessary radiographs based on patient needs. Surveys will be graded as either satisfactory or unsatisfactory. Each student must complete a minimum of 4 acceptable full mouth surveys, 4 acceptable bitewing surveys, and 1 acceptable panorex survey. Each survey must be critiqued, retakes taken, and a final grade given to be considered complete. Students are given unlimited attempts to satisfy this requirement with no penalty on another patient. Surveys must be critiqued within 1 week of the survey. (i.e., Survey taken on Tuesday morning = due by the following Monday). Surveys turned in after one week of taking may not be graded for credit.

- **All radiographs must be completed and submitted by April 30 by 5:00 pm**.
- The NOMAD must be used with 1 BWX survey using the bisecting angle technique. The NOMAD may be used with phosphor plates or sensor for this survey. If the sensor is used, it will also count as one of the sensor BWX requirements.
- The student who is treating the patient must take the patient's radiographs even if the radiographs are not needed for requirements.
- Retakes must be completed at the next appointment after the survey has been graded.
- Radiographs may be taken outside of the student's clinic if it is during a second-year clinic. **Radiographs may not be taken during lunch, before clinic, during 1st year clinic, or after clinic hours.**
- All surveys taken and the justification for each patient exposure must be documented in the progress notes. (Example: FMX-patient has numerous suspicious areas).
- Technique errors, restorations, bone loss, calculus, suspicious areas and those areas requiring referral should be documented on the radiographic critique sheets. Only note existing conditions such as missing teeth if it aids in grading the radiographs.
- **IF A PATIENT CANNOT RETURN FOR RETAKES, THAT PARTICULAR SURVEY WILL NOT BE ACCEPTED AS A COMPLETED SURVEY.** Therefore, it is advisable to discuss this with your patient before the need arises. If the patient cannot return, it must be documented on the Communication Log and in the progress notes.
- **Any patient wanting their radiographs sent to their DDS must have the retakes taken to send a diagnostic survey.**
- Not taking retakes on a patient will affect your Comprehensive Care grade on your CER, which in turn affects your overall grade for that patient.

Submitting Digital Critique Sheets

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**: **6.25 points** will be deducted for each required retake or circled retake.
- **Improvable**: For each area marked as improvable, **2.09 points** will be deducted.
- **Insufficient Findings/Incomplete Evaluations**: May be classified as either improvable or retake, depending on the nature of the deficiency.

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**: **16.66 points** will be deducted for each required retake or circled retake.
- **Improvable**: For each area marked as improvable, **8.34 points** will be deducted.
- **Insufficient Findings/Incomplete Evaluations**: May be classified as either improvable or retake, depending on the nature of the deficiency.

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.

GSR 10: Calculus Detection

Calculus detection is considered a basic skill. Each student must successfully complete one calculus detection on their Clinical Evaluation patient or a Class IV or V patient. The student will be graded on their calculus detection skills and must detect 80% of the calculus charted by 2 instructors in 2 quadrants. Only subgingival "clickable" calculus will be recorded for the calculus detection patients. **** If the student identified calculus that at least one instructor does not confirm, 1 point will be deducted.** The student will be given 2 attempts to successfully complete this requirement. If the student is striving for an 'A' in clinic, this requirement must be passed on the first attempt.

GSR 11: EagleSoft Periodontal Charting

The student will complete one digital periodontal chart using Eaglesoft software. The student will enter the Periodontal Maintenance patient's full periodontal chart data from this semester (GSR 5), into Eaglesoft. The Grading Form (p. 48) will be submitted to the clinic counselor with the patient chart for grading, within 72 hours of patient completion.

GSR 12: Private Practice Patients

The number of patients seen as Private Practice will depend on the grade the student is striving to achieve.

Patient Criteria for Private Practice Patients

Private practice patients should be adult (A) or Geriatric (G) patients (18 years of age or older), either prophy Class I or Class II, have a minimum of 12 natural teeth and must be successfully completed in a 2-hour time segment or less. Students will class their own patient. If a faculty screens and classes the patient, they will be ineligible as a Private Practice patient, however, the student will still get the points for the patient. **One of these patients needs to be a perio case type III or IV.** Documentation of the time will be recorded on the CER by an instructor and initialed.

- **The two-hour time includes all data collection, scaling, patient education, and plaque free. Radiographs and medical history are not included in the 2-hour period.**
- **An instructor and dentist will check the patient at completion of all data collection, oral prophylaxis and plaque free but before fluoride treatment**. The checking of the patient at the end is not included in the 2-hour time.
- Students should class the patient themselves and begin treatment. **Informed consent should be signed by the patient and student before any scaling is initiated.** Failure to do so may result in the loss of patient points for the student.
- Faculty will sign the Informed Consent after all paperwork has been checked.
- The student is responsible for informing their pod instructor of their intent to do private practice. The students' start and finish times are to be written on the CER by an instructor and initialed.
- Upon completion of the patient, the student will be required to enter treatment notes, assign insurance codes, and complete or update a dental chart in EagleSoft.
- To receive credit for the Private Practice patient, the student will need to complete a submission in Blackboard.
- See pages 60-62 in the Appendix for more information.

These patients are intended to prepare the student for private practice by enhancing their efficiency and patient management skills.

GSR 13: Sealant Patients

The number of pit and fissure sealant patients will depend on the grade the student is striving to achieve. This information can be found on the table above. Sealants should be placed on those susceptible teeth that are caries free and are at risk for caries due to deep pits and fissures and according to the Dental Hygiene Oral Health Risk Assessment & Profile Form. Teeth designated by the D.D.S. **upon completion of the dental charting** are eligible to be sealed. Ask the D.D.S. at the time they are examining your patient to designate the teeth to be sealed. The recommended teeth to be sealed should be marked with a red 'S' on the designated teeth on the dental charting and in the comments area of the CER. Teeth that are sealed will be verified by the tooth number on the CER and in the progress notes. Once the designated sealants have been placed, the sealed teeth should be marked with a blue 'S' on the dental charting. The D.D.S. should award a grade on the CER after checking the sealant placement.

- Students will not be permitted to go back AFTER dental charting is complete and have another DDS identify teeth to be sealed.
- Sealant teeth MUST be designated at the time of dental charting, or the patient will not qualify.

Sealants can **only** be placed after completion of **all** scaling including spot checks; all quadrants have been graded on the CER; and polishing/plaque free has been completed and graded. Pumice should be used after the polishing procedure only on the teeth to be sealed. Fluoride is placed after the sealants have been checked.

GSR 14: Ultrasonic Quadrants

The number of graded and acceptable ultrasonic quadrants will depend on the grade the student is striving to achieve. This information can be found on the table above. Students must have the ultrasonic quadrant checked prior to any hand scaling. If hand scaling has begun, then the quadrant is no longer eligible for an ultrasonic grade.

The Ultrasonic scaler may be used on any class patient this semester. It may be indicated for those patients with heavy plaque, stain, ortho, deep pockets, etc. Permission is not necessary to use the Ultrasonic on any type of patient if there are no contraindications on the medical history. Students will only be graded on the use of the Ultrasonic on patients prophy class IV and above, unless otherwise documented by an instructor. Usage of the Ultrasonic scaler that is contraindicated on a patient will receive an Unsatisfactory grade on the Professional Judgement form for that day and no credit for the patient.

GSR 15: Professional Judgement & Professionalism

Demonstrating professional behavior and ethical judgment is an integral component of patient care. A student should exhibit a professional attitude and always conduct themselves in a professional manner.

A professional dress code is stated in the student handbook and compliance with this code is expected. This grade will reflect the student's performance in relation to punctuality, professional appearance, professional judgment, professional ethics, instrumentation skills, documentation, time management, infection control, organizational skills, and patient rapport. As stated in the Clinic Manual, documentation is an important part of professional judgement. Students are expected to create and maintain the patient record accurately, completely, and legibly. 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. The average 38 points must be obtained to meet minimal clinic requirements. In addition, three or more missed Trajecsys clock-ins or clock-outs will also result in a one-point deduction from the same grade category.

GSR 16: Community Service

Provides graduates with the abilities and experience to value community service and contribute to the advancement of the dental hygiene profession. The students are provided with community- based experiences to enhance awareness of diverse, underrepresented and underserved populations outside the university setting. Refer to the Grading Scale requirements for the number of hours needed for the grade the student is striving to attain.

GSR 17: Cancellation

Students are allowed **twenty (20) hours** of non-productive time without grade penalty. **If the student accumulates more than twenty hours of non-productive clinic time, the final letter grade in DHYG 2262 will be lowered by one letter.** Students are expected to have a patient in their chair through the completion of the semester. The student is to remain in their cubicle even when the patient cancels or no shows. It should be documented on the back of the Cancellation CER what activities the student participated in during this time. The Cancellation CER time should be signed by the pod instructor at the end of clinic. If the student leaves the clinic for any reason, the student must notify a clinic instructor before leaving. Completion of the student requirements is not an excuse for non-productive time. It is to the student's benefit to continue practicing clinical skills throughout the semester. Approved non-productive time (cancellation) learning activities may include, but are not limited to:

- Completing assignments through Dentalcare.com
- Critiquing radiographs
- Chart audits
- Practicing the use of the Intraoral Camera techniques on a typodont
- Instrument sharpening
- EagleSoft probe charting
- EagleSoft dental charting
- Practicing sensor or NOMAD radiographs on the DXTRR manikin
- Study for National Board exam

GSR 18: Nutritional Counseling Patient

Counseling patients about the relationship between their diet and dental health is an integral part of total patient care. Students enrolled in General and Dental Nutrition learned many nutritional principles. This semester the student will have the opportunity to apply the learned nutritional principles in a practical setting. Each student will identify a caries susceptible patient for nutritional counseling based on specific needs and the LIT Caries Risk Assessment. Former patient education patients may not be used for the nutritional counseling session. Each student must complete all required forms (same as used for the Personal Food Diary Project). The student will bring the patient into clinic on their clinic day for a one-on-one counseling session in the patient education room. If the student has finished treatment on this patient, the patient must be willing to return for the counseling session. All completed clinical forms will be turned in at the time of the counseling session. The written summary will be due by 12:00 pm the next school day after the session. The summary should be emailed to the instructor who listened to the counseling session or to their clinical counselor.
Evaluation criteria are outlined on the Nutritional Counseling Evaluation form found at the end of this syllabus. A grade of at least 75% must be obtained to be considered acceptable.
Instructions, forms, and grade sheet can be found on pages 47-54.

GSR 19: Periodontal Maintenance Patient/Patient Education Patient

The periodontal patient from the Fall semester will be utilized for one formal Periodontal Maintenance patient education session and a post-care plan comparing all the patient's data and progress. The student will schedule the periodontal patient for maintenance appointment(s). During the initial periodontal maintenance appointment, the student will begin by performing the following: intra/extra oral exam, periodontal assessment, dental charting, a full periodontal charting recording all probing depths (6 points), gingival margin measurements (6 points), CAL (6 points), furcation areas, mobility, full mouth bleeding score, gingival index, and plaque score. The student will be required to obtain a minimum of one digital photo using the *Shofu EyeSpecial* digital dental camera. The patient education session will be done after all data collection, informed consent, and risk assessment have been completed and checked. The patient education competency will be conducted in the patient education room. You will need to plan ahead for this session. During the patient education session, the student will assist the patient in evaluating his/her progress toward specified goals and objectives set in the Fall. The student will review with the patient a comparison perio chart from the pre- and post- periodontal charting completed in the Fall using the Eaglesoft software program. This will be compared to the paper periodontal chart from the current semester. The student will assist the patient in determining further steps that may need to be taken to reach goals and objectives, modify home care techniques if indicated, and introduce a supplemental oral hygiene aide (interproximal brush, etc.) based on the patient's assessment findings. The student will scale all four quadrants, perform plaque free, administer Arestin if indicated, and give fluoride treatment. This can be done over the course of one or more appointments, depending on the patient's needs, severity, and findings. After the last perio maintenance appointment, students will complete a Post-Care Plan for the patient. See pages 35-41 for more detailed information regarding the Periodontal Maintenance Patient, Patient Education Competency Evaluation, and Periodontal Maintenance Post-Care Plan.

NOTE: If a student's periodontal patient from the Fall semester absolutely cannot return in the Spring for periodontal maintenance, you must select another patient that will meet the requirements for this competency. The alternate patient will need to be approved by Mrs. DeMoss or your clinical counselor and MUST meet the following criteria: be a patient that was seen by the student in the Fall semester; have periodontitis; received chairside patient education (this should be done with all patients); and preferably be a good candidate to administer Arestin.

GSR 20: Radiographic Evaluation

The student will be required to successfully complete one radiographic interpretation. This evaluation requires the student to identify landmarks, suspicious areas, restorations, unusual conditions and

technique errors on periapical, bitewing, and panoramic images. The evaluation will be taken in the clinic Blackboard course and Respondus Lockdown Browser will be used. The date for the evaluation will be **Feb 19- 21**. A score of **90%** or higher is required for successful completion of this evaluation. If a student is unsuccessful on the first attempt, they are required to meet with the clinic coordinator for remediation before a 2nd attempt can be scheduled. Students will have 3 attempts to successfully complete this requirement. Failure to achieve this score on the third attempt may result in dismissal from DHYG 2262.

GSR 21: Clinical Competencies

Prepare for the competencies by practicing the required skill and reading the evaluation prior to attempting. Students may not ask questions about the competency during the evaluation. Have the competency printed, attached to a clip board, your name, date, and patient name filled in and ready for

the instructor. Once a skill evaluation or competency is completed, student must submit a digital copy of the completed grade sheet into the DHYG 2262 Blackboard section.

- **Clinical Evaluation Competency – pages 33-35**
- **Patient Education Competency – pages 36-38**
- **Root debridement Competency – pages 43-45**
- **Geriatric Patient Competency – pages 46-47**
- **Manikin Mock Board Competency – pages 60-61**

ADDITONAL CLINIC INFORMATION

Patient Selection

Patient selection is very important; therefore, it is advisable to select a variety of patients to enhance clinical experience. Students are highly encouraged to identify their higher-class patients early in the semester. Using the last half of the semester for the lower-class patients (Class I and II). **SCREENING NEW PATIENTS WHO HAVE NOT BEEN SEEN IN THE CLINIC BEFORE WILL HELP YOU IN LOCATING THOSE HIGHER-CLASS PATIENTS YOU WILL NEED AT THE BEGINNING OF THE SEMESTER.**

Students may screen patients outside of their clinic time with the permission of the Clinic Coordinator. Students must reserve a clinic chair prior to the date you want to screen.

*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, PRIVATE PRACTICE PATIENT REQUIREMENTS OR SEALANT REQUIREMENTS.

- **DH STUDENTS, FACULTY/STAFF, DENTISTS, OR HYGIENISTS MAY NOT BE USED FOR ANY REQUIREMENTS, SUCH AS SKILL EVALUATIONS OR COMPETENCIES, FOR THE COURSE OTHER THAN POINTS, SEALANTS, PRIVATE PRACTICE PATIENT REQUIREMENTS AND/OR RADIOGRAPHS.**

*Each student may choose to waive the fee for one patient per semester.
SERVICES RENDERED TO PATIENTS WILL BE CONDUCTED BY ONE (1) STUDENT (i.e., Mary and Susie cannot earn credit for Miss Smith, who is a class VIII) unless preapproved by the instructor. 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 on CER

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, and not completing post-calculus evaluation are **some** examples of behaviors that will result in an unacceptable grade in this area. **Three or more U's** in Comprehensive Care on clinic CERs will result in a one-point deduction from the student's **Professional Behavior and Ethical Judgement** semester average. Three U's in Comprehensive Care on clinic CERs

will result in a one-point deduction from the student's Professional Behavior and Ethical Judgment semester average. Four U's will result in a second one-point deduction, and additional U's 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 Assessments

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 sign after the patient and student has signed them. A grade will be assigned for the risk assessment on the CER.

Grading of Data Collection

All data collection will be graded at one time (all data will be graded at completion of intra/extra, periodontal assessment, periodontal charting, radiographs, and dental charting). The student must have radiographs displayed before any data is graded. Students may begin scaling before having dental charting evaluated if a dentist is not available. All other data must be evaluated and informed consent signed before scaling can begin.

Evaluation of Scaling Procedures

Evaluation criteria for scaling includes calculus removal, stain removal, and tissue trauma. Prophy class IV and below requires one instructor to evaluate scaling for credit. Significant tissue trauma will be noted on the CER and may be reflected in the patient grade. Prophy class V or higher requires an evaluation from two instructors. 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. (IE. 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.)

Post Calculus

All patients class V and above must be scheduled two weeks after prophylaxis for re-evaluation (Post Calculus). The student is expected to complete periodontal charting: recording all 4mm or greater pockets, recession, furcation, mobility, frenal involvement and inadequate zones of attachment, record all bleeding points, thoroughly explore, re-scale needed areas, and have the treatment evaluated by an instructor. Only one instructor will check post calculus evaluation. In the event the patient does not return for the post calculus evaluation, the student will not get full patient points for this patient and will receive a U in Comprehensive Care and a 2-point deduction in total patient points.

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, or 7:30 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, or 7:45 PM**. **Repeated late dismissals of patients may result in disciplinary action.**

Intraoral Camera

An intraoral camera is available for use by students. It is highly recommended that the student become familiar with this tool. The intraoral camera is often used in private practice and the Dental Hygienist may be expected to use it. You may want to use the camera on a patient during clinic. Cancellation time is a good time to practice with the intraoral camera on a typodont or another student.

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 2262 Blackboard submission link. This **must** be done within one week of completing the patient, for the faculty advisor to monitor patient

completion and randomize audits. 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 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 2262.**

Sterilization Duty
Each student is assigned 6 clinic sessions of sterilization. Students are expected to arrive 15 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 2nd 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 post-op procedures.

Use of Blackboard System for record keeping
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 CER's, clinical competencies, course requirements (i.e. Private Practice patients, Special Needs patients, Perio Maintenance treatment plan, etc.)
Not submitting CER's on time could prohibit a student from receiving points from that patient.

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 Clinical Timekeeping Policy

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). If the issue is not reported or documented within the required time frame, the missed use will still count toward the penalty. Consistent and accurate use of Trajecsys is part of professional responsibility and mirrors the timekeeping expectations required in real clinical practice.

CLINICAL GRADING CRITERIA FOR SATISFACTORY ON "CER"

	S	U
Medical/Dental History	no errors	1 or more
Head/Neck & Oral Exam and Dental Charting	0-1 errors	2 or more
Periodontal Assessment	0-1 errors	2 or more
Informed Consent and Risk Assessment	0-3 errors	4 or more
Periodontal Charting (per quad)	0-3 errors	4 or more

Ultrasonic Scaling- More than two calculus deposits, stain and/or plaque remaining per quadrant will result in a U. 0-2 deposits=S.

Scaling- Errors include evaluation of rough tooth surfaces, tissue trauma, and calculus.

	GRADE/QUADRANT	
Class I	1 surface	2 or more
Class II	2 surface	3 or more
Class III	3 surfaces	4 or more
Class IV	4 surfaces	5 or more
Class V	5 surfaces	6 or more
Class VI	6 surfaces	7 or more
Class VII	7 surfaces	8 or more
Class VIII	8 surfaces	9 or more

Polishing Plaque Free (surfaces/mouth) 0-2 surfaces 3 or more

Fluoride Treatment- Tray fluoride application: Failure to have plaque free or remaining calculus deposits checked prior to application; failure to dry teeth prior to application, place saliva ejector, stay with patient the entire time; or give incorrect patient instruction or failure to check tissue response can result in a "U". Varnish fluoride application: failure to have plaque free or remaining calculus deposits checked prior to placement or give incorrect patient instruction will result in a "U".

Tissue Trauma (surfaces/mouth) 0-2 surfaces 3 or more surfaces

Pit and Fissure- Proper occlusion maintained, no evidence of voids in sealant, cannot be displaced with explorer, somewhat high but other criteria satisfactory = "S". Voids in sealant material or is removed with explorer = "U".

Post Cal Evaluation – Graded for entire mouth. Calculus, stain and plaque are evaluated.

	S	**U**
Class V	4	5 or more
Class VI	5	6 or more
Class VII	6	7 or more
Class VIII	7	8 or more

Post-op Perio Charting- (per quad) 0-3 errors= S 4 or more=U

	S	**U**
Radiographs-BWX	Equivalent to 4 improvables/75% or higher	More than 4 improvables/74% or below
Radiographs-FMX	Equivalent to 12 improvables /75% or higher	More than 12 improvables/74% or below
Radiographs-PNX	2 improvables /75% or higher	More than 2 improvables/ 74% o below
Comprehensive Care	no errors/patient	1 or more errors/patient
Chart Audit	no errors/patient	1 or more errors/patient
Consumer Survey	no error	Survey not completed

Approved: Initials/date

PROGRESS CHECKS/CLINICAL COUNSELING

As a dental hygiene student, you have responsibilities in tracking your grades and clinical requirements to monitor your progress throughout your program.

1. Stay Organized:
   - Keep a well-organized file for clinic containing the course syllabus and requirements list.
   - Maintain an appointment calendar tracking patient appointments and due dates.
2. Understand Program Requirements:
   - Familiarize yourself with the specific grading criteria and clinical requirements outlined by your dental hygiene program. These can be found in the Clinic syllabus and LIT Dental Hygiene Program Student Handbook.
   - Be aware of the minimum standards for grades and clinical performance.
3. Regularly Check Grades:
   - Stay on top of your academic progress by regularly checking your grades through Blackboard.
   - If you notice discrepancies or have concerns about your performance, communicate with your clinical advisor promptly.
4. Clinical Documentation:
   - Keep accurate records of your clinical experiences, including patient cases, procedures performed, and any required documentation.
   - Submit clinical paperwork on time and ensure it meets the program's standards.
5. Attend Feedback Sessions:
   - Attend progress checks and mid-semester counseling with clinical advisor to discuss your performance, areas for improvement, and any concerns you may have.
   - Use feedback as an opportunity to enhance your skills and address weaknesses.
6. Seek Help When Needed:
   - If you are struggling clinically, seek assistance from instructors.
   - Do not hesitate to ask questions and clarify doubts during clinical sessions.
7. Utilize Requirement Tracking Chart:
   - Maintain detailed Requirement Tracking Chart, ensuring it is accurate and reflects the procedures and patients you have completed.
   - Review clinical requirements regularly to track your progress toward meeting program expectations.
8. Stay Informed About Policies:
   - Stay informed about academic and clinical policies within your program.
   - Understand the consequences of not meeting requirements and be proactive in addressing any issues.
9. Take Responsibility for Your Progress:
   - Recognize that tracking your progress is ultimately your responsibility.
   - Be proactive in seeking guidance, addressing challenges, and advocating for your own success.

By taking these steps, you can actively monitor your progress, stay on top of requirements, and ensure a successful journey through the Spring semester.

On the next page you will find the weeks of progress checks. Students must meet with their clinical advisors to report on their progress in clinic. Students must bring their CER's and clinical requirement tracking chart **(pages 26-31)** to each appointment filled in with current information. Please be prepared to discuss how many points have been started, patient issues, what requirements are met, etc.
Students will be required to upload the clinical requirement tracking chart in Blackboard after each progress check appointment.
**** If the student is not prepared for their appointment, they will be rescheduled for a later time.**

Approved: Initials/date

DATES FOR PROGRESS CHECK/CLINICAL COUNSELING

Week of February 9
Week of April 6

MID-SEMESTER CLINICAL COUNSELING
Week of March 16

FINAL CLINICAL COUNSELING
Week of May 4

If there is a clinical issue that needs to be addressed outside of your appointed time, see your clinical advisor for an appointment

STUDENT AND FACULTY ACADEMIC AND CLINICAL COUNSELING ASSIGNMENTS

Cruz	Mendoza	DeMoss
Poole, Alyssa	Landry, Carli	Morton, Victoria
Moore, Lauren	Cazares, Andrea	Bland, Carlee
Upshaw, Brianna	Bell, Brittney	Nguyen, Whitney
Roccaforte, Haley	Newcost, Loren	Dotson, Kailee
Sosa, Shelsy	Dennis, Kyauhna	Flores-Molina, Jeisi
Ringer, Breanna	Aguilara, Yadira	Padilla, Yadira
Bravo, Robin	Linton, Ravean	Richard, Alanna
Cisneros, Elizabeth		

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.

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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 CLINICAL 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 the grade book 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 156 hours (39 days) of clinic time. Students should have 24 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.

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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.

REQUIREMENT TRACKING RECORD	A	B	C	D/F
Requirements			**Minimal Competency**	
TOTAL PATIENT POINTS	**48 Total points** 22 points in Class III and above	**45 Total points** 19 points in Class III and above	**42 Total points** 16 points in Class III and above	
POINTS STARTED (I AND II)				
POINTS FINISHED (I AND II)				
POINTS STARTED (III AND ABOVE)				
POINTS FINISHED (III AND ABOVE)				
ADULT PATIENTS	**8 patients** 1.	**8 patients** 2.	**8 patients** 3.	 4.
	5.	6.	7.	8.
GERIATRIC	**2 patients** 1.	**2 patients** 2.	**2 patients**	
MEDICAL/DENTAL HISTORY	**12 patients**	**11 patients**	**10 patients**	
ORAL EXAMS	**12 patients**	**11 patients**	**10 patients**	
	12 patients	**11 patients**	**10 patients**	

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PERIODONTAL ASSESSMENTS										
DENTAL CHARTING	**12 patients**			**11 patients**			**10 patients**			
POLISHING/PLAQUE FREE	**12 patients**			**11 patients**			**10 patients**			
FULL PERIODONTAL CHARTING	**1 patient**			**1 patient**			**1 patient**			
	1. (Periodontal Maintenance patient)									
SPECIAL NEEDS	**3 patients**			**2 patients**			**2 patients**			
	1.			**2.**			**3.**			
PERIODONTAL STAGING CATEGORY	**Stage I or II**			**4 patients**						
				1.	**2.**	**3.**	**4.**	**5.**		
	Stage III or IV			**3 patients**						
				1.	**2.**	**3.**				
PERIODONTAL GRADING CATEGORY	**Grade A or B**			**4 patients**						
				1.	**2.**	**3.**	**4.**			
	Grade C			**1 patient**						
				1.						
RADIOGRAPHS (TOTAL)	**4 FMX, 4 BWX, 1 PANOREX (document when the survey is complete & graded)**									
FMX	**1. (Sensor)**		**2. (Sensor)**		**3. (Sensor)**		**4.**			
BWX	**1. (Sensor)**		**2. (Sensor)**		**3. (Sensor)**		**4. (NOMAD)**			
PANOREX	**1.**									
CALCULUS DETECTION	**1 patient (Clinical Evaluation patient)**									
	1.									
EAGLESOFT PERIO CHARTING	**1 patient (Periodontal Maintenance patient)**									
	1.									

PRIVATE PRACTICE PATIENTS	**6 patients**			**5 patients**			**4 patients**					
	1.	2.		3.	4.		5.	6.				
SEALANT PATIENTS	**4 patients**			**3 patients**			**2 patients**					
	1.	2.		3.	4.							
ULTRASONIC QUADRANTS	**12 quadrants**			**10 quadrants**			**8 quadrants**					
	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.
PROFESSIONAL JUDGEMENT & ETHICAL BEHAVIOR	**Average of 40**			**Average of 39**			**Average of 38**			**Average below 38**		
COMMUNITY SERVICE	**5 hours**			**4 hours**			**3 hours**					
	1 hour		2 hours			3 hours			4 hours			5 hours
CANCELLATION TIME	**Up to 20 hours before penalty occurs**											
	Hrs/date	Hrs/date	Hrs/date	Hrs/date	Hrs/date	Hrs/date	Hrs/date	Hrs/date	Hrs/date	Hrs/date		
	Hrs/date	Hrs/date	Hrs/date	Hrs/date	Hrs/date	Hrs/date	Hrs/date	Hrs/date	Hrs/date	Hrs/date		
NUTRITIONAL COUNSELING PLAN (75% or higher)	**Passing on initial attempt**			**Passing on 2nd attempt**			**Passing on 2nd attempt**					
	Pass	Fail		Pass			Fail					
PERIODONTAL MAINTENANCE PATIENT POST-CARE PLAN	**90 and above**			**86-89**			**85 or below**					
	Grade:											
CLINICAL COMPETENCIES	**Meet minimal competency on all evaluations on initial attempt**			**Meet minimal competency on 4 evaluations on initial attempt**			**Meet minimal competency 3 evaluations on initial attempt**			**Does not meet all requirements for a 'C'**		
CLINICAL EVALUATION	**Pass on initial attempt (date):**			**Pass on 2nd attempt (date):**								
ROOT DEBRIDEMENT	**Pass on initial attempt (date):**			**Pass on 2nd attempt (date):**								
GERIATRIC PATIENT	**Pass on initial attempt (date):**			**Pass on 2nd attempt (date):**								
PATIENT EDUCATION	**Pass on initial attempt (date):**			**Pass on 2nd attempt (date):**								
MANIKIN MOCK BOARD	**Pass on initial attempt (date):**			**Pass on 2nd attempt (date):**								

**** All Clinical Competencies must be passed in order to meet requirements. Student will be given 2 attempts. If not successful on the 1st attempt, the student must schedule a remediation session with an instructor.**

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COMPETENCY AND EVALUATION FORMS

CLINICAL EVALUATION COMPETENCY

Clinical Evaluation Competencies will be on 2 designated days, 3/18/26 and 3/19/26. Each student will be assigned one of these dates on the first day of clinic. The students selected patient must be available to return on the assigned testing day.

The following pages contain criteria, instructional information, and evaluation forms for the Clinical Evaluation Competency. The student will have two hours to complete this evaluation. The student has 2 attempts to pass this competency.

Criteria for Clinical Evaluation patient
Student is responsible for patient selection using the following criteria.

- **CALCULUS DETECTION**: Each tooth has four surfaces: mesial, distal, facial and lingual. A qualifying surface is a tooth surface upon which there is "clickable" subgingival calculus. A calculus detection will be completed prior to the examination to qualify the patient by the student and by 2 dental hygiene faculty.

- **PATIENT REQUIREMENTS:** Patient must be 18 years or older and should be a Prophy Class IV or V. The patient should have a minimum of 12 "clickable" surfaces on a minimum of 6 teeth in one quadrant; 2 posterior teeth from another quadrant may be added if needed. Eight (8) of the twelve (12) qualifying surface must be on posterior teeth.

- **DEFINITION OF QUALIFYING SUBGINGIVAL CALCULUS:**
  - Distinct and easily detectable
  - Definite "jump" or bump felt with an explorer with one or two strokes
  - Interproximal deposit felt from lingual and/or buccal
  - Ledges and/or ring deposits

- **EXEMPTIONS:** Calculus surfaces located on supra erupted or partially erupted third molars. A third molar is considered erupted if the occlusal plane of the third molar is in alignment with the occlusal plane of the rest of the teeth. A third molar with tissue covering the tooth, even though it is in the occlusal plane is also exempt.

- **QUALIFYING SURFACES:** The twelve qualifying surfaces must be on natural teeth and must not have the following: Class III furcations, Class III mobility, retained deciduous teeth or orthodontic bands. (Bonded lingual arch wires are acceptable.) Surfaces with greater than 6-millimeter pockets are discouraged.

- **ULTRASONIC USE:** Use of the ultrasonic will be allowed on this examination unless contraindicated.

Once the patient has been selected for this evaluation, the student will complete all clinic data collection on the patient and calculus detection on the entire mouth. ONLY SUBGINGIVAL CLICKABLE AREAS WILL BE NOTED ON THIS DETECTION. Two instructors will then do a blind check to evaluate the student's detection skills and to determine qualifying surfaces for the evaluation. The student must detect 80% of the agreed-upon surfaces found by the 2 faculty members. Only the surfaces agreed upon by the two (2) instructors will be used in qualification and evaluation.

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On the day of the Clinical Evaluation Competency exam, the student will review the medical/dental history and obtain all necessary signatures before beginning.
The student should use current radiographs and periodontal charting during the evaluation.
After the medical/dental history is signed, the student will wait in the clinic front office while the patient is examined by an instructor to determine that the patient still qualifies. The patient will be checked in by one faculty.

Anesthesia may be used on this examination.

Students will be given a start time after the administration of local anesthesia, if needed.

The student is advised to use the entire two hours to complete the evaluation. If a break is needed, get a 'stop time', and upon return, have your time restarted.

The student will place a clean napkin on the patient, rinse their mouth, have a clean mirror and explorer, and tidy the station (remove any bloody gauze, etc.) when ready for check out. The student will return to the clinic front office during the checkout procedure. The patient will be checked for clickable or burnished subgingival calculus, supragingival calculus that was not removed, and excessive tissue trauma. Two instructors will do a blind check to evaluate the student's performance. After the final instructor has completed the checkout, the student will dismiss their patient.

LIT Dental Hygiene Program **CLINICAL EVALUATION COMPETENCY**			
DHYG 2262			
LIT Competency Statement	P2. Assume responsibility for dental hygiene actions and care based on accepted scientific theories and research as well as the accepted standard of care. PC 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. PC 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		Perio Stage	H G I II III IV
Patient		Prophy Class	0 1 2 3 4 5 6 7 8
Any critical error results in a score of 'Unacceptable'. The student has 2 attempts on this competency.		Grade	☐ Acceptable ☐ 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	Utilizes proper infection control procedures	Yes		
2	Applies basic and advanced principles of dental hygiene instrumentation	Yes		
3	Demonstrates proper use of the ultrasonic scaler	Yes		
4	Obtains informed consent prior to treatment; maintains clinical records	Yes		
5	Explains procedure and rationale of procedure to the patient	Yes		
6	Procedures are carried out in an efficient and systematic manner	No		
7	Utilizes periodontal charting and radiographs during procedure	No		
8	Removes calculus without excessive tissue trauma	Yes		
9	Demonstrates professional conduct and ethical judgement during treatment	Yes		

COMMENTS:

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PERIODONTAL MAINTENANCE PATIENT

During the Fall semester, each student completed a periodontal patient in the clinic setting. This patient had a two-part care plan, formal patient education sessions, and was tracked on their progress throughout the non-surgical periodontal treatment phase. This semester, the patient will return for periodontal maintenance therapy. The periodontal maintenance phase can be completed over the course of one or more appointments, depending on the patient's severity and treatment needs. At the initial maintenance appointment, the student will complete the following: intra/extra oral exams, periodontal assessment, dental charting, full periodontal charting (including 6-point probing depths, 6-point gingival margin measurements, 6-point CAL, furcation areas, mobility, and bleeding points), full mouth bleeding score, gingival index, and plaque score. The full periodontal chart will be entered into Eaglesoft within 72 hours of patient completion (see GSR 11, p. 15). The student will also be required to obtain a minimum of one digital photo using the *Shofu EyeSpecial* digital dental camera.

After assessment findings, informed consent, and risk assessment have been completed and checked, the student may proceed to the patient education session (competency). Students are expected to prepare in advance for this session. Prior to the session, the student must create a comparison periodontal chart in Eaglesoft using the pre- and post- periodontal charts entered in Eaglesoft during the Fall semester. Instructions on creating the Eaglesoft comparison chart can be found in Blackboard. The Eaglesoft comparison chart will be utilized during the patient education session to show the individual's periodontal progress and changes throughout the NSPT phase. This will then be compared to the paper periodontal chart from the current semester to further explain progression, areas of improvement, or areas that have not improved. During this session, students are also expected to review patient progress from previously established goals and objectives and assist the patient in determining additional steps needed to reach goals and objectives, modify home care techniques if needed, and introduce an appropriate oral hygiene/ interdental aide (interproximal brush, etc.) based on the patient's assessment findings. After the patient education session, all other patient treatments may be completed (quadrant scaling, plaque free, Arestin, and fluoride). (Also see GSR 19, page 18)

Be thorough in the documentation for this patient. At the conclusion of treatment, students will write a periodontal maintenance post-care plan documenting all findings, education, and treatment from this semester; and comparing patient progress from last semester. Students will discuss the relationships of the findings to the patient's state of periodontal disease and progression. Care plan template and rubric are on pages 38-42. A blank template is also available on Blackboard.

All post-care plans must be submitted through the DHYG 2262 Blackboard, within 72 hours of completing patient treatment, and will be graded by the assigned clinical counselor. Students will also submit the patient chart with the Eaglesoft Periodontal Charting grade form (p. 48) to their clinical counselor for grading.

PATIENT EDUCATION COMPETENCY EVALUATION CHECKLIST:

Patient Education*: This skill evaluation will be conducted in the patient education room.*
See page 18 for more information regarding the periodontal maintenance patient education patient.
Session:

1. Utilizes time effectively and efficiently. (Session should be no longer than 20 minutes)
2. Uses current infection control procedures
3. Preparation of operatory is appropriate for procedure and effective instructional materials are present.
4. Professional behavior and ethical judgment demonstrated by;
    - providing for patient comfort
    - providing proper patient communication
    - accepting constructive criticism

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- adapting to new situations
- instilling confidence in the patient
- explaining procedures to the patient
- exhibiting self-confidence to perform procedure

5. Student reviews progress towards **ALL** goals and objectives with patient from the Fall semester.
6. A review of previous topics is discussed to check the patient's understanding and retention from the Fall semester.
6. Student assists patient in evaluating his/her own oral condition and relates goals and methods of evaluation to the oral conditions present. (Patient carries out home-care regimen and the student discloses the patient.)
   - Do not have the patient brush prior to the patient education session unless the patient has not brushed within 4 hours of the appointment.

   If the patient has not brushed 4 hours prior to the appointment, let the patient brush with no assistance, take the plaque score, and give any instruction in the patient education room.

7. The student will review with the patient the comparison perio chart of CAL's and probing depths generated by EagleSoft. The Eaglesoft comparison perio chart showing the Fall data, will be utilized to make comparisons to the Spring semester in order to identify areas of improvement or areas that need attention.
8. Student modifies patient's technique in the patient's mouth. Evaluate technique by having patient demonstrate technique and re-disclose patient. Modify areas where indicated. (Based on plaque/bleeding scores.)
   - If indicated, student should introduce a supplemental OH/ interdental aide
   - The student should consider whether an alternative interdental aide may be more beneficial to the patient based on the findings from the initial assessment. Consider the patient's plaque and bleeding scores, is the patient compliant with flossing, or does the patient have Class 2 or 3 embrasures, etc.
9. Student stresses the patient's responsibility for home/self-care in partnership with the clinician.
10. Student discusses current concepts of dental practice as well as basic principles of dental disease as they apply to the patient's needs. Instructions are individualized with the use of available visual aids, pamphlets and models.
11. The level of information is appropriate for the learning level of the individual.
12. The patient is involved in the learning process by answering questions, stating opinions or performing skills, etc., throughout the session.
13. The information and discussion follow a logical sequence starting with background knowledge and a review of what the patient is already aware of before advancing to new topics or more in-depth information.
14. The student actively searches for opportunities to provide positive reinforcement and provides that reinforcement.
15. Student reviews methods that are used to evaluate progress.
16. Student determines patient current oral health status by comparing to last semester and determines an appropriate recall interval based on information collected.

LIT Dental Hygiene Program **PATIENT EDUCATION SESSION COMPETENCY**			
DHYG 2262			
LIT Competency Statement	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 HP5. Promote the values of oral and general health and wellness to the public and organizations within and outside the profession. PC10. Use critical decision-making skills to reach conclusions about the patient's dental hygiene needs based on all available assessment data. PC11c. Establish a collaborative relationship with the patient in the planned care to include etiology, prognosis, and treatment alternatives.		
Student		Date:	
Instructor		Perio Stage	H G I II III IV
Patient		Prophy Class	0 1 2 3 4 5 6 7 8
Any critical error results in a score of 'Not Acceptable' and the student must repeat the competency.		Grade	☐ Acceptable ☐ 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	N/A	N/A	N/A
3	Maintain clinic and laboratory records	Yes		
4	Identifies patient needs, reviews goals, and identifies progress towards goals with patient	Yes		
5	Student reviews previous topics to verify patient understanding	Yes		
6	Assists patient in evaluating home care and modifies as needed	Yes		
7	Selects appropriate interdental aid for patient based on findings	Yes		
8	Reviews and compares the full periodontal charting from the Fall (using the Eaglesoft comparison chart) to the Spring, looking for areas that have shown healing vs. areas that need attention	Yes		
9	Demonstrates oral hygiene procedures	No		
10	Emphasizes patient responsibility in oral health care partnership	Yes		
11	Individualizes instruction based on patient need and learning level	Yes		
12	Involves patient and provides positive reinforcement	No		
13	Determines recall schedule based on data collected from appointment, session is no more than 20 minutes.	No		
	Comments:			

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PERIODONTAL MAINTENANCE POST-CARE PLAN TEMPLATE

Patient Name_____ Age_____

Date of initial exam _____ Date post-perio (fall semester) _____

Dates of periodontal maintenance visits_____

*All information documented should be used to evaluate patient's periodontal disease status, risk, prognosis, and individualized treatment/ education needs. Patient findings should be correlated to the multi-factorial periodontal disease process, including- systemic and local risk factors, progression of disease, healing potential, management of disease, and prevention of recurrence. Failure to evaluate and correlate patient findings to the periodontal disease process will constitute loss of points.

1. Medical History: (including systemic conditions altering treatment, pre-medication, medical clearance) explain steps to be taken to minimize or avoid occurrence, effect on periodontal diagnosis and/or care. Compare findings to last semester and note any changes or updates.

_____

2. Dental History: (past dental disease, response to treatment, attitudes, dental I.Q., chief complaint, present oral hygiene habits, effect on periodontal diagnosis and/or care)

_____

3. Extra/ Intra-oral and Dental Examination: (lesions noted, facial form, habits and awareness, consultation) and (caries, attrition, midline position, malpositioned teeth, occlusion, abfractions). Compare findings to last semester and note any changes, updates, and effects on perio.

_____

4. Periodontal Examination: (color, contour, texture, consistency, etc.)

a. Prophy Class _____ Periodontal Stage & Grade_____
b. Gingival Description:
c. Plaque Index: Appt 1_____ 2____ (include additional appointments if needed)
d. Gingival Index: _____
e. Bleeding Index: Appt 1_____ 2___ (include additional appointments if needed)
f. Comparison of indices from last semester to now & relationship to perio:

_____

5. Periodontal Chart: (Periodontal Maintenance full mouth probe depths, recession, CAL assessment, furcation, mobility, & bleeding- what do these findings indicate regarding the patient's periodontal status?)

_____

6. Treatment and Patient Education: (Include all treatment provided and detailed account of patient education)
Appt 1:

Appt 2:

Appt 3: (add any additional appointments, if needed)

7. Prognosis: (Based on attitude, age, number of teeth, systemic health, malocclusion, periodontal examination, maintenance availability)

8. Supportive Therapy, patient attitude and response: Suggestions to patient regarding re-evaluation, referral, and recall schedule. Patient's attitude and level of cooperation towards periodontal maintenance therapy and recall.

9. Assessment of Changes and Goal Progress:

a. Describe changes since the post-perio appointment- such as plaque control, bleeding tendency, gingival health, probing depths, patient oral hygiene habits
b. Which goals from patient's nonsurgical periodontal treatment (fall semester) did the patient achieve?
c. Which goals did they not achieve and why?

10. Self-Assessment: What did you feel that you did well with the patient? What improvements could be made? Were there any topics that you would have addressed differently? How?
Include any other reflections you have toward the periodontal patient experience.

DATE_____ **NAME**_____

PERIODONTAL MAINTENANCE POST-CARE PLAN EVALUATION

LIT Dental Hygiene Competency	P3 PC9 PC10 PC12 PC13	• Continuously perform self-assessment for lifelong learning and professional growth • Systematically collect, analyze, and record data on the general, oral, psychosocial health status of a variety of patients. • Use critical decision-making skills to reach conclusion about the patient's dental hygiene needs based on all available assessment data. • Provide specialized treatment that includes preventive and therapeutic services designed to achieve and maintain oral health. • Evaluate the effectiveness of the implemented clinical, preventive, and educational services and modify as needed.

All information should have evaluated and be correlated to periodontal disease; the progression of, the healing of, and the prevention of. Failure to evaluate and correlate to periodontal disease on this write-up will constitute loss of points.

Topic area	Points	Excellent 5	Good 4	Fair 2	Unacceptable 0
Medical History		Identifies all systemic conditions altering treatment, steps taken to avoid medical problem, effect on dental hygiene diagnosis and/or care. Relates many medical history findings to periodontal disease: its progression, healing, and prevention	Identifies several systemic conditions altering treatment, steps taken to avoid medical problem, effect on dental hygiene diagnosis and/or care. Relates several medical history findings to periodontal disease: its progression, healing, and prevention	Identifies at least one relevant systemic condition altering treatment, steps taken to avoid medical problem, effect on dental hygiene diagnosis and/or care. Relates at least one relevant medical history finding to periodontal disease: its progression, healing, and prevention	Fails to identify any relevant systemic conditions altering treatment, steps taken to avoid medical problem, effect on dental hygiene diagnosis and/or care. Fails to relate any medical history finding to periodontal disease: its progression, healing, and prevention
Dental History		Identifies all elements of the dental history, its effect on dental hygiene diagnosis and/or care. Relates many dental history findings to periodontal disease: its progression, healing, and prevention	Identifies several elements of the dental history, its effect on dental hygiene diagnosis and/or care. Relates several dental history findings to periodontal disease: its progression, healing, and prevention	Identifies at least one relevant element of the dental history, its effect on dental hygiene diagnosis and/or care. Relates at least one relevant dental history finding to periodontal disease: its progression, healing, and prevention	Fails to identify any elements of the dental history, its effect on dental hygiene diagnosis and/or care. Fails to relate any dental history finding to periodontal disease: its progression, healing, and prevention
Extra/ Intra-oral & Dental Exams		Identifies all findings of the oral and dental exams, steps taken to avoid a medical problem, effect on dental hygiene diagnosis and/or care. Relates many exam findings to periodontal disease: its progression, healing, and prevention	Identifies several findings of the oral and dental exams, steps taken to avoid a medical problem, effect on dental hygiene diagnosis and/or care. Relates several exam findings to periodontal disease: its progression, healing, and prevention	Identifies at least one relevant finding of the oral and dental exams, steps taken to avoid a medical problem, effect on dental hygiene diagnosis and/or care. Relates at least one exam finding to periodontal disease: its progression, healing, and prevention	Fails to identify any finding on the oral and dental exams, steps taken to avoid a medical problem, effect on dental hygiene diagnosis and/or care. Fails to relate any exam finding to periodontal disease: its progression, healing, and prevention
Periodontal Exam					
Gingival Exam & Dental Indices		Describes all characteristics of the gingival exam by quadrant. Evaluates many of the indices and relates to periodontal disease	Describes several characteristics of the gingival exam by quadrant. Evaluates several of the indices and relates to periodontal disease	Describes at least one characteristic of the gingival exam by quadrant. Evaluates one index and relates to periodontal disease	Fails to describe any characteristics of the gingival exam by quadrant. Fails to evaluate any index and relate to periodontal disease

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Periodontal Charting		Describes all of the findings of the periodontal examination and relates many findings to periodontal disease.	Describes several of the findings of the periodontal examination and relates several to periodontal disease.	Describes at least one of the findings of the periodontal examination and relates at least one to periodontal disease.	Fails to describe any of the findings of the periodontal examination. Fails to relate any to periodontal disease.
Treatment & Patient Education		Assesses all of the patient education needs. Accurately plans many of the treatment options and patient education sessions. Many of the patient education topics are appropriate.	Assesses several of the patient education needs. Accurately plans several of the treatment and patient education sessions. Several of the patient education topics are appropriate.	Assesses at least one of the patient education needs. Plans at least one of the treatment and patient education sessions. At least one of the patient education topics are appropriate.	Fails to assess any of the patient education needs. Fails to plan any of the treatment and patient education sessions. Patient education topics are not appropriate.
Prognosis		Describes all the prognosis characteristics by attitude, age, number of teeth, systemic background, malocclusion, tooth morphology, recall availability, and periodontal examination.	Describes several of the prognosis characteristics by attitude, age, number of teeth, systemic background, malocclusion, tooth morphology, recall availability, and periodontal examination.	Describes any of the prognosis characteristic by attitude, age, number of teeth, systemic background, malocclusion, tooth morphology, recall availability, and periodontal examination.	Fails to describe any of the prognosis characteristics by attitude, age, number of teeth, systemic background, malocclusion, tooth morphology, recall availability, and periodontal examination.
Supportive therapy & Patient attitude		Describes all of the suggestions made to patient regarding re-evaluation, referral, and recall schedule. Includes date of recall appt.	Describes several of the suggestions made to patient regarding re-evaluation, referral, and recall schedule. Includes date of recall appt.	Describes any of the suggestions made to patient regarding re-evaluation, referral, and recall schedule. Date of recall not included.	Fails to describe any of the suggestions made to patient regarding re-evaluation, referral, and recall schedule. Date of recall not included
Assessment of changes and Goal progress		Describes all of the changes occurring from treatment including plaque control, bleeding, gingival health, probing depths.	Describes several of the changes occurring from treatment including plaque control, bleeding, gingival health, probing depths.	Describes any of the changes occurring from treatment including plaque control, bleeding, gingival health, probing depths.	Fails to describe any of the changes occurring from treatment including plaque control, bleeding, gingival health, probing depths.
Self-Assessment & Basic requirements		Thoughtful self-assessment of the periodontal patient experience. Thoughts are highly organized and logical; word usage is correct and very professional; correct spelling, grammar, and sentence structure. Plan is submitted within 72 hours. All records are updated and properly identified.	Self-assessment of the periodontal patient experience. Thoughts are generally organized and logical; word usage is adequate and somewhat professional; errors in spelling, grammar, or sentence structure. Many of the records are updated and properly identified.	Incomplete self-assessment. Thoughts are somewhat disorganized, and vague. Word usage is sometimes inappropriate and detracts from professional tone, numerous errors in spelling, grammar, or sentence structure. Not all records are updated and properly identified.	Thoughts are very disorganized, extremely vague, and difficult to follow. Word usage is frequently inappropriate and detracts significantly from the professional tone, numerous errors in spelling, grammar, and sentence structure. Many records are not updated or properly identified
TOTAL POINTS (50 points possible)					

Late submissions will not be accepted.
Comments:

Approved: Initials/date

CRITERIA FOR ROOT DEBRIDEMENT COMPETENCY

- On this competency evaluation, the student must use the following instruments:
  - Anterior Gracey 1/2
  - Mesial Gracey 11/12 or 15/16
  - Distal Gracey 13/14 or 17/18

- This patient must be a Class III or higher and a perio stage III or IV.
- An instructor will select 2-3 teeth to be evaluated during this competency evaluation.
- If the patient is a Class IV or higher, the ultrasonic may be used prior to beginning this competency.
- * = designates an advanced skill using the Gracey curet

Purpose: smoothing the tooth surfaces to lessen immediate recolonization of bacteria.

GENERAL MANAGEMENT

1. Utilizes time effectively and efficiently.
2. Utilizes the mirror effectively.
3. Maintains correct patient/operator positioning.
4. Adjust the dental light for maximum illumination.
5. *Uses current infection control procedures.
6. Uses air and evacuation equipment effectively.
7. Preparation of operatory is appropriate for procedure.
8. *Maintains patient records
9. *Professional behavior and ethical judgment demonstrated by:
   - *Providing for patient comfort
   - Providing proper patient communication
   - Accepting constructive criticism
   - Adapting to new situations
   - Instilling confidence in the patient
   - *Explaining procedures to the patient
   - Exhibiting self-confidence to perform procedure
10. *Meets patient selection criteria of having at least two proximal and one facial/lingual surface to root plane. Must demonstrate competency in anterior areas as well posterior areas.
11. *Utilizes radiographs and periodontal charting to determine sulcus topography and root morphology.

ACTIVATES ROOT DEBRIDEMENT STROKES

12. Holds curet in the modified pen grasp.
13. *Establishes a stable fulcrum (intra or extraoral).
14. *Determines correct working end of curet.
15. Places curette on the surface to be smoothed making sure the blade is flush against the tooth surface.
16. Inserts the tip under the free gingival to the epithelial attachment, being sure to keep blade angulation at 0 degrees.
17. *Establishes working angulation (45-90 degrees) with lower shank parallel to tooth surface.
18. Uses a light exploratory stroke coming back to the free gingival margin to confirm the confines of the pocket and topography of the root surface.
19. Applies lateral pressure against tooth with thumb and index finger.

Approved: Initials/date

20. *Demonstrates instrumentation of a furcation and/or concavity adjacent to the furcation
21. *Activates a series of moderate to light pull or push-pull strokes, starting with a short stroke and making each successive overlapping stoke a millimeter or so longer.
22. *Executes a controlled shaving stroke with moderate length.
23. *Demonstrates many multidirectional strokes; covering the entire root surface.
24. Pivots on fulcrum and rolls instrument between thumb and index finger to adapt to the tooth surface.

EVALUATION BY FACULTY

25. *The entire tooth surface feels smooth.
26. *Tissue laceration is kept to a minimum.

LIT Dental Hygiene Program **ROOT DEBRIDEMENT COMPETENCY**			
DHYG 2262			
LIT Competency Statement	P2 Assume responsibility for dental hygiene actions and care based on accepted scientific theories and research as well as the accepted standard of care. PC12 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. PC13 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		Perio Stage	H G I II III IV
Patient		Prophy Class	0 1 2 3 4 5 6 7 8
Any critical error results in a score of 'Unacceptable' and the student must repeat the competency.		Grade	☐ Acceptable ☐ 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	Yes		
3	Maintain clinic and laboratory records	Yes		
5	Utilizes periodontal charting and radiographs for pocket depth and topography	Yes		
6	Explains procedure and rationale to their patient	Yes		
7	Utilizes sharp and correctly contoured instruments	No		
8	Obtains calculus removal on selected teeth without excessive tissue trauma	Yes		
9	Insures patient's comfort with appropriate anesthesia	Yes		
10	Demonstrates professional conduct and ethical judgment	Yes		
Comments:				

Approved: Initials/date

Geriatric Patient Competency Evaluation

Patient Requirements:

- 60 years of age or older, no exceptions.

Student Instructions:

- The patient may be any class.
- The instructor will sign the history, release and HIPAA documents
- Obtain the correct paperwork for the geriatric patient.
- Obtain a complete medical history prior to the patient's appointment to save time looking up dental concerns for drugs the patient may be taking.
- The only procedures that may be done prior to the appointment are the medical/dental history and have the patient classed.
- **The student, patient and instructor will sign the Informed Consent/Risk Assessment prior to any scaling but after all data collection is checked.**
- Record detailed patient education information and **recommendations made to the patient** in the progress notes.
- Make sure you follow the format for the evaluation; if you have questions, you must ask them prior to the start of the appointment.
- Complete #12 on the competency form after the patient's appointment. Discuss thoroughly any treatment modifications that had to be considered prior to and/or during patient treatment.
- The competency will be completed with the chart audit. Submit the competency form to your advisor when the chart is submitted for audit.

Instructor Instructions:

- Approve the patient for the competency evaluation and sign the appropriate paperwork. Observe the student at intervals appropriate to the criteria on the evaluation
- Complete the written competency evaluation form when the student is finished and return it to the student.
- The competency <u>will not be completed</u> until the chart is audited.

Approved: Initials/date

LIT Dental Hygiene Program

Competency Evaluation

Geriatric Patient

DHYG 2262

LIT Competency Statement	PC9. Systematically collect, analyze, and record data on the general, oral, and psychosocial health status of a variety of patients. PC10. Use critical decision making skills to reach conclusions about the patient's dental hygiene needs based on all available assessment data. PC11. 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. PC12. 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. Evaluate the effectiveness of the implemented clinical, preventive, and educational services and modify as needed.

Student		Date:	
Instructor		Perio Stage	H G I II III IV
Patient		Prophy Class	0 1 2 3 4 5 6 7 8
Any critical error results in a score of 'Not Acceptable' and the student must repeat the competency.		Grade	☐ Acceptable ☐ 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 clinic and laboratory records	Yes		
4	Obtain a complete medical/dental history and release	Yes		
5	Explains procedure and rationale to their patient	Yes		
6	Perform an adequate oral assessment and record the information properly	No		
7	Present the patient with an appropriate informed consent/risk assessment which the patient, student, & faculty sign before treatment starts	Yes		
8	Obtains removal of calculus	Yes		
9	Selects appropriate polishing agent and uses sound polishing technique	Yes		
10	Flosses all interproximal surfaces	Yes		
11	Achieves an 85% or higher on the CER for this patient	Yes		
12	List any treatment modifications required or considered for this patient in Blackboard. Submit the chart to your clinical counselor ready for chart audit.	Yes		

COMMENTS:

Approved: Initials/date

EAGLESOFT SOFTWARE PERIODONTAL CHARTING

EagleSoft is a dental practice management software that offers various tools and features to streamline administrative and clinical tasks in a dental office. While it is commonly used for general dental practice management, it may also include specific features for periodontal charting. Periodontal charting is essential for dental hygiene students and practitioners in monitoring and managing the health of the gums and supporting structures of the teeth.

Here are some purposes of using EagleSoft periodontal charting software for dental hygiene students:

1. **Comprehensive Patient Records:** EagleSoft allows dental hygiene students to maintain detailed and comprehensive electronic records of each patient's periodontal health. This includes information on probing depths, attachment levels, bleeding, and other relevant clinical data.
2. **Efficient Data Entry:** The software provides a user-friendly interface for entering periodontal data, making it easier for students to record and update information during patient appointments. This efficiency helps in saving time and reducing errors associated with manual charting
3. **Visual Representation:** EagleSoft often includes visual charting tools that allow dental hygiene students to create graphical representations of periodontal conditions. This can aid in better understanding and communication of the patient's oral health status.
4. **Tracking Progress over Time:** Periodontal charting software enables the tracking of changes in a patient's periodontal health over time. This historical data can be crucial for monitoring the effectiveness of treatments and interventions.
5. **Treatment Planning:** The software may assist in creating treatment plans based on the periodontal charting data. Dental hygiene students can use these tools to develop and communicate appropriate treatment strategies for their patients.
6. **Integration with other Features:** EagleSoft may integrate periodontal charting with other features of the software, such as appointment scheduling, billing, and imaging. This integration helps in creating a more seamless workflow for dental professionals.
7. **Educational Tool:** For dental hygiene students, EagleSoft periodontal charting software can serve as an educational tool. It allows students to practice and refine their charting skills in a digital environment, preparing them for real-world clinical scenarios.

   Overall, the use of EagleSoft periodontal charting software in dental hygiene education enhances the efficiency of clinical practice, improves record-keeping, and contributes to better patient care through informed decision-making and treatment planning.

   This semester, a third full periodontal charting will be entered into EagleSoft for the periodontal patient, using the data collected at the patient's periodontal maintenance appointment. (See GSR 5 & 11)

   The EagleSoft Software Periodontal Charting grade form should be placed in the patient's chart and turned into the clinical counselor for grading within 72 hours of patient completion.

Approved: Initials/date

LIT Dental Hygiene Program **EagleSoft Software Periodontal Charting Grade Form**			
DHYG 2262			
LIT Competency Statement	**PC9. Systematically collect, analyze, and record data on the general, oral, and psychosocial health status of a variety of patients.**		
Student		Date:	
Instructor		Perio Stage	H G I II III IV
Patient		Prophy Class	0 1 2 3 4 5 6 7 8
		Grade	☐ Acceptable ☐ Unacceptable

More than 3 errors in one category are unacceptable. All conditions should be charted according to the patient's dental chart using LIT dental charting guidelines.

Acceptable = 0-1 U's in total categories. Not Acceptable = 2 or more U's in total categories.

The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.		Errors	A	U
1	Correctly charted 6 probe depths per tooth from the Periodontal Maintenance periodontal charting. (recorded as PD in EagleSoft)			
2	Correctly charted 6 gingival margin measurements per tooth from the Periodontal Maintenance periodontal charting. (recorded as GM in EagleSoft)			
3	Correctly charted any Furcations from the Periodontal Maintenance periodontal charting. (recorded as FG in EagleSoft)			
4	Correctly charted any Mobility from the Periodontal Maintenance periodontal charting. (recorded as MOB in EagleSoft)			
5	Correctly charted 6 bleeding points per tooth from the Periodontal Maintenance periodontal charting.			
6	Turned in patient chart with this grade form included, within 72 hours of patient completion.			
COMMENTS:				

Nutritional Counseling Project

PATIENT ASSESSMENT INSTRUCTIONS

Objectives

Upon completion of this project, student will be able to:

1. Objectively assess their patient's dietary risks of caries.
2. Practice the process of recording and analyzing food intake for its cariogenic value.
3. Use one's nutritional and dental knowledge in contributing to better general and oral health for self and patients.

Procedure (All required forms may be found on Blackboard)

- Fill out the LIT Caries Risk Assessment
- 3-day Food Diary and Carbohydrate Intake Analysis
- Counseling Session will be done with a patient
- Type Written Summary Report (one page)
- All forms will be uploaded into Blackboard.

1. Food Diary Form

A. Have your patient record everything he/she eats for 3 consecutive days, then type it in on the Food Diary Form in your Syllabus. This will be for your patient during the Counseling Session. For one of the days, after you have explained about fermentable carbohydrates, have them circle in red/highlight on the food diary which foods they think are Fermentable Carbs in their diet during the counseling session. Do not choose days when they are dieting, fasting, or ill.

- Ask them to be accurate in determining the amounts they ate or drank.
- Ask them to remember to include extras such as mayonnaise on your sandwich, butter on your toast, salad dressing, chewing gum, and fluids (e.g., water, alcohol).
- Have them use brand names whenever possible (e.g., Cheerios, McDonald's).
- Ask them to record food preparation methods, when applicable (e.g., baked, fried, grilled).
- Do not include supplements.

2. Fermentable Carbohydrate Analysis Worksheet

A. Transfer just the fermentable CHO food items from the Food Diary to this worksheet.

B. For each food circled/highlighted, comment on why it is cariogenic or not cariogenic. The patient needs to highlight/circle the fermentable CHO only on one day of the food diary. You may have the foods already listed on this form.

C. Total the number of minutes of acid exposure each day. Consider that one exposure may include several fermentable CHOs, and that not every meal is cariogenic. 2 hours/day is considered high.

D. The Fermentable Carb Analysis Worksheet is to be typed and placed directly with each Day of Food Diary that it corresponds to. Ex. Day 1 of Food Diary has a corresponding Ferm Carb Worksheet. Label Both as Day 1, Day 2 etc.

E. Average the three days on the last day. You will need the average**.**

3. LIT Caries Risk Assessment

- Fill out the assessment

4. Written Summary: Total of 1 page

Approved: Initials/date

- A brief written summary of the counseling session will be due to your clinic counselor the day after the counseling session is completed. The summary will be uploaded with all other forms in Blackboard. The summary should include information from the session that identifies eating habits and nutritional choices that impact the patient's oral health. It should also include healthy options given to the patient to improve their oral health. The summary should conclude with statements addressing what was learned from the nutritional counseling session, what you did that was good about the session, and how you could improve. One statement should include what the patient learned, and one should include what the student learned.
- Please refer to the Assignment & Examination Policies section regarding the use of A.I.

- **Professionalism**
  Edit your paper.
  - Grammar/spelling
  - Completeness—did you turn in all parts of the assignment? Neatness
  - Accuracy—correct values and calculations, information presented, appropriate dental terms
  - Logic of conclusions and appropriateness of recommendations—your conclusions must be consistent with the evidence, and your recommendations must be in line with current nutrition knowledge

Evaluation

The LIT Caries Risk Assessment, 3-day Food Diary, Carbohydrate Intake Analysis Worksheet, Nutritional Counseling Rubric and the written summary should by uploaded into Blackboard by 12:00 P.M. on the DAY FOLLOWING YOUR NUTRITIONAL COUNSELING SESSION. Ten percent will be deducted from the total grade of the project for each day (except weekends) that it is late.

You are graded on the written summary and oral counseling. See page 53 for Nutritional Skill Evaluation Rubric.

Lamar Institute of Technology Dental Hygiene Oral Health Risk Assessment and Profile

PATIENT NAME: _____

Risk assessment provides information regarding factors influencing an individual's susceptibility or potential risk for the onset or progression of certain oral diseases beyond those noted during traditional clinical assessment. A thorough annual assessment of an individual's risk factors significantly influences formulation of individualized, patient-specific treatment preventive self-care strategies as well as patient management and expected outcome.

RESTORATIVE RISK FACTORS (Caries, Trauma/Structural Breakdown)	**Date**	**Date**	**Date**	**Recommended Preventive Care and Treatment (Date Entry)**
*Demineralization				
Infrequent dental exams				
Prior caries experience /5or more restorations				
Poor/faulty restoration margins				
Exposed root surfaces/erosion/abrasion				
Missing teeth				
Malocclusion				
Poor oral hygiene				
*Cariogenic diet (Frequent daily exposure to sugars and simple carbohydrates, 5 or more)				
*Decreased salivary flow				
Mentally challenged				
Large amalgams involving cusps				
Chronic TMJ problems				
Functional oral habits/bruxing				
Contact sports (without use of mouth guard)				
Physical disorders (e.g. seizures)				
Fixed orthodontic appliances				
***Generally = High Risk**				
SUMMARY OF **RISK LEVEL** (Circle one)	Low	Low	Low	
	Mod	Mod	Mod	
Relative to individuals without the risk factor	High	High	High	

Risk Level is determined by the number, type and /or combination of existing risk factors related to **the patient's responses during the interview process** concerning beliefs, reported severity of conditions/chief complaints, as well as clinical findings. The factors listed have the potential to be any of the 3 levels; low, if only 1 or 2 factors present (i.e. age); moderate, if at least 3 factors are present; high, if more than 3 factors or if the factor exists in combination with other factors that may increase the patient's risk. (**= High Risk**). ★

Approved: Initials/date

Food Diary Form

FOOD DIARY Day_____				
TIME	**PLACE**	**FOOD EATEN**	**AMOUNT EATEN**	**HOW PREPARED**

Instructions:

1. List *everything* you eat or drink on 3 consecutive, typical days.
2. Use 2 weekdays and 1 weekend day.
3. Include extras such as chewing gum, sugar and cream in coffee, or mustard on a sandwich.

Carbohydrate Intake Analysis Worksheet

Carbohydrate (CHO) Intake Analysis Worksheet			
Fermentable CHO	**Cariogenic?**	**Reason**	**Period of Exposure to Enamel**
		TOTAL EXPOSURE TIME:_____	

Average:
Day 1 + Day 2 + Day 3 = sum of all acid exposures / 3 days = average

____ + _____ + _____ = _____/3=_____

Approved: Initials/date

Patient Nutritional Counseling Skill Evaluation

LIT Competency Statement	P3. Continuously perform self-assessment for lifelong learning and professional growth. HP6. Evaluate and utilize methods to ensure the health and safety of the patient and the dental hygienist in the delivery of dental hygiene.

Student Name: _____ Patient Name: _____
Instructor: _____ Grade: _____
Date: _____

The following criteria will be used to determine a competency of 75% or higher on the Nutritional Counseling Skill Evaluation

1= Meets all requirements 1/2= Needs improvement 0= Requirements not met

	Points earned	
Forms/Reports		
1		LIT Caries Risk assessment is completed and assessed.
2		Correctly completed the Food Diary Form
3		Carbohydrate Intake analysis is completed and correctly assessed.
Dietary Assessments		
4		Highlighted cariogenic foods that are consumed in excess.
5		Appropriately provided realistic modifications
6		Correctly and adequately provided a relationship to the health of the oral cavity
Counselor Characteristics		
7		Student utilizes principles to encourage learning and patient participation. Use of "ask before you tell" methodology to determine patient's level of knowledge prior to each concept. Student also asks questions following each concept to determine learning.
8		Student encourages patient participation
9		Rapport is developed with the patient by pleasant attitude and as a serious counselor.
Counseling Session		
10		Introduction includes the reason for the counseling session as it relates to dental disease. Discusses Caries Risk Assessment information findings with patient.
11		The "Why" of the diet is assessed by asking the patient to describe a typical day's routine and/or typical weekend routine. Student determines oral hygiene as it relates to eating habits.
12		Patient records a 3 day food intake diary which includes a weekend. The 3-day food intake is obtained by the student prior to the counseling session.
13		CONCEPT I: interaction of tooth, plaque, and sugar is discussed.
14		CONCEPT II: mealtime exposure, limiting frequency of sweet exposure (eating sweets all at one time) is discussed.
15		CONCEPT III: need to include at least one firm food with each meal (to stimulate saliva).

	Points earned	
16		Student explains the reaction of bacterial enzymes in plaque on sugar to change into acid with an exposure time of 20 min. for beverages and 40 min for Fermentable Carbohydrates.
17		Student asks patient to circle in Red/Highlight all Fermentable Carbohydrates on a selected day.
18		CONCEPT IV: the effects of the different forms of sugar on the oral environment are discussed.
19		Student calculates acid exposure time to determine total minutes per day. Explains 120 min. or > is considered HIGH
20		Patient makes a conclusion based on the results concerning its relation to his caries rate or other disease problem (compares between meals and mealtime, relates total acid time to norm, etc.)
21		Student assists patient (if necessary) by suggesting diet recommendations personalized according to patient established habit patterns and verbal communication in counseling session.
22		Student asks the patient to summarize in his own words "what have you learned today?"
23		Student assists patient in stating 2 or 3 realistic goals patient plans to make.
Written Summary		
24		Student writes a summary in narrative style.
25		Specific dietary modifications were explained
26		Identifies eating habits and nutritional choices that impact the patient's oral health.
27		Lists healthy options given to the patient to improve their oral health.
28		A conclusion was included addressing what was learned from the counseling session by the patient and the student, what went well and how the session could have been improved.
Professionalism		
29		No spelling or grammatical errors
30		All forms were included
31		Written summary and all forms are turned in by 12:00 pm on the day following the Nutritional Counseling Session.
Comments:		

Approved: Initials/date

SPECIAL NEEDS PATIENT EVALUATION

The Special Needs Patient Evaluation assesses the student's knowledge, critical thinking, and ability to apply theoretical concepts to practical, patient-centered situations. The goal is to ensure that dental hygiene students are well-prepared to provide safe, effective, and compassionate care to individuals with complex medical needs.

Patient Requirements:

• Special needs patients are defined as patients whose medical, physical, psychological, or social situations may make it necessary to modify procedures to provide dental hygiene treatment for that individual.
• Special needs patients may have mobility issues, be mentally disabled, immunocompromised, have a complex medical problem, or be a child with behavioral or emotional conditions. (see Clinical Practice of the Dental Hygienist by Wilkins for a list of special needs patients)
• The patient can be of any age and any prophy class and/or periodontal case type.

Student Instructions:

• The Special Needs Patient Evaluation will be completed after the patient has completed total treatment in the clinic.
• It is advised that the student get approval for the patient prior to beginning the patient.
• There is no time constraint to finish this patient.
• The student is to individualize and consider all treatment modifications and dental hygiene interventions that may be needed to treat the special needs patient identified for this evaluation.
• Patient education topics should also address the special needs of the patient.
• The student is to assess the appointment with the patient and identify all modifications that had to be considered and/or implemented during the appointment.
• Be very thorough in your descriptions and write-up of the modifications.
• The student is to submit the Special Needs Evaluation in Blackboard within 48 hours of completion of the patient.
• The patient's chart must be turned to their clinical advisor 48 hours after the patient is complete. Have the chart prepared for audit upon submission.
• Each question has a maximum point value of 20 points. A minimum score of 75% must be achieved to obtain an 'Acceptable' on this competency.

Instructor Instructions:

• Approve the patient for the competency evaluation and initial beside the patient's name on the evaluation paper.
• The student should be thorough when discussing the treatment modifications for the special needs patient.
• Grade the competency evaluation through Blackboard once the student has completed the patient and has submitted the chart.
• The chart audit may be done at the same time.
• Students have 48 hours after the completion of the patient to turn in the evaluation.

Approved: Initials/date

LIT Dental Hygiene Program **Special Needs Patient Evaluation**			
DHYG 2262			
LIT Competency Statement	P2 Assume responsibility for dental hygiene actions and care based on accepted scientific theories and research as well as the accepted standard of care. PC10 Use critical decision-making skills to reach conclusions about the patient's dental hygiene needs based on all available assessment data. b. Identify patient needs and significant findings that impact the delivery of dental hygiene services.		
Student		Date:	
Instructor		Perio Stage	H G I II III IV
Patient		Prophy Class	0 1 2 3 4 5 6 7 8
If 'Unacceptable' grade is achieved, the student will need to designate another patient to complete this evaluation.		Grade	☐ Acceptable ☐ Unacceptable

Special Needs Patients are defined as patients whose medical, physical, psychological, or social situations may make it necessary to modify procedures in order to provide dental hygiene treatment for that individual. Special needs patients would include but are not limited to patients with the following: mobility issues, mentally disabled, immunocompromised, complex medical problem, mental illness, or children with behavioral or emotional conditions.

The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.	
1.	**MEDICAL KNOWLEDGE:** Describe the patient's special need/s. Address the importance of obtaining a thorough medical history before treating the patient. (You may write on the back)
2.	**ASSESSMENT SKILLS:** Explain and describe any treatment modifications that you had to consider, plan for, or prepare for prior to treatment. Explain and describe any treatment modification that you had to perform during treatment. What were the outcomes of your expectations? Be specific and thorough in your answer. (You may write on the back)
3.	**MEDICATION MANAGEMENT:** How did you inquire about a patient's medications (if applicable), and why is it crucial for dental hygiene care?
4.	**EMERGENCY PREPAREDNESS:** How would you prepare for and/or respond to a medical emergency during a dental hygiene appointment if this patient presented one?

5.	**PATIENT COMMUNICATION:** What patient education topics did you address with this patient? What specific items did you need to address due to the patient's special need? (You may write on back)
Instructor Comments:	

MANIKIN MOCK BOARD EXAMINATION COMPETENCY

A mock board exam simulates the atmosphere and conditions of the actual licensing or board certification exam. It helps students familiarize themselves with the format, time constraints, paperwork, and types of tasks they must complete. This mock exam aims to prepare the student for success on the official board examination.

The purpose of the Manikin Mock Board Examination Competency is to evaluate the student's ability to:

- Detect calculus
- Remove calculus
- Accurately measure periodontal pockets
- Appropriately manage treatment

Grading of the Manikin Mock Board Examination Competency follows the ADEX guidelines set in the ADEX Dental Hygiene Candidate Manual.
The student must make 75% to pass this competency. Student will have 2 attempts.

Calculus removal, periodontal probing measurement, final case presentation and tissue management are evaluated by 2 instructors. The student's periodontal probing measurements must be with (+/-) 1mm of the examiners.

Each instructor examines the manikin independently and will record their findings. The instructors are unable to see the evaluation of the other instructor during the checkout process.

Grading of treatment management includes hard or soft tissue damage to the dentition or the gingiva.

- Minor soft tissue damage:
  - A laceration/abrasion that is $\leq$ 3mm
- Major soft tissue damage:
  - A laceration/abrasion that is > 3mm and would require sutures, periodontal packing, or further follow-up treatment.
  - Amputation of papilla
  - An unreported broken instrument tip in the sulcus or soft tissue

- Minor hard tissue damage:
  - Slight hard tissue damage that is inconsistent with the procedure or pre-existing condition
- Major hard tissue damage:
  - Damage to the hard tissue that is inconsistent with the procedure or pre-existing condition

LIT Dental Hygiene Program

MANIKIN MOCK BOARD COMPETENCY

DHYG 2262

LIT Competency Statement	P2. Assume responsibility for dental hygiene actions and care based on accepted scientific theories and research as well as the accepted standard of care. PC 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. PC 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			
The following criteria will be used to determine a competency of 75% or higher on this evaluation. Failure to achieve 75% will result in a retest.		Grade	☐ Acceptable ☐ Unacceptable

Seventy-five percent (75%) is needed to be acceptable.			
SKILLS ASSESSMENT	CRITERIA	Possible Points	Points Earned
CALCULUS DETECTION	• 4 assigned maxillary teeth • 4 surfaces per tooth (M, D, F, L) • 16 surfaces evaluated for presence or absence of subgingival calculus (1 point each)	16	
CALCULUS REMOVAL	• One mandibular quadrant assigned for scaling • 12 assigned surfaces evaluated for calculus removal (5.5 points each)	66	
FINAL CASE PRESENTATION	• Evaluation of calculus removal on all remaining surfaces within assigned quadrant. Calculus remaining: o 1 surface (-3 points) o 2 or more surfaces (-6 points)	6	
PERIODONTAL PROBING MEASUREMENT	• 2 assigned teeth (1 anterior; 1 posterior) • 6 measurements per tooth (DF, F, MF, DL, L, ML) • 12 measurements evaluated (1 point each)	12	
SOFT TISSUE DAMAGE	• One point penalty for each site of minor soft tissue damage; up to 3 sites. • Four or more of minor sites or 1 major site of damage = automatic failure		
HARD TISSUE DAMAGE	• One point deducted for each site of minor hard tissue damage, up to 3 sites • Four or more minor damage sites or 1 major site of damage = automatic failure		
	TOTAL POINTS	100	

Approved: Initials/date

PRIVATE PRACTICE PATIENT

For dental hygiene students preparing to graduate, seeing a private practice patient serves as a critical step in refining their clinical skills and demonstrating their readiness to enter the professional world. Working with a real patient in a "private practice setting" allows students to apply their academic knowledge and hands-on training in a more realistic, fast-paced environment. The two-hour time limit set for the session is designed to challenge the student's speed and efficiency, pushing them to manage their time effectively while maintaining high standards of care. This experience not only tests their technical ability to complete assessments, cleanings, and other procedures within a designated timeframe, but it also fosters essential professional qualities such as patient communication, problem-solving, and adaptability under pressure. Successfully navigating these tasks prepares students for the demands of a dental hygiene career, where they will need to balance patient care with time management while ensuring excellent clinical outcomes.

REQUIREMENTS:

- Must be an adult or geriatric patient aged 18 or older.
- The patient must have a minimum of 12 natural teeth.
- The patient should be a prophy Class 1 or 2 determined by the student.
    - If a faculty member screens or classes the patient, the patient will no longer qualify as a Private Practice patient.
    - The student will still receive credit for the patient points as long as the final CER grade is an 85% or higher.
- One private practice patient must be a Periodontal Stage 3 or 4.
- The student will utilize EagleSoft with the Private Practice patient for the following:
    - Entering treatment notes
    - Insurance coding for procedures performed
    - Dental charting

PROCEDURE:

- The student will complete the medical and dental history with the patient along with any other initial forms that need signatures.
- Once the medical and dental history has been checked and graded by a faculty member, the student may class the patient.
- Radiographs can be taken prior to the appointment or on the day of the appointment. Radiographs are not a part of the 2-hour time period.
- When the student is ready, a faculty member will start their time and designate the Private Practice on the CER.
- The student will have 2 hours to complete the following: the Extraoral exam, Intraoral exam, Periodontal assessment including all probing depths 4mm or higher, gingival margin measurements where indicated, and CAL calculations, dental charting (initial and clinical), plaque score, bleeding score, patient education and patient oral hygiene instruction, Risk Assessment, Informed Consent, Scaling all 4 quadrants, polish and/or plaque free procedures.
    - The Informed Consent MUST be signed by the student and patient prior to scaling but after the data collection has been completed.
    - Instructors will sign the Informed Consent at the end of the appointment after the assessment data has been graded.

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- When the student has finished treatment, they must sign up for Extraoral exam, Intraoral exam, and dental charting check with the DDS on duty, and periodontal assessment and scaling checks with their Pod instructor. A stop time will be documented on the CER.
- Any designated sealants and/or fluoride application may be done after completion of all the assessment data checks and scaling checks and is not part of the time.

END OF APPOINTMENT:

- The length of time the patient will be in the dental chair can vary based on whether radiographs are taken on the day of the appointment; waiting for check-out of procedures; restroom breaks, etc.
- The student may document 4 hours on the patient CER for any private practice patient.
- With the remaining time, the student can complete the EagleSoft documentation required for the Private Practice patient.
- Once all EagleSoft documentation has been completed, the student must turn in the patient chart to their clinical counselor. The patient CER must be in the chart and the chart ready for audit.
- The grading criteria for the Private Practice patient can be found in the Private Practice submission area in EagleSoft.

EAGLESOFT TREATMENT NOTES:

- Treatment notes **must** be done on the day of the appointment and will be noted by a date stamp in EagleSoft.
- Select the correct patient in EagleSoft> click 'Note History' > Change the 'Note Type' to ***Chart Note*** (do not leave as *General Note*)> Enter chart notes (see below for what is included) > click 'Save Note'

EagleSoft Chart Notes should include the following:

- Medical/ Dental History positive findings
- Vital signs
- Chief complaint/patient concerns
- Services/Treatment completed
- Periodontal status and findings
- Extraoral, intraoral, and dental exam positive findings
- Presence of plaque and calculus (note the amount and location)
- Presence of inflammation and bleeding (light, moderate, or heavy) and (generalized or localized)
- Patient's current OH habits
- Patient Education/OH instruction/recommendations
- Referrals
- Recall frequency
- Digital signature of clinician

EAGLESOFT INSURANCE CODING:

Insurance coding is crucial in the dental office because it ensures accurate billing, proper reimbursement, and compliance with insurance guidelines. Correct coding helps avoid claim denials, reduces the risk of fraud, and streamlines the financial processes by clearly documenting the services provided. It also enables dental professionals to communicate effectively with insurance companies, ensuring that patients receive the coverage

they are entitled to and that the practice maintains a steady revenue flow. Proper insurance coding is essential for both financial stability and legal compliance in a dental practice.

- If a patient has been seen in the LIT Dental Hygiene Clinic previously and has been documented that they have periodontal disease, then that patient will be coded as a Periodontal Maintenance patient.
- If the patient is a new patient to the clinic, the student must determine under which insurance code the patient meets the criteria.

EAGLESOFT DENTAL CHARTING:

- If the patient has been previously dental charted in EagleSoft, the student is expected to make any necessary updates.
- It is in the best interest of the student to check the dental charting for accuracy before submitting for grading.

PRIVATE PRACTICE COMPLETION:

- The student will complete the submission for the private practice patient through Blackboard.
- A grade of 75% or higher will be required on the documentation in EagleSoft to receive credit for the Private Practice patient.
    - See Blackboard for grading criteria
- The student must also receive a grade on the CER of 85% or higher to receive credit for the patient.
- The patient chart, along with the CER, must be submitted to the clinical counselor for grading of the EagleSoft documentation and Private Practice finalization.
- The chart should be ready for audit upon submission.