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

LAMAR INSTITUTE OF TECHNOLOGY

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

MODE OF INSTRUCTION
Face to Face

PREREQUISITE/CO-REQUISITE:

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

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

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

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

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

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

## INSTRUCTOR CONTACT INFORMATION

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

| DDS/Instructors | RDH/Instructors |
|---|---|
| Dave Carpenter, DDS | Jaimie Bruno RDH, BAAS |
| Sam Giglio, DDS | Leslie Carpenter RDH, BS |
| Kristina Mendoza, DDS | Rhonda Cruz RDH BS |
| William Middleton, DDS | Rebecca Ebarb RDH, BS |
| Robert Smith, DDS | Renee Sandusky, RDH, BS |
| | Cynthia Thompson RDH, BS |

*Changes with each semester

## REQUIRED TEXTBOOK

1. Boyd, Linda D., Mallonee Lisa F., Wyche Charlotte J., (2021). *Wilkins' Clinical Practice of the Dental Hygienist* 13th ed., Jones & Bartlett Learning,
   LCCN: 2019917179

2. Nield-Gehrig, J. (2021). *Fundamentals of Periodontal Instrumentation and Advanced Root Instrumentation* (8th ed.). Jones & Bartlett Learning,
   LCCN: 2015037519

3. Current Drug Reference Book (same as required for pharmacology)

## REQUIRED MATERIALS and SUPPLIES

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

COURSE CALENDAR

| DATE | TOPIC | READINGS (Due on this Date) | ASSIGNMENTS (Due on this Date) |
|---|---|---|---|
| January | MLK DAY/ CAMPUS CLOSED | | |
| | Screening day for T-TH clinic<br>1st Clinic Day for T-TH | Syllabus: Screening Patients | You can schedule up to 4 patients per clinic session |
| | Screening day for M-W clinic<br>1st Clinic Day for M-W | Syllabus: Screening Patients | You can schedule up to 4 patients per clinic session |
| | Students are allowed to sign up for screening patients/taking x-rays outside of their assigned clinic time. | | You must sign up in the appointment book. Space is limited |
| February | NO CLINIC TDHA Convention | | |
| | NO CLINIC<br>Fluoride Varnish Program | | Meet at Bingman Head Start School Time TBA |
| March | Mid Semester Clinical Counseling | | Check with your clinical advisor |
| 3-11 to 3-15 | SPRING BREAK | | |
| April | **All X-ray Requirements are due for both clinic sessions** | | |
| | Last Clinic Day for T-TH clinic | | All Requirements Due |
| | Last Clinic Day for M-W clinic | | All Requirements Due |
| May | End of Semester Clinical Counseling | | Check with your clinical advisor |
| | Clinic Cleanup | | See posted schedule |

## ATTENDANCE POLICY

### *Absenteeism*

In order to ensure the students in the dental hygiene program achieve the necessary didactic and clinical competencies outlined in the curriculum, it is necessary that the student complete all assigned lecture classes, clinical and laboratory hours. It is the responsibility of the student to attend class, clinic or lab. The instructor expects each student to be present at each session.
It is expected that students will appear to take their exams at the regularly scheduled examination time. 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 lecture class, clinic or lab, it is **mandatory that you call the appropriate instructor prior to the scheduled class, clinic or lab time**. **An absence will be considered unexcused if the student fails to notify the course faculty prior to the start of class, clinic, or lab. Attendance through Blackboard Collaborate is considered an absence. The course instructor must be notified at least one hour prior to the beginning of class/lab if the student plans to attend through Blackboard Collaborate.** The student is responsible for all material missed at the time of absence. Extenuating circumstances will be taken into account 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. **Fall/Spring Semesters:**
   Dental hygiene students will be allowed **two excused absences** in any lecture, clinic or lab. Absences must be accompanied by a written excuse on the next class day. In the event that a student misses class, clinic or lab beyond the allowed absences, the following policy will be enforced:
      2 absences = notification in Starfish
      Beginning with the third absence, **2 points** will be deducted from the final course grade for each absence thereafter.
      **Two** (2) points will be deducted from the final course grade for each unexcused absence.

### *Tardiness*

Tardiness is disruptive to the instructor and the students in the classroom. A student is considered tardy if not present at the start of class, clinic or lab. It is expected that students will arrive on time for class, clinic or lab, and remain until dismissed by the instructor. If tardiness becomes an issue, the following policy will be enforced:
   Tardy 1 time = notification in Starfish
   Tardy 2 times = is considered an unexcused absence. (See the definition of an unexcused absence)
If a student is more than 15 minutes late to any class period, it will be considered an unexcused absence.

**Students should plan on attending classes, labs and 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, classes, labs or clinic time.

## DROP POLICY

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.

## COURSE REQUIREMENTS

| Course Requirements | Letter Grade | Letter Grade | Letter Grade | Incomplete |
|---|---|---|---|---|
| Competencies | A | B | C | X |
| Instrument Recirculation (Sterilization) | ★ 1 try | ★ | ★ | x |
| Patient Assessment | ★ | ★ | ★ | x |
| Pedodontic Patient | ★ | ★ | ★ | x |
| Radiographic Evaluation | ★ | ★ | ★ | x |
| Skill Evaluations | ★ | ★ | ★ | x |
| Mid-Term Skills Assessment<br>Use of the Mirror, Explorer for Calculus Detection | ★ | ★ | ★ | x |
| Sickle Scaler | ★ | ★ | ★ | x |
| Universal Curet | ★ | ★ | ★ | x |
| Periodontal Debridement | ★ | ★ | ★ | x |
| Slow Speed Handpiece | ★ | ★ | ★ | x |
| Patient Education Sessions (3) | ★ | ★ | ★ | x |

| Patient Points | A | B | C | Incomplete |
|---|---|---|---|---|
| Total points in class 1 and 2 patients | 12 | 10 | 10 | x |
| Total points in class 3 patients | 9 | 9 | 6 | x |
| Periodontal Classification | | | | |
| Gingivitis | 2 | 2 | 2 | x |
| Periodontitis Stage 1 or 2 | 3 | 3 | 3 | x |

*All requirements must be met. Any student considered incomplete cannot continue in the program.

+Continued on the next page

## COURSE REQUIREMENTS CONTINUED

| Satisfactory Assessments | Letter Grade | Letter Grade | Letter Grade | Incomplete |
|---|---|---|---|---|
| | A | B | C | X |
| Med/Dent Hx | 8 | 7 | 6 | x |
| Oral Exams | 8 | 7 | 6 | x |
| Perio Assessment | 8 | 7 | 6 | x |
| Dental Charting | 8 | 7 | 6 | x |
| Plaque Free | 8 | 7 | 6 | x |
| Satisfactory Radiographs | | | | |
| FMX (1 using sensor) | 3 | 3 | 3 | x |
| BWX (1 sensor, 1 plates, 1 Nomad) | 3 | 3 | 3 | x |
| Pedo FMX (allowed to use Dexter for 1 pedo survey) | 1 | 1 | 1 | x |
| Pedo BWX | 1 | 1 | 1 | x |
| Panoramic | 1 | 1 | 1 | x |
| Care Plans | | | | |
| | 3 | 2 | 2 | x |
| Sealant Patient | | | | |
| | 1 | 1 | 1 | x |
| Community Service Hours | | | | |
| FL Varnish Program | 3 | 3 | 3 | x |
| Professional Judgement and Ethical Behavior Average Score | | | | |
| | 40 | 39 | 38 | x |

COURSE EVALUATION

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

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

*Skill Evaluations and Competencies are graded as Acceptable (A) or Not Acceptable (U). Three attempts are allowed for each skill evaluation and competency except for the Radiographic evaluation and Mid-term Assessment

* Mid-Term Skills Assessment is graded as A or U. One attempt is allowed.
*Care Plans are graded as a percentage. A score of 75% or better is required. Patients for Care Plans must be approved by your clinical advisor.
*Radiographic Evaluation is scored as a percentage. A score of 80% or better is required.

## 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).

## 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.

## 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

### *Examination and Quiz Policy*

Examinations will be based on objectives, lecture notes, handouts, assigned readings, audiovisual material and class discussions. Major examinations will consist of multiple choice, true/false, matching, short answer, and case study questions. No questions will be allowed during exams.

Students are expected to complete examinations as scheduled. 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. All make-up examinations must be taken within two (2) weeks from the scheduled exam date. All examinations will be kept on file by the Instructor. 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 all assignments due on the day of absences unless prior arrangements have been made with the Instructor.

Students may use personal equipment, such as a computer, MacBook, laptop, iPad, to take their exams and may 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 test. 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.

### *Mandatory Tutoring*

If a student receives a failing grade on any major exam, the student will be required to meet with course instructor within 2 weeks of the failed exam. One on one concept review by appointment

with the course instructor will be provided and/or written academic warning when a student is failing to meet minimal requirements in the classroom setting.

*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 classroom and lab. Texting on cell phones will not be allowed during class or clinic.

*Late coursework*

*Assignments, Quizzes 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/quiz/test.*

*Remediation*

Remediation is available by appointment.
See Student Handbook for more information about remediation policies.

*** 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 OUTLINE: See Course Requirements

# APPENDIX I
## Skill Evaluations

Skill Evaluations

- Instructions for the Skill Evaluations are located with the evaluation forms in this appendix.
- Skill evaluations cannot be done during any make-up clinic time unless approved by the clinic coordinator
- Skill Evaluation forms should be available to instructors at all times during clinic.
- All Skill Evaluations must be successfully completed in order to complete DHYG 1260.
    - *Students will be allowed 3 attempts at each skill evaluation or competency and 1 attempt at the Mid-Term Skills Assessment. It is the student's responsibility to set up remediation time after an unsuccessful attempt. If after the allotted number of attempts, the student's performance is not acceptable (U), he or she cannot progress in the program.
    - Skill evaluations cannot be performed on any student enrolled in the dental hygiene program, faculty, dental hygienist or dentist.

## Time Allotment for Skill Evaluations

| | | Time: |
|---|---|---|
| 1. | Using the Mirror and Explorer for Calculus Detection* | 30 minutes |
| 2. | Sickle Scalers* | 30 minutes |
| 3. | Universal Curet* | 30 minutes |
| 4. | Use of the Slow Speed Handpiece | 30 minutes |
| 5. | Patient Education | 15-20 minutes |
| 6. | Periodontal Debridement (two quadrants) | 2 hours |

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

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

## Anterior and Posterior Sickle Scalers

### Patient Requirements

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

### Student Instructions

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

### Initial Use of the Sickle Scalers

General Management

- Utilizes time effectively and efficiently
- Utilizes mirror effectively
- Maintains correct patient/operator positioning.
- Adjust the dental light for maximum illumination.
- Uses current infection control procedures.
- Uses air and evacuation equipment effectively.
- Preparation of operatory is appropriate for procedure.
- Selects appropriate instruments and maintains sharpness.
- Professional judgment and ethical behavior demonstrated by:
- Providing 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 the self-confidence necessary to perform the procedure

### *Grasp

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

***Fulcrum:**

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

***Instrument Positioning:**

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

***Instrument Activation:**

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

Instructor Instructions

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

*Denotes basic principles of dental hygiene skills

Patient Education Skill Evaluation (Three Sessions)

## Patient Requirements

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

## Student Instructions

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

## Instructor Instructions

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

Mid-term Skills Assessment

## Requirements

- This skill evaluation will be done on a typodont with information to determine the periodontal classification. The student will perform calculus detection and a periodontal assessment.

## Student Instructions

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

### *Mirror

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

## Explorer

### *Grasp

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

### *Fulcrum

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

***Instrument Positioning**

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

***Instrument Activation**

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

Instructor Instructions

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

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

Manikin Skill Assessment: Calculus Detection and Periodontal Assessment

**Purpose:**

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

**Components:**

Calculus Detection:

1: Supragingival Calculus Detection-Students will examine the manikin's teeth for the presence of supragingival calculus using appropriate instruments (e.g., explorers, scalers).

Emphasis on proper technique, angulation, and effective removal without causing damage to the manikin's teeth.

2: Subgingival Calculus Detection-Students will use periodontal probes and explorers to locate and assess subgingival calculus. Emphasis on gentle probing and accurate detection of calculus deposits below the gumline.

Periodontal Assessment:

1: Gingival Health Assessment-Students will evaluate the gingival health of the manikin by assessing color, contour, and consistency. Proper use of a periodontal probe to measure pocket depths and identify areas of concern.

2: Periodontal Charting-Students will record findings on a periodontal chart, accurately documenting probing depths, bleeding points, and other relevant information.

Emphasis on clear and concise charting to communicate the status of the manikin's periodontal health.

**Evaluation Criteria:**

Technique and Instrumentation:

1: Proper use of explorers, scalers, and periodontal probes.

Correct angulation and pressure during instrumentation.

Ability to differentiate between supragingival and subgingival calculus.

2: Gingival Health Assessment:

Accurate evaluation of gingival color, contour, and consistency.

Systematic probing and identification of abnormal conditions.

Periodontal Charting:

Accuracy in recording probing depths and bleeding points on the periodontal chart.

Clarity and completeness of charting.

Professionalism:

Adherence to infection control protocols.

Efficient use of time and resources.

## Scoring:

Each component will be scored on a scale of 1 to 5, with 1 being inadequate and 5 being exceptional. An overall score will be calculated based on the cumulative scores from all components.

Feedback and Remediation:

After the assessment, students will receive constructive feedback on their performance, highlighting areas of strength and areas needing improvement. Remediation strategies and resources will be provided to help students enhance their skills.

This manikin skill assessment aims to ensure that dental hygiene students develop the necessary competence in calculus detection and periodontal assessment, preparing them for clinical practice.

## Periodontal Debridement Skill Evaluation

### Patient Requirements

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

### Student Instructions

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

### Instructor Instructions

1. Identify an appropriate patient for the evaluation
2. The deposits may or may not be "clickable", but should be distinct and easily detectable
3. The calculus deposits must have been agreed upon by two (2) instructors
4. Two (2) instructors will calculus chart the indicated quadrants and produce a guide for the student showing the location of each agreed upon deposit
5. There should be eight to no more than 10 deposits that the student will be required to
6. remove completely for this evaluation
7. Use your professional judgment to determine which deposits will be counted while making
8. up the guide form
9. Students sign-up for about 30 minutes of time on the clinic sign-up sheet or more if necessary

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

## Universal Curet Skill Evaluation

### Patient Requirements
- Adult over the age of 18
- Prophy Class III and instructor approval
- Perio classification G or I
- Adequate calculus to observe both anterior and posterior instrumentation techniques

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

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

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

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

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

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

Instructor Instructions

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

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

Slow Speed Handpiece Use

Patient Requirements
- Adult over the age of 18
- Any Prophy Class or Perio classification

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

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

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

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

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

*USE OF AUXILIARY POLISHING INSTRUMENTS:

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

7. Make sure you floss completely after you have used this instrument

Instructor Instructions

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

*Denotes basic principles of dental hygiene instrumentat

# APPENDIX 2

# COMPETENCY EVALUATIONS

## Competency Evaluations

A. Instructions for the competency evaluations are located with the evaluation forms in this Appendix.

B. Competency evaluations may be attempted twice

C. Your competency evaluation forms must be on a clipboard & should be available to the instructors at all times during clinic.

D. All competency evaluations MUST be successfully completed in order to complete DHYG 1260.

## Time Allotment for Competency Evaluations

| | |
|---|---|
| 1. Patient Assessment | See instructions |
| 2. Pedodontic Patient | See instructions |
| 3. Instrument Re-circulation and Clinic Readiness | Inform instructor, no sign up required |

***Skill evaluations and Competency evaluations cannot be performed on any student enrolled in the dental hygiene program or an instructor.**

## Instrument Re-Circulation and Clinic Readiness Competency Evaluation

Students are required to arrive 15 minutes prior to the start of clinic when reporting for sterilization duty. Sign in with the clinic receptionist upon arrival.

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

9. The student will demonstrate knowledge of proper biohazardous waste handling and disposal by following the procedures in the risk management manual.
10. The student will demonstrate effectiveness as a team member by performing the following for peers and faculty during scheduled sterilization time:
    - Assistant
    - Messenger
    - Supply retrieval

- Make sure your instructor is aware of the procedures you are completing, check with her throughout the session
- Make sure the instructor has your Competency form at the beginning of the session and that it is completed at the end of the session

Instructor Instructions

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

***Students are required to sign in with Mrs. Byrd when they arrive for sterilization duty. The arrival time is 15 minutes prior to the start of that clinic.**

## Patient Assessment Competency Evaluation

### Patient Requirements

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

### Student Instructions

1. Must be scheduled in the skill evaluation book in the clinic with your Pod instructor.
2. **You MUST have an instructor present before you review the patient's health history and obtain vital signs.** Time will start as soon as the patient health history is started. The instructor will sign the history, release and HIPAA documents**. No other documents or procedures will be checked or signed until check out.**
3. Make sure you have all of the necessary paper work or forms at your operatory.
4. Have the health history signed by an instructor before you begin the patient assessment.
5. Complete all of the assessment examinations in the two-hour examination time period. This will include:
    a. **Medical/dental history and vital signs (BP must be taken 2 times)**
    b. **Head and Neck and Intraoral Examination**
    c. **Periodontal Assessment (including plaque score and home care regimen)**
    d. **Dental Charting**
    e. **Complete the Informed Consent Document (Including patient signature)**
6. Radiographs, if necessary, will be taken during the appointment but will be excluded from the time limit. Radiographs may be taken prior to the examination.
7. Notify your instructor when you have completed the assessment competency or if you need to take a break for any reason. You must get a stop and start time.

### Instructor Instructions

1. Record a start time for the student as soon as the patient is seated in the chair and the student is ready to start the medical history.
2. Make sure you are available for observing the student during each of the required elements of the competency; including review of the medical history and taking vital signs (**teaching stethoscope is required**). Students are expected to obtain the blood pressure 2 times. Sign the medical history after the student has completed the review.
3. **Give the student time out for radiographs. Write the stop and start times on the evaluation form.**
4. Record the time the student is finished.
5. Begin evaluation of the assessments.
6. Record any feedback on the competency evaluation form and review it with the student.

## Pedodontic Patient Competency Evaluation

### Patient Requirements:

- 5 to 10 years of age, no exceptions.
- No complicated medical history problems
- One parent/legal guardian **MUST** accompany the patient. Students may not see their own children.

### Student Instructions:

1. Must be scheduled in the skill evaluation book in the clinic with your Pod instructor.
2. **Your Instructor MUST be present before you start the medical history for this patient**. The instructor will sign the history, release and HIPAA documents. **No other documents or procedures will be checked or signed until check out.**
3. Obtain the correct paperwork for the child patient.
4. **Have the parent sign the Informed Consent prior to any treatment.**
5. Try to obtain a complete medical history prior to the child's appointment.
6. **You have 2 hours to complete this patient, NOT including check out.** Any necessary radiographs may be taken at a date prior to the competency.
7. The fluoride treatment is not included in this competency evaluation
8. Record detailed patient education information and **recommendations made to the parent** in the progress notes.
9. Make sure you follow the format for the evaluation; if you have questions you must ask them prior to the start of the appointment.

### Instructor Instructions:

1. Approve the patient for the competency evaluation, observe the medical/dental history and vital signs (teaching stethoscope is required) and sign the appropriate paperwork. No other paper work will be checked or signed until check out.
2. Observe the student at intervals appropriate to the criteria on the evaluation
3. Make sure you record stop and start times for radiographs
4. Check all paperwork and evaluate all procedures when the student is finished
5. Complete the written competency evaluation form when the student is finished

# APPENDIX 3
# GUIDELINES FOR RADIOGRAPHS

## Radiographic Guidelines:

### Grading Criteria:

1. Each radiograph will be graded utilizing the criteria established in DHYG 1304.

### Procedures:

1. Decide on the appropriate radiographs needed for the patient. Select equipment accordingly.
2. 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).
3. 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.
4. Surveys are to be completed by the due date in the schedule.
5. All surveys must be completed, critiqued and submitted online to be graded by your clinical advisor. When submitting x-rays note in the subject line of your email the instructor's name. Only after submission and grading, will you know how many retakes are needed. Retakes must be done regardless of whether or not the series is acceptable. You will only take radiographs the patient needs and you will take the type of radiographs that are best for your patient.

### Radiographic Evaluation:

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

## APPENDIX 4
## INTRODUCTORY CLINIC INFORMATION

# Introductory Clinic Information

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

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

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

II. Cancellation Time (Non-productive Time)

1. It is your responsibility to explain the necessity of keeping scheduled appointments and of notifying you at least 24 hours in advance if your patient cannot keep the appointment. The maximum time allowed is 14 hours. After 14 hours the final grade drops by one letter grade.
2. Patients should be told they can leave messages for you by calling the Dental Hygiene Clinic number (880-8020).
3. Check your folder and the bulletin board regularly to receive messages.
4. Confirm all appointments 24 hours prior to the scheduled appointment time.
5. You should record any cancellations or missed appointments in the patient's progress notes and call log. The Dental hygiene program cannot be accused of abandoning a patient if there is a record of the missed or cancelled appointments. This patient will also be identified as non-compliant if they ever desire treatment at the LIT Dental Hygiene Clinic again.
6. Communication forms will be made for all patients and an entry of student/patient communication will be recorded for each contact. Contact with new patients who have no record yet will still be recorded on a communication form which will be kept in the student's file area in a folder especially labeled for that purpose. When the patient comes in for their first appointment this form will be placed in their patient folder.
7. Students are responsible for monitoring the arrival of their patients. No one is allowed to hang out in the reception office. Have your patient notify you when they arrive. If you have a cancellation, you may opt to go recruit a patient from the building. You must inform your Pod instructor. When you return you need to inform the same instructor of your return. If you have no patient you must use your clinic time constructively and document it on the back of the cancellation CER. An instructor must sign it.

## III. Patient Fees

1. See Table below

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

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

## IV. Planning

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

## V. Patient education, plaque and bleeding scores

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

## VI. Dismissing patients at the end of an appointment

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

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

You are allowed to see two children this semester. Children must be accompanied by a parent or legal guardian, no one else is allowed to sign the informed consent unless a legal document is used. The form is available on Blackboard under DHYG 1260. See the clinic coordinator if you have questions.

VIII. LIT Appointment Policy

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

IX. Sterilization Duty

Each student will be assigned to work in Sterilization approximately 4 times during the semester. This assignment is not optional. Students who schedule patients during their scheduled in-session assignment will be required to reschedule their patients. Students who miss any part of their assignments will be required to make up that session and an additional 4-hour session outside of your clinic time. You must arrive 15 minutes prior to the start of clinic. DO NOT BE LATE.

X. Patient Transportation and Parking:

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

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

XI. Patient Records:

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

XII. Patient Confidentiality:

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

XIII. Instruments:

The student is expected to care for and monitor their instruments. Students on sterilization duty have specific duties; they are not there to be your assistant. If you are taking radiographs outside of your normal clinic time, you are solely responsible for anything used. LIT and the faculty are not responsible for missing instruments and/or instrument breakage.

XIV. Patient Rights:

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

1. Considerate, respectful and confidential treatment.

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

XV. Medically Compromised Patients:

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

XVI. Hepatitis and HIV Positive Patients:

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

XVII. Herpes Simplex Infection:

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

XVIII. Professional Judgement and Ethical Behavior:

Students are required to display attitudes and behaviors consistent with accepted standards of professional conduct. Therefore, evaluation of professional behavior occurs continuously through-out the curriculum. There will be six opportunities for faculty to observe the students and complete a Professional judgement and Ethical Behavior scoring rubric. If accepted standards are not met, a student may have points deducted from the professional judgement and ethical behavior score. A minimal score of 38% must be met in order to progress in the program. For repetitive breaches of professional standards, a student may be administratively withdrawn from the Program without the opportunity for readmission. The following professional characteristics are among those encouraged, observed, and evaluated throughout the dental hygiene curriculum: clinic readiness, professional appearance, professional judgement, professional ethics, instrumentation skills, infection control, time management, organization skills, documentation, and patient rapport. Students are expected to demonstrate these characteristics, both in their academic and clinical pursuits.

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

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

- The pod system will be utilized in the clinic setting to enhance student learning.
- The Pod system requires each clinical instructor 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.

# APPENDIX 5

## APPOINTMENT PLANNING

## APPOINTMENT PLANNING

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

I. Appointments

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

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

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

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

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

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

## II. Pre-appointment preparation

A. Carry out all pre-appointment infection control procedures.
B. Pick up your patient's chart from the file cabinet.
C. Set up only those items necessary for the procedures to be performed during the appointment. You must plan ahead! For the first appointment you will need one instrument cassette, patient record forms, disclosing solution, mouth rinse, hand mirror, and disposables (gauze, etc.).
D. Your patient will check in with the clinic receptionist.
E. Greet your patient and seat on time. If you are running behind schedule, please notify the patient and the clinic receptionist. She will need to know how long you will be delayed - be honest do not underestimate. If more than 15 minutes will be required, you should stop where you are with your current patient and start where you left off at their next appointment. Remember, it will take about 15 minutes to post and pre-op before you are able to seat your next patient.

## III. Fill out the CER

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

Cancellation Time or Non-productive Time (CER #51 J)
When a patient cancels or does not show for his appointment you must use a Cancellation CER. You must record the reason for the non-productive time (cancellation, patient no-show, mismanagement of time, etc.) and what you did during your non-productive time, on the reverse of the CER. Students who have cancellation time may be assigned radiographs to critique or case studies to complete in their operatory. Students will not be allowed to sit in the receptionist's office. **An instructor MUST initial the Cancellation CER opposite the time notation on the day the non-productive time has occurred.**

Sterilization (CER #50 S)
You will have one CER to record time spent on sterilization duty.

Student Illness (CER #53I)
A student illness CER will be executed only when a clinic absence is not excused or when an excused clinic absence is not made up prior to clinic counseling dates. See your clinic counselor or clinic coordinator for instructions on how to record your time in this situation.

Screening (CER #52X)
Students are encouraged to have their patients screened prior to setting up appointments for them. Patients are not charged for screening alone but will be charged the appropriate fee if radiographs are taken.

B. Patient Name ___________________________ (fill in patient's name)

C. Pat# / Code _____________________________

Enter the patient's name on the CER. Each patient will be logged into your clinic records after an instructor reviews the medical/dental history on the first appointment. A numerical sequence of patients will be developed starting with your first patient.

D. Student Name __________________________ (fill in student name)

E. Clinic I II III

- Circle whichever clinic course you are in

F. Prophy Class: 0 1 2 3 4 5 6 7 8

Periodontal Stage/Grade

1. Your instructor will determine your patient's prophy class and will circle and initial this area. Prophy class can usually be determined clinically without radiographs. The student will determine periodontal stage/grade and will obtain instructor confirmation prior to treatment procedures. Periodontal stage/grade requires radiographs and in some cases determination of the CAL. Be sure to have your patient classed before their first appointment is concluded. **This is your responsibility!**
2. Both the Prophy class and the Periodontal Stage/Grade designations will be recorded on the patient's progress notes in the left margin where the date is written.

## IV. Initial paper work and Histories

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

1. Medical/Dental History
   a. Make sure this is filled out completely - vital signs, etc.
   b. Have patient sign and date
   c. Student signature
   d. If medications (prescriptions, OTC or Herbal medications) are listed follow this procedure:
      (1) At the initial appointment look up the drug in the PDR or other drug reference (don't forget the internet for herbal medications) and record any treatment modifications or contraindications for dental treatment on the second sheet of the medical history.
      (2) By the second appointment have a drug card for each prescription the patient is taking. You do not have to write a drug card for OTC medication or herbal medications or supplements (herbal or others).

(3) Drug cards accompany the medical/dental history on the second patient visit and will be reviewed by the instructor. The instructor will note the cards have been done by initialing the drug card space on the second sheet of the medical history.

e. If the medical history indicates a consultation with an MD is required, the student will attempt to reach the MD by phone and FAX a Medical Release form to the MD for completion before the student can proceed with patient treatment.

<u>FAX NUMBER 880-8081</u>

(1) At the discretion of the instructors and depending on the reason for the medical release the student may perform some limited procedures prior to receiving a medical release. An instructor will evaluate each patient and inform you what can be done.

(2) The best way to avoid wasted time is to obtain a preliminary medical history over the phone when making the initial appointment.

2. Patient Application for Treatment and Release Form. Have your patient read, sign and date this form. Your instructor will initial this form at the first appointment when the Medical/Dental history is reviewed. No other signatures are required during the semester in which the patient begins treatment. If seen in subsequent semesters, a new signature and initials must be obtained.

3. LIT Appointment Policy form. Have your patient read and sign this form. Please ask if they have any questions, if so clarify the policy for them. Your instructor will initial the form. This form is signed once and does not have to be signed in subsequent semesters

4. Fill out and explain all HIPAA Forms to the patient
   a. Have the patient sign where indicted and give the patient a copy of the policy at LIT.

5. The CER. The CER must be filled out as indicated previously including the start date for the Medical/Dental history.

B. The first appointment

When you have completed all of the above you need to get an instructor to come to your chair to review the important points of the patient's medical/dental history. The instructor may comment or question you regarding any information contained or not contained on the form before placing the grade on the CER. The instructor will check and initial the patient ID, payment receipt, release forms, and HIPAA forms. The need for x-rays will be determined at this time.

C. For second and subsequent appointments the student will update the Medical/Dental history, note any changes by recording the number of the line

item next to the signature line (or N/C if there have been no changes). If additional drugs have been added the student will follow the procedures noted above. The updated Medical/Dental history and other necessary forms will be given to an instructor for signatures.

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

The next section should be done as one exam before being checked by an instructor unless time will not permit completing both. Make sure you list atypical as well as pathologic findings and the suspected etiologies.

A. Head and Neck Exam

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

B. Intraoral Exam

1. Before proceeding with the intra oral portion of the exam, have your patient rinse with antiseptic mouth rinse.
2. Proceed with the exam as listed on the exam form.
3. Do not forget class I occlusion is a malocclusion and must be listed as such, also, determine division classification for all class II occlusions (division I all protruded, division II one or more retruded).

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

**************************************************************************

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

**************************************************************************

VI. Periodontal Assessment

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

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

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

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

B. Soft Tissue Examination

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

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

C. Radiographic Findings

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

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

D. Periodontal Condition

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

E. Calculus Detection

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

## VII. Dental charting

A. A complete dental charting will be accomplished for every patient. The information obtained from the chart will be used to determine biofilm retentive features and the predisposing factors on the periodontal assessment form. The initial findings form is completed by the student. The dentist will check your findings for accuracy. Findings will then be recorded on the dental charting form using the red/blue pencil. (no ink)

B. **Unless otherwise indicated radiographs must be utilized for dental charting.** The radiographs may be taken at the clinic or may be requested from the patient's dentist of record. If the latter is the case the radiographs will be returned after use.

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

"Dental charting with x-rays"

"Dental charting without x-rays"

C. **The dentist will evaluate your dental charting and will complete the following prior to leaving your area:**

1. Grade the dental charting section of the CER
2. Sign the patient's progress notes adjacent to the dental charting notation (make sure the entry states whether or not radiographs were used)

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

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

## VIII. Plaque/Bleeding Score and Home Care Regimen Form

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

B. Each patient shall have an initial full mouth bleeding score recorded during the first or second visit and a partial score at every appointment thereafter using the 6 indicator teeth on the form. Determine the initial bleeding score for each patient by dividing the total number of bleeding points by the total number of possible bleeding points. Example follows: 1. Full mouth score 2. 6 indicator teeth

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

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

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

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

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

A. The following information is recorded
1. Pocket depths (6 readings for each tooth)
2. Tissue heights (6 readings for each tooth)
3. Determination of clinical attachment level (CAL) (6 readings per tooth)
4. Mobility
5. Sensitivity to percussion
6. Suppuration
7. Frenal problems, furcation involvement and IZAG

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

X. **Informed Consent / Care Plan and Risk Assessment Documents**

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

XI. **Dental Hygiene Care Plans**

A. Dental hygiene care planning and patient education will be accomplished on every patient during the course of treatment, written plans are required for the following:
1. The patient you are using for the patient education skill evaluation
2. Another patient approved by an instructor (preferably a class 3)
3. If you are working towards a grade of "A" in this course, a third treatment plan needs to be done on another patient approved by an instructor.

B. Data collection ends with the completion of all assessment forms. **You have 1 week from the date of the last assessment appointment to submit the written care plan to your clinical advisor. (all submissions must be online).**

## XII. Patient Education

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

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

## XIII. Scaling Procedures

When all examination procedures have been completed and patient education has been started, your instructor will ask you to begin therapeutic treatment (the removal of all hard deposits without unnecessary tissue trauma).

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

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

C. When scaling in one quadrant is complete, ask for a scale check from an instructor. Only **the RDH instructors** are allowed to grade scaling, unless otherwise indicated.

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

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

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

## XIV. Polishing/Plaque Free

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

A. Plaque Free (without prophy paste) *

1. You will disclose your patient and proceed to remove all biofilm deposits using slow speed handpiece, brush, floss and instruments if necessary.

2. Re-disclose the patient and have an instructor check when you have determined that all soft deposits are removed.
3. The instructor will indicate any remaining areas. You will record these on the CER and remove them before asking for a re-evaluation.

B. Polishing (using a prophy paste)
1. Disclose the patient and remove all soft deposits and stain using slow speed handpiece, appropriate abrasive prophy paste (remember if you use medium or coarse you must follow with the medium and then fine pastes) brush, floss and instruments, if necessary.
2. Disclose again and when you have determined the patient to be plaque free, have your instructor check.
3. The instructor will indicate any areas that remain and you will remove these before asking for a re-evaluation.

C. Children
Children up to the age of 10 will have a toothbrush prophy done unless there is stain present that cannot be scaled off or heavy plaque. Consult your pod instructor when in doubt.

## XV. Fluoride Treatment

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

A. Follow the procedures regarding patient education and be sure to give your patient a fluoride fact sheet. (Put one in their record when you start treatment)
B. Don't forget to have an instructor check your patient after you are done.
C. Never leave your patient during a fluoride treatment
D. Fluoride Varnish. Fluoride varnish will be done for all children with primary dentition. Patients who have excessive recession will also be offered fluoride varnish. Follow the manufacturer's instructions. Be sure to give appropriate instructions to your patient and one of the patient handouts to take home. Due to the expense of Fluoride varnish you must have instructor's approval to use on adult patients.

## XVI. The last appointment

Make sure all of the following are done <u>before you dismiss</u> your patient for the last time.

A. Procedures are completed <u>and</u> you have a grade and instructors' initials on the CER.
B. The last entry on the progress notes contains the following:
1. Description of the patient's gingival/periodontal condition upon leaving. active treatment
2. Current learning level
3. Referrals from the Informed Consent document for treatment needed or completed if not recorded previously
4. Recall frequency and date
5. Patient's receipt number and payment information, if not recorded previously

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

## XVII. Comprehensive Care Grade

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

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

B. The patient record must be complete

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

C. Completed CER

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

E. Have the chart audited

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

## XVIII. Consumer Survey

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

## XIX. Patient Records

A. **Patient records are NOT to leave the clinic area.**

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

## XX. Chart Audit

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

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

C. Patient charts must be refiled after use. Do not keep them in your mailbox. Your advisor will be ***extremely unhappy*** if this happens.

D. See the Audit Checklist for more information

# APPENDIX 6

## GRADING CRITERIA FOR THE CLINICAL EVALUATION RECORD (CER)

GRADING CRITERIA

| Clinic Procedure | Satisfactory |
|---|---|
| 1. Medical/Dental History | 2 errors |
| 2. Oral Examination | 3 errors |
| 3. Periodontal Assessment | 3 errors |
| 4. Periodontal Charting | 6 errors |
| 5. Radiographic Evaluation | 3 errors |
| 6. Informed Consent | 4 errors |
| 7. Dental Charting | 5 errors |
| 8. Scaling (per quadrant) | |
| A. Class I | 2 errors |
| B. Class II | 3 errors |
| C. Class III | 4 errors |
| *Tissue Trauma | Counted as a scaling error |
| 9. Polishing/Plaque Free | 4 errors |
| 10. Topical Fluoride Trays/Varnish (failure to give a patient post treatment instruction is U) | 3 errors |

Radiographs (3 improvable equal 1 retake)

| | | |
|---|---|---|
| A. | Adult BWX (1 retake + 2 improvable) | 5 improvable |
| | Primary/mixed BWX (1 retake) | 3 improvable |
| B. | Adult FMX (4 retakes + 2 improvable) | 14 improvable |
| | Primary/mixed FMX (2 retakes,2 improvable) | 8 improvable |
| C. | Panoramic | 2 improvable |

Chart Audit 2 errors

***All CER's are filed with the receptionist to access for grade input.**
**Do not keep CER forms in the patient chart. File patient charts at the end of clinic. Never remove charts from the building.**

# APPENDIX 7

## HARD DEPOSIT AND PERIODONTAL CLASSIFICATIONS

## HARD DEPOSIT CLASSIFICATION SYSTEM

Class I: Any condition less than a Class II.

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

Class III: "Clickable" subgingival calculus deposits on at least 10 teeth.

PERIODONTAL CLASSIFICATION SYSTEM

Periodontal Staging:

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

GRADING

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

# APPENDIX 8

## INSTRUCTIONS FOR MID AND FINAL CLINIC COUNSELING

## INSTRUCTIONS FOR MID-SEMESTER CLINICAL COUNSELING

Student:

1. Check your computer grade printout for accuracy. Look at specific procedures and make sure you have the same number of satisfactory and unsatisfactory grades as the computer does. Check the number of complete and incomplete patients, the number of class 1's, 2's, and 3's, you have started and the periodontal case types against what you have recorded on your CER's. Be able to account for your clinic time as listed by clinic session. If you find errors make the corrections on the printout, do not change your CER's! You must be able to document any corrections you have made using CER's, x-ray critique sheets, skill evaluations, competency evaluations and your appointment book. Bring your corrected copy of the computer printout to the clinic counseling session. Check for systemic illnesses and make sure you have payment information if it is not already on the CER's.

2. Pull all of your patient records and CER's and bring them to your counseling appointment. Make sure they contain all of the proper forms and information.

3. Bring your Clinic Manual, including Skill and Competency evaluations and bring your appointment book.

4. Prepare a typed critique of your clinic performance thus far. What do you feel especially comfortable with, what areas do you feel that you need help with, etc.

5. Please bring the clinic requirement tracking form (from the clinic manual) with you to your counseling session. Make sure that you have recorded all of the correct information on this form.

<u>FACULTY</u>

PLEASE MAKE CORRECTIONS AS YOU CHECK THROUGH THE STUDENTS CER'S AND PRINTOUT

1. Record any skill evaluation, competency evaluation or treatment plan grades that have not been recorded on the clinic grade sheet.
2. Check the following on the computer printout for accuracy: Prophy/Periodontal Stage/Grade, Number of requirements met, clinic time, etc.
3. Correct the CER's if necessary.
4. Check the student's patient records for completeness, audit if necessary.
5. If radiographs are not documented on the student grade sheet, please enter them. *Make sure the student can produce a CER and a critique sheet for each survey. Question the student concerning surveys that have not been graded and make sure they intend to turn in any retakes as soon as possible. **Send any problems to the clinic coordinator.**
6. Check student progress towards meeting requirements in clinic including skill and competency evaluations, patient requirements, and radiographs.
7. Check student progress in identifying special patients, i.e. patient education, pedodontic competency, patient assessment competency, etc.
   Check student progress towards attaining their patient points, remember they are working toward a specific grade but have to start out with at least "C" requirements. <u>The student must pass at least one quadrant of scaling to receive points for the completed patient.</u>
8. Make a list of students who need specific patients so we know what their general needs are.

Please return the following:

1. List of patients the student still needs to identify
2. Corrected computer printout
3. Anything else you think we should be aware of

## INSTRUCTIONS FOR FINAL CLINIC COUNSELING

Student:

1. Check your computer grade printout for accuracy. Look at specific procedures and make sure that you have the same number of satisfactory grades as the computer does. Check the number of complete and incomplete patients, the number of Class 1's, 2's, and 3's that you have started and the periodontal classes recorded on the printout against what you have recorded on your CER's. Be able to account for your clinic time as listed by clinic session. If you find errors, make corrections on the printout; do not change your CER's! You must be able to document any corrections that you have made using CER's, x-ray critique sheets, skill evaluations, competency evaluations and your appointment book. Bring your corrected copy of the computer printout to the clinic counseling session.

2. Pull all of your patient records and CER's and bring them to your counseling appointment. Make sure you have your planner available. Make a list of all patients that have not been completed and designate whether or not they will be returning in the fall for completion.

3. Prepare a <u>**typed**</u> critique of your clinic performance. What do you feel especially comfortable with, what areas do you feel that you need help with, etc. Did you utilize your time effectively? If you were not satisfied with your efforts, what might you do to correct the problem? Give this to your clinic counselor.

4. Please bring the clinic requirement tracking sheet from the manual with you to the counseling session. Make sure that you have recorded all of the correct information on the form. If you have requirements that are not completed list these out and explain why they are not completed.

5. Check your CER's against your patient records for special needs. Make sure these are circled on the CER.

6. There were 27 scheduled clinic sessions or 108 hours. This includes 12 hrs. of Sterilization.

7. <u>Return dental materials key to Mrs. Thompson in a coin envelope with your name and drawer number on it.</u>

Faculty:

1. Record any skill evaluation, competency evaluation or treatment plan grades that have not been recorded in the clinic gradebook.

2. Check the following on the computer printout for accuracy: Prophy/Periodontal Stage/Grade, number of requirements met, clinic time, etc. The time should include Sterilization hours. (12 total)

3. Correct the CER's if necessary and make changes in the clinic gradebook

4. Check the student's patient records for audit signatures.

5. If radiographs are not documented on the student grade sheet, please enter them. Make sure the student can produce a CER and critique sheet for each survey. Question the student concerning any surveys that are not graded; we need to account for all radiographs taken. Have the student turn any ungraded surveys in to Dr. Mendoza.

6. Check the student's requirements against the requirement sheet in the manual. If the student has not completed requirements they should provide you with a list of incomplete requirements with reasons for not completing them.

7. Confirm completion of the proper number of prophy and periodontal class patients. Remember the student must have a 75% on the CER and must have passed at least 1 quadrant of scaling.

8. Check Community Service hours. Fl Varnish Program (attended)

9. Write an entry in the student's counseling Notes for failure to complete requirements (any of the requirements).

10. Return the following to the clinic coordinator:
    a. Computer printout with corrections
    b. Written critiques
    c. List of incomplete requirements
    d. CER's as corrected
    e. Dental materials key should be given to Mrs. Harrell.

## APPENDIX 9

## STUDENT REQUIREMENT TRACKING SHEET

STUDENT REQUIREMENT TRACKING RECORD

(Place appropriate patient number in the appropriate space upon completion of treatment. Bring this record with you to all progress checks and counseling sessions.)

PROPHY CLASS

Class I pts (completed) ___ ___ ___ ___ ___ ___

Class II pts (completed) ___ ___ ___ ___ ___ ___

Class III pts (completed) ___ ___ ___

PERIODONTAL STAGING/GRADING

Gingivitis (completed) ___ ___ ___ ___ ___ ___

Stage 1 or 2 (completed) ___ ___ ___ ___ ___ ___

| REQUIREMENT | INDIVIDUAL PATIENT NUMBER | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 3 FMX (1 sensor) | | | | | | | | |
| 3 BWX (1 sensor, 1 Nomad, 1 plates) | | | | | | | | |
| 1 PAN | | | | | | | | |
| PEDO FMX | | | | | | | | |
| PEDO BWX | | | | | | | | |
| MED/DENT HISTORY | | | | | | | | |
| HEAD & NECK/INTRAORAL EXAMS | | | | | | | | |
| PERIODONTAL ASSESSMENT | | | | | | | | |
| ADULT DENTAL CHARTING | | | | | | | | |
| PRIMARY/MIXED DENTAL CHARTING | | | | | | | | |
| SEALANT PATIENT | | | | | | | | |
| PLAQUE FREE/POLISHING | | | | | | | | |
| WRITTEN CARE PLANS | | | | | | | | |
| COMMUNITY SERVICE | | | | | | | | |
| PROFESSIONAL JUDGEMENT SCORES | | | | | | | | |
| CHART AUDIT SCORES | | | | | | | | |
| RADIOGRAPHIC EVALUATIONS | | | | | | | | |
| SKILL EVALUATIONS | | | | | | | | |
| COMPETENCIES | | | | | | | | |
| ABSENCES | | | | | | | | |

CHART AUDIT PROCEDURE:

Students will complete a chart audit on each patient treated in the clinic. (including x-ray only) There is a chart audit checklist located with the other clinical paperwork. It lists all of the paperwork to be included in the patient chart along with the order it should be in. Notations that should be in the progress notes (blue sheet) are listed also. The top section is for the instructor to check off. You have one week after the patient is completed (this includes radiographs once they are graded) to complete a chart audit. Instructors will audit your charts randomly to ensure the correct documentation procedures are being followed. You will receive an A or U on the CER to indicate which charts were audited by an instructor.

*You are allowed only 2 (U)-unsatisfactory chart audits for the semester. You will receive feedback on corrections. Beginning with the 3rd grade of (U) for the chart audit, one point will be deducted from the total of your Professional Judgement and Ethical Behavior scores. This will affect your overall average for this requirement and may lower your clinic grade. Documentation is an integral part of standard dental hygiene care. The documents are legally binding and must be properly processed by the student. It is the student's responsibility to assure this is completed correctly according to LIT Dental Hygiene Program policies.

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

Approved: Initials/date