CLINICAL INTERMEDIATE (DHYG 2261.7A1, DHYG 2261.7B1, DHYG 2261.7C1, DHYG 2261.7D1, DHYG 2261.7E1)

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

MODE OF INSTRUCTION
Face to Face

PREREQUISITE/CO-REQUISITE:
Prerequisite: DHYG 1301, DHYG 1431, DHYG 1304, DHYG 1235, DHYG 1103, DHYG 1219, DHYG 1339, DHYG 2301, DHYG 2133, DHYG 1260.
Co-Requisite: DHYG 1311, DHYG 1339, DHYG 2331.

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

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

- Apply the theory, concepts, and skills involving specialized materials, tools, equipment, procedures, regulations, laws, and interactions within and among political, economic, environmental, social, and legal systems associated with the occupation and the business/industry.
- Demonstrate legal and ethical behavior, safety practices, interpersonal and teamwork skills.
- Demonstrate appropriate written and verbal communication skills using the terminology of the occupation and the business/industry.

INSTRUCTOR CONTACT INFORMATION

Instructor: Ronni Cruz, RDH, BS

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

Email: rcruz@lit.edu (Instructor will respond within 24-48 hours)

Office Phone: (409)-247-4887

Office Location: MPC 206

Office Hours: Mondays 12:30-4:00; Tuesdays 9:00-10:00
Thursdays 7:30-8:00; Fridays 7:30-8:00

REQUIRED TEXTBOOK AND MATERIALS
Nield-Gehrig, Fundamentals of Periodontal Instrumentation & Advanced Root Instrumentation, 8th edition, Lippincott, Williams, & Wilkins, 2017. ISBN: 9781496320209.
Clinic course syllabus and student instruments, gloves, safety glasses/shield, masks, lab coats

COURSE CALENDAR/IMPORTANT DATES TO REMEMBER

AUGUST	
25	First Day of Classes and Clinic
25	***ALL STUDENTS*** in clinic for Ultrasonic Lab (12:30 pm – 3:30 pm)
SEPTEMBER	
1	NO CLINIC – LABOR DAY HOLIDAY
8	***ALL STUDENTS*** in clinic for Gracey curet lab (12:30 pm – 3:30 pm)
Week of 15th	PROGRESS CHECK WEEK
OCTOBER	
2	NO CLINIC – FLUORIDE VARNISH PROGRAM 8:00 AM @ BINGMAN ELEMENTARY SCHOOL – ***ALL MUST ATTEND***
9 - 11	Radiographic Evaluation opens in Blackboard Opens October 9 at 6:00 am and closes on October 11 at 10:00 pm
Week of 13th	MID SEMESTER COUNSELING WEEK
31	*Recommended* – finish periodontal patient quadrant scaling (to allow time for 2-week post-periodontal evaluation)
NOVEMBER	
Week of 3rd	PROGRESS CHECK WEEK
10	*Recommended* – have completed or identified ALL competencies and skill evaluations
18	Research Project Presentations MPC Auditorium 6:00 pm – 9:00 pm
18	Last Tuesday Clinic
19	Last Wednesday Clinic
21	Last Friday Clinic
24	Last Monday Clinic
25	Last Thursday Clinic (***NOTE**: this is a Tuesday–for Thursday clinic students only)
25	**ALL** 2nd year requirements due by 5:00 pm (includes radiographic critiques and chart audits, all documents loaded in Blackboard)
DECEMBER	
Week of 1st	**FINAL CLINIC COUNSELING**
9 & 10	Clinic Clean Up – Assignments TBD

ATTENDANCE POLICY

Absenteeism

In order to ensure the students in the dental hygiene program achieve the necessary clinical competencies outlined in the curriculum, it is necessary that the student complete all assigned clinical hours. It is the responsibility of the student, and expected by the instructors, that each student be present, and on time, at each clinic session.

It is expected that students will take their clinical and radiographic exams at the scheduled examination time, unless arranged with the clinic coordinator. Make-up examinations will be given **only** if the absence is due to illness (confirmed by a physicians' excuse), a death in the immediate family, or at the discretion of the instructor.

If students are unable to attend clinic, it is **mandatory that you contact the appropriate instructor prior to the scheduled clinic time**. **An absence will be considered unexcused if the student fails to notify the clinic faculty prior to the start of clinic.** If a student is too ill to attend class, this will require an absence in clinic on the same day unless the student has Dr. permission to be on campus. Any other absence in clinic will be dealt with on an individual basis and must be discussed with the 2nd year clinic coordinator. Extenuating circumstances will be considered to determine if the absence is excused. Extenuating circumstances might include but are not limited to funeral of immediate family member, maternity, hospitalization, etc. If the student has surgery, a debilitating injury, or an extended illness, a doctor's release will be required before returning to clinic. A Request to be Absent form should be filled out and submitted to the Clinic Coordinator.

- Dental hygiene students are required to makeup all excused absence clinic sessions within 2 weeks of return to clinic and must be scheduled with the clinic coordinator. Extenuating circumstances will be dealt on a one-to-one basis.
- If a student has an unexcused absence, they will receive a written disciplinary action form which will be placed in the student's permanent record and a Professional Judgement and Ethical Behavior form will be given which may affect the students overall Professional Judgement and Ethical Behavior average.
- Any unexcused absence will be added to Cancellation time Clinical Evaluation Record (CER) and the student will lose that clinic time.

Tardiness

Punctuality is an important aspect of professionalism in the field of dental hygiene. Punctuality is not only a reflection of personal commitment but also an essential quality that contributes to a positive and efficient learning environment. Dental hygiene students are expected to be punctual in order to demonstrate their dedication to their education, respect for instructors and peers, and preparation for clinical settings where timely patient care is important. Tardiness can affect the students time spent providing patient care. A student is considered tardy if not present and ready to seat their patient at the start of clinic. It is expected that students will arrive on time for clinic, and remain until dismissed by the instructor. If a student knows they will be tardy, they must contact the appropriate instructor prior to the schedule clinic time.

When a student is tardy, they will receive a written disciplinary action form which will be placed in the student's permanent record and a Professional Judgement and Ethical Behavior form will be given which may affect the students overall Professional Judgement and Ethical Behavior average.

Students should plan on all clinic sessions as assigned throughout the semester. Family outings, vacations and personal business should be scheduled when school is not in session and will not be considered excuses for missing assignments, examinations or clinic time.

DROP POLICY

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

STUDENT EXPECTED TIME REQUIREMENT

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

ACADEMIC DISHONESTY

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

TECHNICAL REQUIREMENTS

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

DISABILITIES STATEMENT

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

Clinical Accommodations Policy

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

STUDENT CODE OF CONDUCT STATEMENT

It is the responsibility of all registered Lamar Institute of Technology students to access, read, understand and abide by all published policies, regulations, and procedures listed in the *LIT Catalog and Student Handbook*. The *LIT Catalog and Student Handbook* may be accessed at www.lit.edu. Please note that the online version of the *LIT Catalog and Student Handbook* supersedes all other versions of the same document.

ARTIFICIAL INTELLIGENCE STATEMENT

Lamar Institute of Technology (LIT) recognizes the recent advances in Artificial Intelligence (AI), such as ChatGPT, have changed the landscape of many career disciplines and will impact many students in and out of

the classroom. To prepare students for their selected careers, LIT desires to guide students in the ethical use of these technologies and incorporate AI into classroom instruction and assignments appropriately. Appropriate use of these technologies is at the discretion of the instructor. Students are reminded that all submitted work must be their own original work unless otherwise specified. Students should contact their instructor with any questions as to the acceptable use of AI/ChatGPT in their courses.

STARFISH

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

ADDITIONAL COURSE POLICIES/INFORMATION

Assignment and Examination Policy

The Radiographic Evaluation Examination will be based on periapical, bitewing, and panoramic landmarks, lesions, anomalies and restorations. The exam will be multiple choice.

Students are expected to the complete examination as scheduled. Make-up examinations will be given ONLY if the absence is due to illness (confirmed by a 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. Students may have access to the examination by appointment during the instructor's office hours. Exams may be reviewed up to two (2) weeks following the exam date. **You may not copy, reproduce, distribute or publish any exam questions**. This action may result to dismissal from the program. A grade of "0" will be recorded for the examination on the day of the exam unless prior arrangements have been made with the instructor.

Students must use their personal equipment, such as computer, MacBook, laptop, iPad, to take their exams and must not use their classmates'. School computers may be used if personal equipment is not available. Respondus Lockdown Browser and Respondus Monitor will be used for examinations therefore, a webcam is required to take the exam. The student is required to show the testing environment at the beginning of the exam to assure the instructor that it is clear of any study materials. Failure to do so will result in a 10-point exam grade deduction. If you need online assistance while taking the test, please call Online Support Desk at 409-951-5701 or send an email to lit-bbsupport@lit.edu.

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

Students with special needs and/or medical emergencies or situations should communicate with their instructor regarding individual exceptions/provisions. It is the student's responsibility to communicate such needs to the instructor.

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 individuals 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 REQUIREMENTS

Students must complete all the clinical requirements at minimal competency to pass the course and progress in the dental hygiene program. *See grading rubric on following page.

COURSE EVALUATION

Final grades will be calculated according to the following criteria:

Each student must meet minimal competency for all requirements in order to pass DHYG 2261. Criteria for achieving a grade of “A”, “B”, “C”, “D” or “F” can be found on the following page of this syllabus. All criteria must be met in each grading category to achieve the desired grade. (EXAMPLE: If all criteria except one are met for a grade of “B” then the student would receive a grade of “C”.) These criteria place the responsibility for learning in the hands of the student and are meant to identify those who strive for excellence in the clinical setting.

The student must achieve successful completion of patients at a minimal competency of **80%**. If the student does not meet minimal competency on a patient, he/she will be responsible for successfully completing another patient at a minimal competency level of **80%**, to satisfy requirements for the course. All clinical requirements must be met to pass this course. All course work must be successfully completed and turned in by the due date and time on the course calendar; this includes radiographs, retakes, and initial chart audits. Failure to complete chart audits by due date could result in receiving no credit for the patient. Failure to successfully complete all course requirements will result in receiving an “F” in DHYG 2261 and dismissal from the DH program. Exclusions from this policy will be dealt with at the discretion of the program faculty. See grading rubric on the following page.

GRADING SCALE

	A	B	C	F
Grading Scale Requirements (GSR)			Minimal Competency	
Total Patient Points (GSR 1)	41 Total points 30 in class III & above	38 Total points 27 in class III & above	35 Total points 23 in class III & above	Does not meet requirements for "C"
Adult Patients (A) (GSR 2)	8 patients	8 patients	8 patients	
Geriatric Patient (G) (GSR 3)	1 patient	1 patient	1 patient	
Adolescent Patient (GSR 4)	1 patient	1 patient	1 patient	
Assessment Data: Acceptable grade on Med/Dent hist, Oral exams, Periodontal assessments, dental charting, polishing/plaque free (GSR 5)	11	10	9	
Radiographic Surveys (total) (GSR 6)	4 FMX, 4 BWX, 1 PNX (1 BWX must be taken vertical)			
Digital X-rays using sensors	Minimum 2 FMX & 2 BWX must be with sensor (counts towards total x-ray requirements)			
NOMAD	Minimum 1 BWX must be with the NOMAD using bisecting angle (counts toward total BWX x-ray requirements)			
Periodontal Stage (GSR 7)	Stage I or II	4 patients		
	Stage III or IV	2 patients		
Periodontal Grade (GSR 8)	Grade A or B	4 patients		
	Grade C	1 patient		
Calculus Detection (GSR 9)	1 patient/IV or V Pass 1st attempt	1 patient/IV or V Pass 2nd attempt	1 patient/IV or V Pass 2nd attempt	
EagleSoft Dental Charting (GSR10)	Pass EagleSoft dental charting 1st attempt	Pass EagleSoft dental charting 2nd attempt	Pass EagleSoft dental charting 2nd attempt	
Special Needs Patient Evaluation (GSR11)	2 patients	1 patient	1 patient	
Sealant Patients (GSR 12)	4 patients	3 patients	2 patients	
Ultrasonic quadrants (GSR13)	12 quadrants	10 quadrants	8 quadrants	
Full Periodontal charting (GSR14)	1 patient	1 patient	1 patient	

	A	B	C	F
EagleSoft Periodontal Probe Charting (GSR15)	Pass EagleSoft full perio charting on 1st attempt	Pass EagleSoft full perio charting on 2nd attempt	Pass EagleSoft full perio charting on 2nd attempt	
Professional Judgment & Ethical Behavior (GSR16)	Average of 40	Average of 39	Average of 38	Average of below 38
Community service (GSR17)	5 hours	4 hours	3 hours	
Written evaluations				
Radiographic Interpretation Evaluation (GSR18)	85% or higher on initial try	85% or higher on 1st re-test	85% or higher 2nd re-test	
Clinical Evaluations				
Periodontal Patient case CER final grade (GSR19)	90 and above	86 - 89	80 - 85	
Clinical Competencies (GSR20)				
Adolescent	Passes on initial attempt	1st re-test	1st re-test	
Recall patient	Passes on initial attempt	1st re-test	1st re-test	
Pit & Fissure Sealants	Passes on initial attempt	1st re-test	1st re-test	
Patient education sessions	All sessions acceptable on initial attempt	2 sessions acceptable + 1 re-test	1 session acceptable + 2 re-tests	
Skill Evaluations (GSR21)				
Difficult calculus patient	Passes 2 of 3 skill evaluations on initial try	Passes 1 skill evaluation on initial try	Passes all skill evaluations	Does not meet requirements for grade of "C"
Gracey Curet	See above	See above	See above	See above
Ultrasonic instrumentation	See above	See above	See above	See above
Cancellation time (GSR22)	Over 20 hours of cancellation time will lower clinic grade by one letter grade.			

Students will have two attempts at successfully completing Clinical competencies and skill evaluations. Failure to successfully complete the competency or skill evaluation on the second try may result in the student repeating DHYG 2261. Exception to this policy is the Radiographic Evaluation. The student will have 3 attempts to pass; each attempt will lower the letter grade for clinic.

*DH students, faculty, dentists, and hygienists may not be utilized for special patients, competencies or for evaluations. THESE PATIENTS WILL ONLY BE USED TO COUNT FOR POINTS AND/OR RADIOGRAPHIC REQUIREMENTS AND SEALANTS.

Grading Scale Requirements (GSR) Defined:

GSR 1: Total Patient Points

The total points required for each grade category are defined in the previous table. Total patient points will be dependent on the grade the student is striving to attain. Each student must ensure that they are obtaining the total points required, as well as the number of points designated for Class 3 and higher patients. The remainder of the points can be obtained in any prophy classification points that the student desires. For the student to be awarded the points for the patient, the patient must be completed at a competency level of 80% or higher on the Clinical Evaluation Record (CER).

A minimum of two (2) quadrants must be satisfactorily scaled and graded (all spot checks done) in order to receive any partial point credit for incomplete patients. **ALL PATIENTS ARE EXPECTED TO BE *COMPLETED**. Incomplete patients may affect the final clinic grade of the student by receiving an Unsatisfactory in the Comprehensive Care grade on the CER. Cases of incomplete patients will be addressed on an individual basis and action on these cases will be at the discretion of the faculty.

*A completed patient is a patient that has had all assessment data completed, all quadrants scaled, polish/plaque free completed, and fluoride treatment unless otherwise noted on the Clinical Evaluation record (CER). All the above stated criteria must have a corresponding grade on the CER with a faculty signature.

Patient Point Value

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

GSR 2: Adult Patients

Each student is required to see a minimum of 8 adult patients this semester. An adult patient is defined as a patient between the ages of 18 – 59. For the student to be awarded credit for an adult patient, the patient must be completed at a competency level of 80% or higher on the Clinical Evaluation Record (CER) (see criteria under GSR 1).

GSR 3: Geriatric Patients

Each student is required to see a minimum of 1 geriatric patient this semester. A geriatric patient is defined as a patient that is aged 60 and older. For the student to be awarded credit for a geriatric patient, the patient must be completed at a competency level of 80% or higher on the Clinical Evaluation Record (CER) (see criteria under GSR 1).

GSR 4: Adolescent Patients

Each student is required to see a minimum of 1 adolescent patient this semester. An adolescent patient is defined as a patient between the ages of 11 – 17. For the student to be awarded credit for an adolescent patient, the patient must be completed at a competency level of 80% or higher on the Clinical Evaluation Record (CER) (see criteria under GSR 1).

GSR 5: Assessment Data

Medical/Dental History

A thorough medical and dental history is a foundational aspect of dental hygiene practice. It enables dental hygiene students to provide safe and effective care, tailor treatments to individual needs, and contribute to overall patient well-being. A thorough review of the patient's medical and dental history is to be completed on every patient at every appointment. Any positive finding should receive follow-up documentation to support the positive finding. Listing of medications and the dental implications must be noted in the follow-up notes on the 1st appointment.

Annual Medical/Dental History Update and HIPAA Acknowledgment Policy

To ensure accurate and up-to-date patient records and compliance with the Health Insurance Portability and Accountability Act (HIPAA), our clinic requires the following to be completed once every 12 months:

1. **Medical/Dental History Update** – Patients fill out a new medical/dental history annually. Keeping this information current helps our clinic provide safe, effective, and personalized care by accounting for any changes in medications, health conditions, allergies, or treatments.

2. **HIPAA Acknowledgment Form** – Patients are also required to sign a new HIPAA Acknowledgment Form each year. This confirms that patients remain informed about their rights under HIPAA and understand how their protected health information (PHI) may be used and disclosed by our clinic.

These updates will typically be completed during the first visit of the calendar year.

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

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

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

- Plaque scores are a part of the Periodontal Assessment. Plaque scores are to be performed on each patient at every appointment. The patient should only brush prior to a plaque score being taken if they have not brushed within 4 hours prior to the appointment. After the plaque score is taken, this gives the student the opportunity to provide education to the patient using a toothbrush and interdental aids. Plaque scores will be randomly checked by faculty in clinic or during chart audits.
- Bleeding scores are a part of the Periodontal Assessment. Bleeding scores are to be obtained on each patient at every appointment. On the initial appointment, a bleeding score should be charted and calculated during the probing of the tissues. The bleeding on probing will be checked by an instructor during the periodontal assessment. On subsequent appointments, the 6 indicator teeth may be used to calculate the bleeding score. The bleeding score gives the student the opportunity to

provide education to the patient. Calculation of bleeding scores will be randomly checked by faculty in clinic or during chart audits.

Dental Charting

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

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

- Have your progress notes and Informed Consent, with any referrals included, ready for the DDS to sign at the time the DDS is checking your patient.

Plaque Free/polishing

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

GSR 6: Radiographic Surveys

A student must demonstrate minimal competency by exposing acceptable quality radiographic surveys. Regardless of requirements, the student will take all necessary radiographs based on patient needs. Surveys will be graded as either Satisfactory or Unsatisfactory. Each student must complete a minimum of 4 acceptable full mouth surveys, 4 acceptable bitewing surveys, and 1 acceptable panorex survey. Each survey must be critiqued, retakes taken, and a final grade given to be considered complete. Students are given unlimited attempts to satisfy this requirement with no penalty on another patient.

Surveys must be critiqued within 1 week of the survey. (i.e., Survey taken on Tuesday morning = due by the following Monday). Surveys turned in after one week of taking may not be graded for credit. Two late survey submissions will result in a "U" in Comprehensive Care.

- **All radiographs must be completed, critiqued and submitted by due date on course calendar.**
- The student who is treating the patient must take the patient's radiographs even if the radiographs are not needed for requirements unless approved by the clinic coordinator.
- Retakes must be done at the next appointment after the survey has been graded.
- Radiographs may be taken outside of the student's clinic time if it is during a second-year clinic. **Radiographs may not be taken during lunch, before clinic, during 1st year clinic, or after clinic hours.**
- When taking radiographs outside of clinic, be aware that the students in that assigned clinic session have priority for all x-ray rooms over 'outside of clinic' students. Outside of clinic students will have to wait until a room is available.
- Outside of clinic students are responsible for the post-op and pre-op of the x-ray room. Also, sterilization students are not responsible for packaging outside students x-ray equipment.
- X-ray rooms cannot be reserved by a student. Students must sign up in the instructor cubicle for an x-ray room **after** the patient's medical/dental history has been signed and the need and type of survey has been determined.

- All surveys taken and the justification for each patient exposure must be documented in the progress notes. (Example: FMX-patient has numerous suspicious areas).
- Technique errors, restorations, bone loss, calculus, suspicious areas and those areas requiring referral should be documented on the radiographic critique sheets. Only note existing conditions such as missing teeth if it aids in grading the radiographs.
- **IF A PATIENT CANNOT RETURN FOR RETAKES, THAT PARTICULAR SURVEY WILL NOT BE ACCEPTED AS A COMPLETED SURVEY.** Therefore, it is advisable to discuss this with your patient before the need arises. If the patient cannot return, it must be documented on the Communication Log and in the progress notes.
- Radiographs will not be graded during clinic unless the patient will be finished in that clinic session and not returning. Have critique sheet filled out and ask your pod instructor to review them at your cubicle. Waiting in radiology for grading may delay your patient treatment time and is not a good use of your clinic time.
- **Any patient wanting their radiographs sent to their DDS, must have the retakes taken in order to send a diagnostic survey.**
- Not taking retakes on a patient will affect your Comprehensive Care grade on your CER, which in turn, affects your overall grade for that patient.
- An FMX survey may not be converted to a BWX credit if retakes are not taken.
- One (1) BWX survey must be acceptable using the NOMAD radiographic system.
- The sensor must be used and acceptable on a minimum of 2 FMX surveys and 2 BWX surveys.

Submitting Digital Critique Sheets

- A digital critique sheet will be submitted to dhcritique@lit.edu for grading purposes.
- Your clinic counselor will be grading your radiographs this semester.
    - In the subject line of your email, type your clinic counselor's last name. (Ex: Subj Line: Cruz)

GSR 7: Periodontal Staging Category

Each student must see a minimum of 4 patients in the Periodontal Staging Category 1 & 2. Each student must also see a minimum of 2 patients in the Periodontal Staging Category 3 & 4. For the student to be awarded credit for a Periodontal Stage category, the patient must be completed at a competency level of 80% or higher on the Clinical Evaluation Record (CER).

GSR 8: Periodontal Grading Category

Each student must see a minimum of 4 patients in the Periodontal Grading Category A & B. Each student must also see a minimum of 1 patient in the Periodontal Grading Category C. For the student to be awarded credit for a Periodontal Grade category, the patient must be completed at a competency level of 80% or higher on the Clinical Evaluation Record (CER).

GSR 9: Calculus Detection

Calculus detection is considered a basic skill. Each student must successfully complete one calculus detection preferably on their Difficult Calculus Evaluation patient or another approved Class IV or V patient. The student will be graded on their calculus detection skills and must detect 75% of the calculus charted by 2 instructors in 2 quadrants. Only subgingival "clickable" calculus will be recorded for the calculus detection patients. The student will be given 2 attempts to successfully complete this requirement. If the first attempt is unsuccessful, remediation with an instructor is required before reattempting the calculus detection exercise. If the student is striving for an 'A' in clinic, this requirement must be passed on the first attempt.

GSR 10: EagleSoft Dental Charting

A complete dental charting will be performed using EagleSoft dental charting software on one patient this semester. The purpose of this evaluation is to give the student experience in charting in a dental software program. The dental charting selected must be approved by your clinic counselor and have been graded by a DDS in clinic. The EagleSoft charting can be done outside of clinic by the student.

The patients dental charting must be uploaded into Blackboard for grading. Please notify your clinic counselor when the dental chart has been uploaded. Instructions on how to use EagleSoft dental charting can be found uploaded in Blackboard. The student will have 2 attempts at successful completion of this evaluation. If striving for a grade of 'A' in clinic, the evaluation must be passed on the first attempt. See further instructions in the Appendix section of this syllabus on pages 54-55.

GSR 11: Special Needs Patients

Special Needs patients are defined as patients whose medical, physical, psychological, or social situations may make it necessary to modify procedures in order to provide dental hygiene treatment for that individual. Special needs patients may have mobility issues, be mentally disabled, immunocompromised, have a complex medical problem, or be a child with behavioral or emotional conditions. (See *Clinical Practice of the Dental Hygienist* by Wilkins for a list of special needs patients). The Special Needs Patient Evaluation will be completed after the appointment and turned in to your clinical advisor. Each student is required to complete a minimum of 1 Special Needs Patient Evaluations this semester. However, if the student is striving for an 'A' in clinic, then they will need to complete a minimum of 2 Special Needs Patient Evaluations this semester. For the student to be awarded credit for a Special Needs patient, the patient must be completed at a competency level of 80% or higher on the Clinical Evaluation Record (CER).

Be thorough in your assessment of the patient and their condition(s) they present. The student has 48 hours after completion of the patient to submit the evaluation. The patient chart, along with the CER, needs to be turned into your clinic counselor and ready for audit. The Special Needs Patient Evaluation directions and a sample form are included in the Appendix section of this syllabus on pages 56-57. The evaluation can be entered directly in Blackboard.

GSR 12: Sealant Patients

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

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

GSR 13: Ultrasonic Quadrants

The number of graded and acceptable ultrasonic quadrants will depend on the grade the student is striving to achieve. This information can be found in the table above. Students must have the ultrasonic quadrant checked prior to any hand scaling. If hand scaling has begun, then the quadrant is no longer eligible for an ultrasonic grade. The Ultrasonic scaler may be used on patients with a prophy classification of 4 or higher as long as there are no contraindications on the medical history. Usage of the Ultrasonic scaler that is contraindicated on a patient will receive an Unsatisfactory grade on the Professional Judgement form for that day and no credit for the patient.

GSR 14: Full Periodontal Charting

An acceptable, complete (6-point) periodontal charting must be completed on the Periodontal Case Patient which includes 6-point pocket depths, 6-point gingival margin measurements, 6-point clinical attachment loss calculations, bleeding points, mobility, furcation involvement, frenal attachment involvement and inadequate zone of attachment areas. The final grade must be documented in Trajecsys.

GSR 15: EagleSoft Periodontal Charting

The student will complete one full periodontal charting using the EagleSoft software. The student will use their Periodontal patient from this semester to complete this requirement. The student will use the **initial full periodontal** charting from the periodontal patient's chart from this semester and transfer the periodontal charting information to the computer using the EagleSoft software. Once the initial 4 quadrants of periodontal charting have been completed, the student has 3 days to turn in the patient's chart to their clinic counselor for grading of the initial periodontal charting in EagleSoft. The student will use the date on the first quadrant of periodontal charting to enter all 4 quadrants. If the same date is not entered for all 4 quadrants, 4 separate periodontal chartings will be made in the patient's chart. A PowerPoint of the steps for this evaluation has been provided on Blackboard. The evaluation form is found in this syllabus on page 59.

GSR 16: Professional Judgement & Ethical Behavior

Demonstrating professional behavior and ethical judgment is an integral component of patient care. A student should exhibit a professional attitude and always conduct themselves in a professional manner. A professional dress code is stated in the student handbook and compliance with this code is expected. This grade will reflect the student's performance in relation to punctuality, professional appearance, professional judgment, professional ethics, instrumentation skills, documentation, time management, infection control, organizational skills, and patient rapport. As stated in the Clinic Manual, documentation is an important part of professional judgement. Students are expected to create and maintain the patient record accurately, completely, and legibly. Three or more U's in chart audits will result in a one-point deduction from the student's **Professional Behavior and Ethical Judgement** semester average.

An average of 38 points must be obtained to meet minimal clinic requirements.

GSR 17: Community Service

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

GSR 18: Radiographic Evaluation

The student will be required to successfully complete one radiographic interpretation. This evaluation requires the student to identify landmarks, suspicious areas, restorations, unusual conditions and technique errors on periapical, bitewing, and panoramic images. The evaluation will be taken in the clinic Blackboard course and Respondus Lockdown Browser will be used. The date for the evaluation is in the Course Calendar. A score of **85%** or higher is required for successful completion of this evaluation. If a student is unsuccessful on the first attempt, they are required to meet with the clinic coordinator for remediation before a 2nd attempt can be scheduled. The student will have 3 attempts to successfully complete this requirement. Failure to meet this score on the third try may result in dismissal from DHYG 2261.

GSR 19: Periodontal Case Grade for Clinic

The periodontal case grade for clinic will reflect the students' clinical work on the periodontal patient. This grade will come from the final grade on the CER for this patient. All patients must be completed

at a minimal competency of 80% on the final CER grade. (The periodontal care plan grades are a part of the Periodontology course).

GSR 20: Clinical Competencies

Prepare for the competencies by practicing the required skill and reading the Competency **prior** to attempting. Students may not ask questions about the competency during the evaluation or have help/assistance from faculty or other students. Have the competency printed, attached to a clip board, your name, date, and patient name filled in and ready for the instructor. Once a competency is completed, students must submit a digital copy of the completed grade sheet into the DHYG 2261 Blackboard section within 1 week of completion.

- **Adolescent Evaluation Competency – pages 52-53**
- **Recall Patient Competency – pages 36-38**
- **Pit & Fissure Sealant Competency – pages 42-44**
- **Patient Education Competency – page 48-51**

GSR 21: Skill Evaluations

Prepare for skill evaluations by practicing the required skill and reading the evaluation **prior** to attempting. Students may not ask questions about the skill evaluation during the observation of the skill while being graded or have help/assistance from faculty or other students. Have the skill evaluation printed, attached to a clip board, your name, date, and patient name filled in and ready for the instructor. Once a skill evaluation is completed, students must submit a digital copy of the completed grade sheet into the DHYG 2261 Blackboard section within 1 week of completion.

- **Difficult Calculus Evaluation – page 34**
- **Gracey Curet Skill Evaluation – pages 39-41**
- **Ultrasonic Instrument Skill Evaluation – pages 45-47**

GSR 22: Cancellation Time

Students are allowed **twenty (20) hours** of non-productive time without grade penalty. **If the student accumulates more than twenty hours of non-productive clinic time, the final letter grade in DHYG 2261 will be lowered by one letter.** Students are expected to have a patient in their chair through the completion of the semester. The student is to remain in their cubicle even when the patient cancels or no shows. It should be documented on the back of the Cancellation CER what activities the student participated in during this time. The Cancellation CER time should be signed by the pod instructor at the end of clinic. If the student leaves the clinic for any reason, the student must notify a clinic instructor before leaving. Completion of the student requirements is not an excuse for non-productive time. It is to the student's benefit to continue practicing clinical skills throughout the semester. Approved non-productive time (cancellation) learning activities may include, but are not limited to:

- Completing assignments through Dentalcare.com
- Viewing instrumentation videos on Blackboard
- Critiquing radiographs
- Chart audits
- Practicing the use of the Intraoral Camera techniques on a typodont
- Instrument sharpening
- EagleSoft periodontal charting
- EagleSoft dental charting
- Practicing sensor or NOMAD radiographs on the DXTRR manikin if radiology rooms are available

CLINICAL TEACHING USING THE POD SYSTEM:

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

TEACHING METHODS

- Faculty demonstrations
- Individual assignments and instruction
- Observation and feedback

PATIENT SELECTION

- Patient selection is very important; therefore, it is advisable to select a variety of patients to enhance the clinical experience.
- SCREENING NEW PATIENTS, WHO HAVE NOT BEEN SEEN IN THE CLINIC BEFORE, WILL HELP YOU IN LOCATING THOSE HIGHER-CLASS PATIENTS THAT YOU WILL NEED AT THE BEGINNING OF THE SEMESTER. The student may screen any patient themselves even if the patient has been previously seen. Please reference the patient's file if the patient has been in the clinic previously. This may give you an indication of the degree of difficulty for that patient.
- There will be some screening done by sterilization; however, it may be beneficial for each student to set aside some clinic time to screen their own patients. Sterilization screening slots are reserved for new patients that call the clinic that desire to be seen.

*Dental hygiene students may treat **ONE** dental hygiene student or faculty/staff member per semester. Students may not use other students, faculty, dentists, or hygienists for skill evaluations or competency evaluations. Also, remember that DH students who are patients are not exempt from payment of customary charges.

- Patients are expected to pay for their visit on the first appointment. You should inform your patient of the fee when scheduling his/her first appointment.
- Each student may choose to waive the fees for one patient per semester.

PERIODONTAL PATIENT CRITERIA

The patient should be a prophy class IV or higher, a Perio Stage II or higher, and have at least 22 teeth. The patient cannot have received comprehensive care at the LIT dental hygiene clinic in the last three (3) years or have been a previous LIT Periodontal Patient which includes patient education sessions.

Before scaling is initiated on this patient:

- All assessment paperwork must be completed and graded on the CER.
- Diagnostic FMX (**with vertical BWX**), gingival index, and intraoral pics must be taken.
- The initial Periodontal Care Plan must be submitted, graded, and approved by Mrs. DeMoss before any scaling begins.

Scaling of the designated periodontal patient will be completed by quadrant scaling. This patient will have a full (6-point) pre-periodontal chart and post-periodontal chart recorded. (See GSR14 for more details) The pre-periodontal charting must be completed by quadrant in conjunction with quadrant scaling. A full-mouth post-periodontal charting is completed at the post-periodontal evaluation appointment.

The student will follow this sequence for treatment/scaling appointments after all assessment data has been collected and care plan graded:

- 1. M/D history, plaque & bleeding score, gingival description, patient education session, local anesthesia (if needed)
- 2. Ultrasonic 1 quadrant AND periodontal chart same quadrant > check by instructor
- 3. Fine scale quadrant> check by instructor.
    - The periodontal chart and ultrasonic quad MUST be checked **before** fine scaling begins.

The Periodontal Patient will also need to return in the Spring semester for a periodontal maintenance visit.

- ❖ *It is highly recommended that two Periodontal Patients are identified, and initial care-plans submitted. This helps ensure that at least one case is completed as required.*

Periodontal Care Plan

Periodontal care plan criteria, submission instructions, and deadlines are outlined in your Periodontology course syllabus. Complete periodontal therapy includes a two-week post-periodontal evaluation (and post-calculus evaluation if needed). *This periodontal patient's quadrant-scaling should be completed by early November to allow two weeks for healing before the final re-evaluation and post-periodontal appointment.*

Periodontal Case Grade for Clinic

The periodontal case grade for clinic will reflect the students' clinical work on the periodontal patient. This grade will come from the final grade on the CER for this patient.
(The periodontal care plan grades are a part of your Periodontology course).

Arestin® Program

- Arestin® will be utilized on your periodontal patient.
- Place the Arestin® during the post periodontal evaluation appointment.
- An instructor will approve the specific sites for Arestin® to be placed after checking the post periodontal charting.
    - Arestin® will be placed in 5 mm pockets or higher approved by the instructor.
- Arestin® is placed before fluoride varnish treatment if fluoride has not been previously applied.
- You will note the use of Arestin® in the progress notes. You will note which teeth and surfaces that were treated with Arestin®.
- Instruct the patient not to brush in these areas for 24 hours and not to floss in these areas for 10 days. Therefore, you will have to inform the patient where these areas are located.
- You will include information about Arestin® in your patient education sessions. If you have finished with patient education, then you will do the education at chairside.
- You will see this patient again in the Spring semester. If the patient still has bleeding in these areas, you may re-treat with Arestin® if indicated.

ADDITIONAL CLINICAL INFORMATION

Drug Cards

Writing drug cards prepares students for patient treatment and for the National Board licensure exam. Each student will handwrite, in ink, on a white 4 x 6 index card all the complete drug information with initials on the top of the card. No typed drug cards will be accepted. Drug cards must be completed by the patient's second appointment (this includes any screening or radiographic appointments).

Periodontal Charting

A periodontal assessment of all patients will be conducted by the student during data collection. All **abnormal conditions** should be documented including: 4mm or greater pockets, recession, furcation, mobility, frenal involvement and inadequate zones of attachment. When any of these abnormal conditions are found, all the following must be documented for that **specific zone** of the tooth: pocket depth, tissue height (TH), and CAL calculated. Bleeding points should also be marked as indicated on all teeth during the initial periodontal assessment. Instructors will also be checking for bleeding when grading the periodontal assessment. Each patients' periodontal classification should then be determined using clinical attachment loss (CAL) as the first indicator, radiographic bone loss is used second; this will help determine the most accurate periodontal diagnosis. The exception to this is the 2nd year periodontal patient, in which all readings must be documented for each tooth.

Informed Consent

All patients must sign an informed consent for treatment. This form is used to educate the patient on procedures to be performed, risks involved with or without treatment, benefits from obtaining treatment, and any referrals made for the patient. After dental charting, any referrals should be noted on this form and signed for by the D.D.S. Referrals should also be noted in the patient progress notes.

- If a patient comes in for x-ray only and is going to return for full treatment: an Informed Consent must be filled out on the day the patient comes in for x-rays.
- When the patient returns to the clinic for their appointment for further treatment, **ANOTHER** informed consent will be required to include all of the procedures. These patients will have 2 Informed Consent forms.
- If your patient comes in for full treatment, which includes x-rays on the same day, 1 informed consent will be required which includes the radiographs taken, as well as the additional treatment that will be given.

Risk Assessments

An oral pathology, a periodontal disease, and a restorative risk assessment will be done on every patient. The student will complete or update these risk assessments when doing the informed consent. The student will present the completed risk assessment form and the informed consent to a faculty to review and sign after the patient and student has signed them. A grade for the risk assessment will be given by the faculty on the CER.

Grading of Data Collection

All data collection will be graded at one time (all assessment data will be graded at the completion of extra/intra, gingival, periodontal charting, radiographs and dental charting). The student should have radiographs correctly displayed in EagleSoft **before** the data will be graded. Student may begin scaling on one quadrant before having dental charting evaluated if the D.D.S. is not available. All other data must be evaluated before scaling can begin.

Plaque and Gingival Bleeding Indices

Plaque scores and bleeding indices utilizing indicator teeth are to be taken on all patients at **every appointment**. Students are expected to do patient education **every appointment** at the chair or at the sink. All plaque and bleeding scores are to be documented on progress notes. Failure to take scores or document

scores will result in an Unacceptable grade on the Comprehensive Care portion of the patient's CER. Random checks of plaque and bleeding score calculations will be checked during clinic or during chart audits.

EagleSoft Software Program

All patients must be entered into the EagleSoft software program. Notes should be made as a communication log for each patient. Write the EagleSoft ID number on the front of each patient chart.

Hand Scaling Patients

All patients who are a prophy class I – III must be hand scaled. The ultrasonic will not be utilized on these patients unless authorized by an instructor.

Evaluation of Scaling Procedures

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

Post Calculus

All patients class V and above must be scheduled two weeks after all quadrant scaling is complete including spots for re-evaluation. The student is expected to thoroughly explore, remove any residual calculus, and have the quadrants evaluated by one instructor. Failure to complete Post Calculus will result in a loss of one patient point, and a U in Comprehensive Care on the CER.

Comprehensive Care Grade on CER

Students are expected to perform comprehensive care on all patients. Not taking retakes by the end of the 2nd appointment, not taking plaque or bleeding scores and recording for each appointment, not critiquing survey and submitting for final grading, not doing diagnosed sealants, not completing post-calculus evaluation, or pre-writing patient charts are some examples of behaviors that will result in an unacceptable grade in this area. **Four or more U's in Comprehensive Care on clinic CERs will result in a one point deduction from the student's Professional Behavior and Ethical Judgement semester average.**

Clinic Time

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

End of Clinic Procedure

At the end of the clinic session students must record their progress notes and obtain all required signatures. This should be done in 15 minutes or less. Instructors will inspect the cubicle for proper post-op procedures. Once the student has been checked by their pod instructor, they may wait in the center area of the clinic for dismissal. Students may not leave until dismissed by the clinic coordinator. Procedure should be done in this order:

1. Transport instruments to sterilization for processing.
2. Write up progress notes
3. Post-op cubicle

All CERs must go back into the designated CER area after each clinic. CERs are not allowed to be stored in the patient chart.

Patient Dismissal

Patients must be evaluated by an instructor before dismissal at each appointment. An instructor must see the patient even if no clinical procedures were completed. Students must sign up for checks by **11:30 AM, 4:30 PM, or 7:30 PM**. Signing up does **not guarantee** that an instructor will be available. Availability depends on how many students have signed up before you. Patients must be dismissed no later than **11:45 AM, 4:45 PM, or 7:45 PM**. **Repeated late dismissals** of patients may result in disciplinary action.

Progress Checks and Clinical Advising

Students must meet with assigned instructor on the dates outlined in this syllabus. There will be no virtual clinic counseling. Students must bring appointment calendar, CER's, and student clinic requirement completion record to all progress checks. Patient charts will be pulled, if needed, for clinical advising.

Patient Files/ Charts

Patient files must be kept alphabetized. When removing a patient chart from the filing cabinets, you must use one of your individual "out cards" to hold the space until the chart is returned.
When not in active use, patient charts MUST be filed back in the appropriate filing cabinets. Files absolutely cannot be kept in your locker, backpack, mailbox, or be taken off campus.

Chart Audits

All patient charts must be audited by the student upon completion of treatment. Students have **one week** following the patient's last appointment to audit the chart, complete the Chart Audit Checklist Form, and submit a digital copy of the patient CER using the DHYG 2261 Blackboard link. This informs faculty advisors that a chart is ready for audit and the patient is complete or not returning. Faculty advisors will complete random chart audits on all students throughout the semester. Chart audits that are not completed by the student within one week of treatment completion will be marked unacceptable and may not be counted toward the patient points.

If a chart audit is found with two or more errors, the student will receive a "U" on the CER for that audit. Receiving unacceptable grades on the CER will affect the patients overall CER grade average. This may determine whether the student will earn credit for the patient.
As stated in the Clinic Manual, documentation is an important part of professional judgement. Students are expected to create and maintain the patient record accurately, completely, and legibly. Four or more U's in chart audits will result in a one point deduction from the student's **Professional Behavior and Ethical Judgement** semester average. (A minimum average of 38 points must be maintained to meet clinic requirements). A student with four or more "unacceptable" chart audits will also need to schedule a time with their clinical advisor to have all patient files audited. The student will remain with the instructor while the charts are audited. Further information regarding chart documentation can be found in the Clinic Manual.

Prepaid Cell Phones

Prepaid cell phones are suggested in order for patients to contact students.

Sterilization Duty

The students assigned to sterilization duty are expected to be in clinic ready to work 30 minutes prior to the beginning of clinic. Upon arrival the student must check in at the clinic front office or with the clinic instructor in charge. The penalty for arriving later than 30 minutes prior to the beginning of clinic will be extra sterilization duty and will be scheduled by the 2nd year clinic coordinator. The amount of extra sterilization duty will depend on what time the student arrived and will be done outside the student's regular clinic day. Computer use, cell phone use, sitting around during assigned sterilization time is not acceptable. There is always something to do during your assigned time. See clinical instructors if you need a job.

DHYG 2261 CLINICAL GRADING CRITERIA FOR SATISFACTORY ON "CER"

		S	U
1.	**Medical/Dental History**	0-1 error	2 or more
2.	**Oral Exam**	0-2 errors	3 or more
3.	**Periodontal Assessment**	see below	pass 3 of 4 sections

*no more than 2 errors on description; no more than 2 errors on radiographic findings; correct staging and grading with supporting rationale; and no more than 3 probing errors per quadrant – must pass 3 out of 4 sections to be considered 'Satisfactory'.

4-5.	**Dental Charting (initial & shading)**	0-4 errors	5 or more
6.	**Informed Consent**	0-2 errors	3 or more
7.	**Risk Assessment**	0-3 errors	4 or more
8.	**Periodontal Charting** (per quad)	0-4 errors	5 or more

*must pass 3 out of 4 quadrants (75%) to pass the periodontal charting

8-11. **Ultrasonic Scaling**- More than three calculus deposits, stain and/or plaque remaining per quadrant will result in a "U". 0-3 deposits="S".

12-15. **Scaling**- Errors include evaluation of: rough tooth surfaces and calculus.

GRADE/QUADRANT

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

16.	**Plaque Free** (surfaces/mouth)	0-4 surfaces	5 or more

17. **Topical Fluoride Treatment**- Failure to remove most dental plaque, dry teeth prior to application, place saliva ejector, stay with patient the entire time, give appropriate patient instruction or check tissue response will result in a "U".

18.	**Tissue Trauma**	0-2 surfaces	3 or more surfaces

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

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

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

		S	U
21.	**Post Periodontal charting** – same criteria as #8		
22.	**Radiographs-BWX**	Equivalent of 4 improvables	More than 4 improvables
23.	**Radiographs-FMX**	Equivalent of 12 improvables	More than 12 improvables
24.	**Radiographs-PNX**	2 improvables – 2 areas that could be improved	Critical error or more than 2 improvables
25.	**Comprehensive Care**	1 error	2 or more errors
26.	**Chart Audit**	1 error/patient	2 or more errors/patient

PROGRESS CHECKS/CLINICAL COUNSELING

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

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

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

Listed below you will find the weeks of progress checks. Students must meet with their clinical advisors to report on their progress in clinic. Students must bring their CER's and clinical requirement tracking chart **(pages 27-29)** to each appointment filled in with current information. Please be prepared to discuss how many points have been started, patient issues, what requirements are met, etc.

**** If the student is not prepared for their appointment, they will be rescheduled for a later time.**

STUDENT AND FACULTY ACADEMIC AND CLINICAL COUNSELING ASSIGNMENTS

Cruz	Mendoza	DeMoss	Thompson	Rogers	Sandusky
Landry, C.	Poole, A.	Wilken, A.	Bravo, R.	Dotson, K.	Morton, V.
Cazares, A.	Moore, L.	Roccaforte, H.	Sosa, S.	Cisneros, E.	Bland, C.
Nguyen, W.	Upshaw, B.	Aguilera, Y.	Ringer, B.	Flores-Molina, J.	Bell, B.
Richard, A.		Linton, R.	Padilla, Y.		
Newcost, L.					
Dennis, K.					

PROGRESS CHECKS

Listed below you will find the weeks of progress checks. You must make an appointment and meet with your clinical advisor during designated weeks to report on your progress in clinic. CER's, requirement completion sheets, and appointment books should be brought to each progress check. Faculty will have access to clinic grades on the computer. If you need to meet with your clinical counselor outside of the assigned times, or need additional times beyond the posted dates, you must make an appointment with your counselor. Your clinical counselor will be grading your radiographs this semester.

Please note: ALL PROGRESS CHECKS AND CLINIC COUNSELING WILL BE DONE IN PERSON – NO VIRTUAL OPTIONS THIS SEMESTER

Week of September 15th
Week of November 3rd

MID-SEMESTER CLINICAL COUNSELING
Week of October 13th

FINAL CLINICAL COUNSELING
Week of Dec 1st

Please make an appointment with your clinical advisor before counseling sessions.

- *Chart Audits will be completed by the student within one week of patient completion or patient not returning. The patient CER must be submitted in Blackboard.
- *All completed skill evaluations, competencies, radiographic critiques, and professional judgement forms must be submitted in Blackboard within one week of finish date.

INSTRUCTIONS FOR MID-SEMESTER CLINICAL COUNSELING

STUDENTS:

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

2. Check your entered time in Trajecsys.

3. At the end of each progress check/clinical counseling session, upload clinical tracking sheet into Blackboard.

FACULTY:

a. Check patient #'s and codes on the grade book in Trajecsys.

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

    b. Check accuracy of clinic time.
    c. Check accuracy for special needs patients
    d. Check accuracy for recall patients.
    e. Corrections to CER's should be done in Trajecsys.
    f. Check Blackboard for submissions

b. Fill out the clinical tracking spreadsheet in the 'R' drive under Gradebooks, Current.

INSTRUCTIONS FOR FINAL CLINICAL COUNSELING

STUDENTS:

c. What to bring:
- Appointment book
- CER's
- Clinic Tracking Chart from syllabus (filled in where applicable)
- Clinic Syllabus (for reference or questions)
- Have all information organized so that finding specific information is easy for you.

2. Check time in Tracjecsys. Be able to document any errors with CER's.

FACULTY:

d. Check and document patient #'s and codes in gradebook. Check accuracy of grades in the grade book in Trajecsys.

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

   b. **Check accuracy of clinic time. Students should have a total of 156 hours (39 days) of clinic time. Students should have 24 hours of sterilization.**
   c. Check accuracy for special needs patients.
   d. Check accuracy for recall patients.
   e. Corrections to CER's should be done in Trajecsys.
   f. Check Blackboard to make sure all skill evaluations, competencies, radiographic critiques, and professional judgement forms have been submitted.

e. Confirm students' final grade for semester.

f. Fill out the clinical tracking spreadsheet in the 'R' drive under Gradebooks, Current.

REQUIREMENT TRACKING RECORD	A	B	C	D/F
Requirements			**Minimal Competency**	
TOTAL PATIENT POINTS	**41 Total points** 30 points in Class III and above	**38 Total points** 27 points in Class III and above	**35 Total points** 23 points in Class III and above	
POINTS STARTED (I AND II)				
POINTS FINISHED (I AND II)				
POINTS STARTED (III AND ABOVE)				
POINTS FINISHED (III AND ABOVE)				
ADULT PATIENTS	**8 patients** 1.	**8 patients** 2.	**8 patients** 3.	 4.
	5.	6.	7.	8.
GERIATRIC	**1 patient** 1.	**1 patient**	**1 patient**	
ADOLESCENT	**1 patient** 1.	**1 patient**	**1 patient**	
MEDICAL/DENTAL HISTORY	**11 patients**	**10 patients**	**9 patients**	
ORAL EXAMS	**11 patients**	**10 patients**	**9 patients**	
PERIODONTAL ASSESSMENTS	**11 patients**	**10 patients**	**9 patients**	

DENTAL CHARTING	**11 patients**			**10 patients**			**9 patients**			
POLISHING/PLAQUE FREE	**11 patients**			**10 patients**			**9 patients**			

RADIOGRAPHS (TOTAL)	**4 FMX, 4 BWX, 1 PANOREX (document when the survey is complete & graded)**				
FMX (2 MUST BE SENSOR)	**1. (Sensor)**	**2. (Sensor)**	**3.**	**4.**	
BWX (2 MUST BE SENSOR, 1 MUST BE NOMAD, 1 MUST BE VERTICAL)	**1. (Sensor)**	**2. (Sensor)**	**3. (NOMAD)**	**4.**	
PANOREX	**1.**				

PERIODONTAL STAGING CATEGORY	**Stage I or II**	**4 patients**			
		1.	**2.**	**3.**	**4.**
	Stage III or IV	**2 patients**			
		1.	**2.**		

PERIODONTAL GRADING CATEGORY	**Grade A or B**	**4 patients**			
		1.	**2.**	**3.**	**4.**
	Grade C	**1 patient**			
		1.			

CALCULUS DETECTION	**1 patient/1ST attempt**	**1 patient/2nd attempt**
	1.	**2.**

EAGLESOFT DENTAL CHARTING	**Pass 1st attempt**	**Pass 2nd attempt**
	1	**2.**

SPECIAL NEEDS PATIENT EVALUATION	**2 Patients**	**1 Patient**	**1 Patient**
	1.	**2.**	

SEALANT PATIENTS	**4 Patients**		**3 Patients**	**2 Patients**
	1.	**2.**	**3.**	**4.**

FULL PERIODONTAL CHARTING	**1 patient (Periodontal patient)**											
	1.											
EAGLESOFT PROBE CHARTING	**1 patient (Periodontal patient)**											
	1.											
ULTRASONIC QUADRANTS	**12 quadrants**			**10 quadrants**			**8 quadrants**					
	1.	**2.**	**3.**	**4.**	**5.**	**6.**	**7.**	**8.**	**9.**	**10.**	**11.**	**12.**
PROFESSIONAL JUDGEMENT & ETHICAL BEHAVIOR	**Average of 40**			**Average of 39**			**Average of 38**			**Average below 38**		
COMMUNITY SERVICE	**5 hours**			**4 hours**			**3 hours**					
	1 hour	**2 hours**		**3 hours**			**4 hours**			**5 hours**		
RADIOGRAPHIC EVALUATION (85% or higher)	**Passing on initial attempt**			**Passing on 2nd attempt**			**Passing on 3RD attempt**					
	Pass	**Fail**		**Pass**	**Fail**		**Pass**	**Fail**				
PERIODONTAL PATIENT CER FINAL GRADE	**90 and above**			**86-89**			**85 or below**					
	Grade:											
CLINICAL COMPETENCIES										**Does not meet all requirements for a 'C'**		
ADOLESCENT	**Pass on initial attempt (date):**			**Pass on 2nd attempt (date):**								
RECALL PATIENT	**Pass on initial attempt (date):**			**Pass on 2nd attempt (date):**								
PIT & FISSURE SEALANTS	**Pass on initial attempt (date):**			**Pass on 2nd attempt (date):**								
PATIENT EDUCATION SESSIONS	**Pass all sessions on initial attempt (date):**			**Pass on 2nd attempt (date):**								
	Session 1: Date			**Session 2: Date**			**Session 3: Date**					
	Pass	**Fail**		**Pass**	**Fail**		**Pass**	**Fail**				
SKILL EVALUATIONS	**Meet minimal competency on all evaluations on initial attempt**			**Meet minimal competency on 2 of 3 evaluations on initial attempt**			**Meet minimal competency on all evaluations**			**Does not meet all requirements for a 'C'**		
DIFFICULT CALCULUS EVALUATION	**Pass on initial attempt (date):**			**Pass on 2nd attempt (date):**								
GRACEY CURET	**Pass on initial attempt (date):**			**Pass on 2nd attempt (date):**								
ULTRASONIC INSTRUMENTATION	**Pass on initial attempt (date):**			**Pass on 2nd attempt (date):**								

CANCELLATION TIME	Up to 20 hours before penalty occurs									
	Hrs/date	Hrs/date	Hrs/date	Hrs/date	Hrs/date	Hrs/date	Hrs/date	Hrs/date	Hrs/date	Hrs/date
	Hrs/date	Hrs/date	Hrs/date	Hrs/date	Hrs/date	Hrs/date	Hrs/date	Hrs/date	Hrs/date	Hrs/date

COMPETENCY AND EVALUATION FORMS

Instructions for Ultrasonic Practice Lab

Set Up:

- Set up typodont head on assigned unit
- Bring ultrasonic and ultrasonic inserts to clinic
- Bring faceshield and mask
- Work with assigned partner
- Bring the *Fundamentals of Periodontal Instrumentation & Advanced Root Instrumentation, 8th edition,* with you to clinic.

Disinfect:

- With utility gloves, disinfect:
    - mobile table
    - ultrasonic unit
    - insert hose
- Set by ultrasonic unit:
    - Connect power cord
    - Connect foot pedal
    - Connect water supply

Barrier:

- Remove utility gloves, wash hands, and put on exam gloves
- Place a barrier across the mobile table covering the ultrasonic unit
- Attach a handpiece to the insert hose and place on top of barrier

Procedure:

- Turn on power
- Purge/flush the water line for 2 minutes
- On new digital units purge for 30 seconds
- Insert the universal tip
- Adjust the spray to a fine mist

Application:

- Using Module 26 – Powered Instrumentation pages 708
- The student will demonstrate the use of the ultrasonic scaler in all quadrants.
- Faculty will assist during the practice.
- The student partner will suction during practice time.
- Faculty will evaluate the student according to the evaluation module.
- Students will switch when instructed.

Instructions for Area-Specific Curet and Advanced Fulcrum Practice Lab

Set Up:

- Set up typodont head on assigned unit
- Bring all area-specific curets to clinic – Gracey 1/2, 11/12, 13/14, 15/16, 17/18
- No pre-op needed for this practice day (i.e. disinfection, barriers)
- Bring the *Fundamentals of Periodontal Instrumentation & Advanced Root Instrumentation, 8th edition,* with you to clinic.

Instruction:

- Work with an assigned partner.
- Each will practice by:
    - Identifying the correct working end
    - Adapting the gracey curets to the tooth
    - Applying a working stroke
- Faculty will assist you during the practice session.

Application:

- Using Module 19 – Area-Specific Curets page 485-486
- The student will demonstrate the use of the gracey curet on the following areas:
    - Area 1 = Teeth #3, #7
    - Area 2 = Teeth #12, #15
    - Area 3 = Teeth #19, #24
    - Area 4 = Teeth #27, #31
- Faculty will evaluate your skill level in each treatment area with an “S” or “U”.

DIFFICULT CALCULUS EVALUATION

The following pages contain criteria, instructional information, and evaluation forms for the Difficult Calculus Evaluation.

***STUDENTS MUST PASS THEIR ULTRASONIC SKILL EVAL AND CALCULUS DETECTION PRIOR TO THIS EVALUATION**

Criteria for Difficult Calculus Evaluation

The student is responsible for patient selection using the following criteria.

- **Calculus Detection-**Each tooth has four surfaces: mesial, distal, facial and lingual. A qualifying surface is a tooth surface upon which there is "clickable" subgingival calculus.
- **Definition of "Clickable" Calculus-**"Bump" with thickness that is readily discernible
  - A definite "jump" is felt with the explorer
  - An interproximal deposit felt from the lingual and/or buccal
- **Surfaces-**A minimum of twelve (12) qualifying surfaces must be present in one quadrant or one quadrant plus up to 4 additional teeth. At least four (4) surfaces must be located on molar teeth. A maximum of six (6) of the surfaces may be located on the anterior teeth (canine to canine).
- The twelve (12) qualifying surfaces must be on natural teeth and must not have the following: Class III furcations, Class III mobility, pocket depth exceeding 6mm, gross decay, and orthodontic bands. (Bonded lingual arch wires are acceptable.)
- **Patient Requirements-**Patient should be at least a prophy class IV and should not have pocket depths greater than 6 mm. Prior to scaling, the student will complete a full patient assessment including calculus detection. It is part of the exam to do thorough calculus detection. Two instructors will check the proposed quadrant for qualification and the calculus detection will be scored at this time. The student must score 75% on the calculus detection. Only the surfaces agreed upon by the two instructors will be used in qualification and evaluation. The student should scale the entire treatment area selected to insure the deposits are removed. The student will not be informed which deposits to remove or which deposits the instructors found during detection. The student must remove seventy five percent (75%) of those deposits to meet minimum competency for the scaling evaluation. It should be noted that removal of 75% of deposits does not guarantee attaining competence on this patient. **Failures also can occur due to habitual incorrect instrumentation, incorrect clock positions, excessive trauma, excessive amounts of deposits left and non-professional behavior.**
- **Basic Instrumentation skills that will be assessed are:** fulcrum placement, grasp, activation of instrument, adaptation of tip/toe, working stroke, exploratory stroke, clock positions of operator.
- **Advanced instrumentation skills that will be assessed are:** advanced fulcrum positions, ability to adapt instruments to depth of the pockets, advanced activation of working stroke.
- **Ultrasonic Use-**The use of the ultrasonic will be allowed on the difficult calculus evaluation and will be evaluated based on selected power settings, effective use of active tip, correct adaptation, and pressure used.
- **Designated Time-**Two (2) hours will be allowed for this evaluation.
- **Day of Evaluation:** The student must inform their Pod instructor at the beginning of clinic of their plan to perform this assessment.

LIT Dental Hygiene Program
DIFFICULT CALCULUS EVALUATION

DHYG 2261

LIT Competency Statement	P2 Assume responsibility for dental hygiene actions and care based on accepted scientific theories and research as well as the accepted standard of care. PC.12 Provide specialized treatment that includes preventive and therapeutic services designed to achieve and maintain oral health. a. Perform dental hygiene interventions to eliminate and/or control local etiologic factors to prevent and control caries, periodontal disease, and other oral conditions. b. Control pain and anxiety during treatment through the use of accepted clinical and behavioral techniques. PC.13 Evaluate the effectiveness of the implemented clinical, preventive, and educational services and modify as needed. a. Determine the outcomes of dental hygiene interventions using indices, instruments, examination techniques, and patient self-report.

Student			Date:		
Instructor		Circle one:	Healthy Gingiva	Gingivitis	Perio Stage_____
Patient			Prophy Class	0 1 2 3 4 5 6 7 8	
Any critical error results in a score of 'Unacceptable' and the student must repeat the competency.			Grade	☐ Acceptable ☐ Unacceptable	

The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.		Critical Error	Yes	No
1	Utilize accepted infection control procedures	Yes		
2	Apply basic and advanced principles of dental hygiene instrumentation	Yes		
3	Maintain clinic and laboratory records; obtains informed consent prior to treatment.	Yes		
4	Identifies information which may contraindicate treatment	Yes		
5	Explains procedure and rationale to their patient	Yes		
6	Procedures are carried out in an efficient and systematic manner	No		
7	Utilizes radiographs and periodontal charting during procedure	No		
8	Removes calculus without excessive tissue trauma	Yes		
9	Completes procedure in designated time	Yes		
10	Demonstrates professional conduct and ethical judgment	Yes		

Comments:

CONTINUING CARE (RECALL) COMPETENCY EVALUATION

The following pages contain criteria, instructional information and competency forms for the Recall Evaluation.

Patient Selection

The patient must be 18 years of age or older with a minimum of eighteen teeth. The patient should be a patient of record at the LIT Dental Hygiene Clinic who has received comprehensive treatment in previous semesters. The patient should be a prophy class I or II. The student is given 2 hours to complete the evaluation which does not include data collection, patient education, and fluoride application.

Evaluation Procedure

Students will perform all assessment procedures, take plaque and bleeding scores and conduct patient education with their patient. All assessment data must be graded before proceeding to evaluation. The clinical dental hygiene instructor will determine if the patient qualifies for the recall evaluation. The patient may be classed before the evaluation by the instructor during the grading of the assessment data. Patient education must be done to determine the patient's retention or recall of topics and/or skills from the previous semester. Once qualification is determined, a start time will be established, and the student will begin work on the patient. If the patient is seen on a different day, the student must inform the pod faculty that the evaluation will be attempted and a start time given. If the student fails to get a start time before starting the evaluation, then the student will not get credit for this evaluation. At the end of the 2 hours, the patient will be checked again for completion of scaling and polishing. Following the evaluation, the fluoride application will be provided but it will not be considered as part of this evaluation. (The evaluation, which includes all scaling and polishing/plaque free, must be completed within one clinic session. Time needed for up-dating data will not be included in the two-hour evaluation time and may be done at a different appointment.)

Please allow adequate time for check in and check out. There should be at least 20-30 minutes of clinic time left to allow for check out and fluoride treatment. Keep in mind, if there are deposits remaining, the student must return to the patient, remove the deposits, have the areas rechecked, and then apply fluoride.

The instructor will observe the student at different intervals during the scaling and polishing. Please schedule this with the instructor so observation can occur.

- **Basic Instrumentation skills that will be assessed are:** fulcrum, grasp, activation of instrument, adaptation of tip/toe, working stroke, exploratory stroke.
- **Advanced instrumentation skills that will be assessed are:** advanced fulcrum positions, ability to adapt instruments to depth of the pockets, advanced activation of working stroke.

EagleSoft Documentation

At the end of treatment, each patient will have an EagleSoft chart. The student is expected to include a completed dental charting, periodontal charting/probing depths and gingival margin measurements if present, and treatment notes detailing all treatment completed on the patient.

Student Self-Assessment

Once the patient has completed treatment, the student is required to complete a self-assessment of the treatment provided to the patient. The chart should be turned into the instructor that is grading the self-assessment including the competency paper and the chart should be ready for audit. The self-assessment will be completed in Blackboard. The competency paper should be uploaded into Blackboard once grading is completed.

LIT Dental Hygiene Program

CONTINUING CARE (RECALL) Competency

DHYG 2261

LIT Competency Statement	P2 Assume responsibility for dental hygiene actions and care based on accepted scientific theories and research as well as the accepted standard of care. PC.12 Provide specialized treatment that includes preventive and therapeutic services designed to achieve and maintain oral health. a. Perform dental hygiene interventions to eliminate and/or control local etiologic factors to prevent and control caries, periodontal disease, and other oral conditions. b. Control pain and anxiety during treatment through the use of accepted clinical and behavioral techniques. PC.13 Evaluate the effectiveness of the implemented clinical, preventive, and educational services and modify as needed. a. Determine the outcomes of dental hygiene interventions using indices, instruments, examination techniques, and patient self-report.

Student			Date:		
Instructor		Circle one:	Healthy gingiva	Gingivitis	Perio Stage _____
Patient			Prophy Class	0 1 2 3 4 5 6 7 8	
Any critical error results in a score of 'Unacceptable' and the student must repeat the competency.			Grade	☐ Acceptable ☐ Unacceptable	
Start time:			Stop time:		

The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.		Critical Error	Yes	No
1	Utilize accepted infection control procedures	Yes		
2	Apply basic and advanced principles of dental hygiene instrumentation	Yes		
3	Maintain clinic and laboratory records	Yes		
4	Identifies information which may contraindicate treatment	Yes		
5	Explains procedure and rationale to their patient	Yes		
6	Procedures are carried out in an efficient and systematic manner	No		
7	Utilizes radiographs and periodontal charting during procedure	Yes		
8	Obtains removal of calculus (passes quadrants)	Yes		
9	Has more than one area of tissue trauma per quadrant	Yes		
10	Selects appropriate polishing agent and uses sound polishing technique	Yes		
11	Flosses all interproximal surfaces of all teeth	Yes		
12	Completes procedure in designated time	Yes		
13	Reviewed previous patient education topics or skills with patient	Yes		
14	Demonstrates professional conduct and ethical judgment	Yes		
15	Satisfactorily completed all required documentation in EagleSoft	Yes		
16	Satisfactorily completed self-assessment	Yes		
Comments:				

CONTINUING CARE (RECALL) SELF-ASSESSMENT

Upon completion of your recall patient, please **completely and thoroughly** answer the following questions in Blackboard. Be **thorough** in your self-assessment. You will have 48 hours after completion of your patient to turn this into the instructor that graded your competency or to your clinical counselor. Answer the following questions completely:

<table>
<tr><td colspan="6">LIT Dental Hygiene Program
Continuing Care (Recall) Evaluation Self-Assessment</td></tr>
<tr><td colspan="6">DHYG 2261</td></tr>
<tr><td>LIT Competency Statement</td><td colspan="5">PC10 Use critical decision-making skills to reach conclusions about the patient's dental hygiene needs based on all available assessment data.
b. Identify patient needs and significant findings that impact the delivery of dental hygiene services.</td></tr>
<tr><td>Student</td><td colspan="2"></td><td>Date:</td><td colspan="2"></td></tr>
<tr><td>Instructor</td><td></td><td>Circle one:</td><td>Healthy gingiva</td><td>Gingivitis</td><td>Perio stage _____</td></tr>
<tr><td>Patient</td><td colspan="2"></td><td>Prophy Class</td><td colspan="2">0 1 2 3 4 5 6 7 8</td></tr>
<tr><td colspan="3"></td><td>Grade</td><td colspan="2">☐ Acceptable
☐ Unacceptable</td></tr>
<tr><td colspan="6">The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria:</td></tr>
<tr><td colspan="6">Please address the following questions during your self-assessment of the Continuing Care (Recall) Evaluation appointment.</td></tr>
<tr><td>1.</td><td colspan="5">Upon evaluation of data from last semester when comparing to this semester, has the patient demonstrated improvement in their oral health? If improvement was noted, explain or support your findings and where they are documented.
If the patient did not demonstrate improvement, why do you think the patient did not show improvement? Support your answer with findings.</td></tr>
<tr><td>2.</td><td colspan="5">When reviewing patient education topics that were presented to your patient last semester, was the patient successful in retaining the information and successful in demonstrating any skills that were taught? Explain or support your answer as to why you thought the patient was successful or not successful. If you had to review topics, how did you approach this with your patient? Did your approach change or did you try to explain the topic/topics/skills differently?</td></tr>
<tr><td>3.</td><td colspan="5">Upon reflection of the appointment with the patient, what specifically do you feel went well? In what areas do you feel could have been improved? Be specific in your own evaluation or approach to this appointment.</td></tr>
</table>

GRACEY CURET SKILL EVALUATION CHECK LIST

On this skill evaluation, the student must use the following instruments:

- Anterior Gracey 1/2
- Mesial Gracey 11/12 or 15/16
- Distal Gracey 13/14 or 17/18
- This patient should be a Class IV or higher prophy class
- The patient should be approved by a clinical dental hygiene instructor and the instructor will select the quadrant where the gracey curets will be used and demonstrated throughout the quadrant
- The student may use the ultrasonic on this patient prior to the Gracey curet
- * = designates a basic skill using the Gracey curet

General Management:

1. Utilizes time effectively and efficiently.
2. Utilizes mirror effectively.
3. Maintains correct patient/operator positioning.
4. Adjust the dental light for maximum illumination.
5. *Uses current infection control procedures.
6. Uses air and evacuation equipment effectively.
7. *Reviews patient's dental charting and radiographs to determine any areas where instrumentation may be contraindicated.
8. Preparation of operatory is appropriate for procedure.
9. Selects appropriate instruments and maintains sharpness.
10. *Maintains patient records
11. *Professional behavior and ethical judgment demonstrated by:
    - *providing for patient comfort
    - providing proper patient communication
    - accepting constructive criticism
    - adapting to new situations
    - instilling confidence in the patient
    - *explaining procedures to the patient
    - exhibiting self-confidence to perform procedure

Grasp:

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

Fulcrum:

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

Instrument Positioning:

22. *Determines the correct working end and use the lower cutting edge for instrumentation.
23. *Adapts the side of the toe 1/3 flush with the tooth surface at the gingival margin or under supragingival calculus deposit
24. *Inserts the instrument by closing the face of the blade against the tooth surface and inserting with an exploratory stroke until the side of the tip 1/3 is positioned under the ledge of the calculus deposit.

Instrument Activation:

25. *Angulates the cutting edge correctly by maintaining the terminal shank as close to parallel as possible to the long axis of the tooth.
26. Tightens grasp and increases lateral pressure using thumb, index and or middle finger.
27. *Initiates short, powerful 2mm vertical, oblique or horizontal overlapping strokes in a coronal direction to **remove deposit**.
28. *Relaxes grasp between each calculus removal stroke, closes blade, if necessary, and repositions blade to continue removing deposit with channel scaling strokes.
29. *Uses correct wrist/arm/hand motion to produce vertical, oblique and/or horizontal strokes. Use digital activation in areas where movement is restricted, such as furcation areas and narrow, deep pockets.
30. Pivots on fulcrum finger and rolls the instrument between index finger and thumb to maintain instrument adaptation when entering the interproximal areas.
31. Pivots on fulcrum finger and rolls instrument between thumb and index finger to adapt to buccal/labial or lingual surfaces.
32. Moves the instrument in the direction the toe faces.

LIT Dental Hygiene Program **GRACEY CURET SKILL EVALUATION**					
DHYG 2261					
LIT Competency Statement	P2 Assume responsibility for dental hygiene actions and care based on accepted scientific theories and research as well as the accepted standard of care. PC12 Provide specialized treatment that includes preventive and therapeutic services designed to achieve and maintain oral health. a. Perform dental hygiene interventions to eliminate and/or control local etiologic factors to prevent and control caries, periodontal disease, and other oral conditions. b. Control pain and anxiety during treatment through the use of accepted clinical and behavioral techniques. PC13 Evaluate the effectiveness of the implemented clinical, preventive, and educational services and modify as needed. a. Determine the outcomes of dental hygiene interventions using indices, instruments, examination techniques, and patient self-report.				
Student			Date:		
Instructor		Circle one:	Healthy gingiva	Gingivitis	Perio Stage _____
Patient			Prophy Class	0 1 2 3 4 5 6 7 8	
Any critical error results in a score of 'Unacceptable' and the student must repeat the competency.			Grade	☐ Acceptable ☐ Unacceptable	

The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.		Critical Error	Yes	No
1	Utilize accepted infection control procedures	Yes		
2	Apply basic principles of dental hygiene instrumentation	Yes		
3	Maintain clinic and laboratory records	Yes		
4	Identifies information which may contraindicate treatment	Yes		
5	Explains procedure and rationale to their patient	Yes		
6	Utilizes sharp and correctly contoured instruments	No		
7	Obtains removal of calculus without excessive tissue trauma (passes quadrant)	Yes		
8	Insures patient's comfort with appropriate anesthesia	No		
9	Demonstrates professional conduct and ethical judgment	Yes		
Comments:				

PIT & FISSURE SEALANT COMPETENCY CHECK LIST

Patient Selection:

1. A clinic dentist will determine the teeth to be sealed.
2. Sealants **must** be designated during the dental charting process. It is the student's responsibility to ask the dentist for teeth to be designated.
    a. Sealants can only be placed on teeth with no restorations or suspicious areas.
3. Sealants must be documented on Informed Consent by the dentist that designated the sealants.
4. Sealants will not be applied until the patient has had all data collection graded, all quadrants scaled, checked, and graded, and polishing/plaque free completed and graded.
5. Fluoride will be applied **after** the sealants have been applied and checked for retention and accuracy by the clinic dentist.

General Management:

1. Utilizes time effectively and efficiently.
2. Utilizes mirror effectively.
3. Maintains correct patient/operator positioning.
4. Adjust the dental light for maximum illumination
5. Uses current infection control procedures.
6. Uses air and evacuation equipment effectively.
7. Preparation of operatory is appropriate for procedure.
8. Selects appropriate instruments and maintains sharpness.
9. Professional behavior and ethical judgment demonstrated by:
    - providing for patient comfort
    - providing proper patient communication
    - accepting constructive criticism
    - adapting to new situations
    - instilling confidence in the patient
    - explaining procedures to the patient
    - exhibiting self-confidence to perform procedure

Preparation

10. Student assembles appropriate equipment
    - sealant kit
    - cotton rolls
    - saliva ejector and HVE tip
    - curing light
    - air/water syringe
    - articulating paper
    - floss
    - cotton pliers, explorer, mirror
    - fluoride application supplies
11. Evaluates teeth for cleanliness.
12. Isolates teeth.

Procedure

13. Air dries surface to be sealed for 30 seconds.
14.Tooth surface is adequately etched
15. Correct motion used (dabbing motion for liquid, no motion for gel)
16. Correct time (read manufacturer's instructions for correct time)
17. Covers only surface to be sealed
18 Teeth are thoroughly rinsed for 30-60 seconds per tooth
19. Teeth are thoroughly dried with air
20. Etched teeth present characteristic chalky white appearance (if not, re-etch)
21. Sealant is brushed onto the etched surface
22. Excess sealant is removed with cotton

Apply Light:

22. within 3mm of the tooth surface
23. for the appropriate period of time. (Light will beep or turn off)

Operator Evaluation

24. Rinse
25. Examine surface with explorer to check for voids
26. Check the interproximal contact with floss for adequate sealant placement
27. Utilize articulating paper to evaluate occlusion
28. Exploring confirms a smooth, hard surface
29. Absence of air bubbles
30. Sealant concentrated in central pits and fissures
31. Inclined planes are covered (1/2 to 2/3)
32. Occlusal relationship is maintained
33. Interproximal contacts are free of sealant material

LIT Dental Hygiene Program

PIT AND FISSURE SEALANT COMPETENCY

DHYG 2261

LIT Competency Statement	P2 Assume responsibility for dental hygiene actions and care based on accepted scientific theories and research as well as the accepted standard of care. PC12 Provide specialized treatment that includes preventive and therapeutic services designed to achieve and maintain oral health. a. Perform dental hygiene interventions to eliminate and/or control local etiologic factors to prevent and control caries, periodontal disease, and other oral conditions. b. Control pain and anxiety during treatment through the use of accepted clinical and behavioral techniques. PC13 Evaluate the effectiveness of the implemented clinical, preventive, and educational services and modify as needed. a. Determine the outcomes of dental hygiene interventions using indices, instruments, examination techniques, and patient self-report.				
Student			Date:		
Instructor		Circle one:	Healthy gingiva	Gingivitis	Perio Stage _____
Patient			Prophy Class	0 1 2 3 4 5 6 7 8	
Any critical error results in a score of 'Unacceptable' and the student must repeat the competency.			Grade	☐ Acceptable ☐ Unacceptable	

The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.		Critical Error	Yes	No
1	Utilize accepted infection control procedures	Yes		
2	Apply basic and advanced principles of dental hygiene instrumentation	No	N/A	N/A
3	Maintain clinic and laboratory records	Yes		
4	Identifies information which may contraindicate treatment	Yes		
5	Explains procedure and rationale to their patient	Yes		
6	Utilizes correct technique in adequately etching the tooth surface	Yes		
7	Utilizes correct technique for curing the sealant	No		
8	Explores to examine surface for adequate sealant placement	Yes		
9	Utilizes articulating paper to evaluate and maintain proper occlusion	No		
10	Demonstrates that interproximal contacts are free of sealant material	Yes		
11	Demonstrates professional conduct and ethical judgment	Yes		

Comments:

ULTRASONIC INSTRUMENTATION SKILL EVALUATION CHECK LIST

- **<u>This evaluation must be successfully completed prior to attempting Difficult Calculus Evaluation.</u>**
- On this skill evaluation, the student will use:
    - Universal insert
    - Slimline insert
- This patient must be a Class IV or higher prophy class
- * = designates a basic skill using the ultrasonic instrument

General Management

1. Utilizes time effectively and efficiently.
2. Utilizes mirror effectively.
3. Maintains correct patient/operator positioning.
4. Adjust the dental light for maximum illumination
5. *Uses current infection control procedures.
    - Uses patient ultrasonic bib
    - Uses high volume evacuation during procedure
    - All appropriate PPE for operator and patient
6. *Uses air and evacuation equipment effectively.
7. Preparation of operatory is appropriate for procedure.
8. *Reviews patient's dental charting and radiographs to determine any areas where instrumentation may be contraindicated.
9. *Reviews patient's medical history for any contraindications for ultrasonic use.
10. *Maintains patient records.
11. *Select appropriate insert for the area in which you are working.
12. *Professional behavior and ethical judgment demonstrated by:
    - *providing for patient comfort
    - providing proper patient communication
    - accepting constructive criticism
    - adapting to new situations
    - instilling confidence in the patient
    - *explaining procedures to the patient
    - exhibiting self-confidence to perform procedure

Determines Function of Equipment

13. Turns power on the ultrasonic unit and attaches water to proper outlet
14. Places foot control on floor within easy access
15. Bleeds water line for two minutes
16. Allow water to surface top of opening of hand piece, place insert into handpiece of the magnetostrictive units or screws insert into the Piezo units
17. Adjust water and power setting holding hand piece over cup or sink
18. Adjust water flow to appropriate spray

Grasp and Fulcrum

19. *Uses a light, gentle modified pen grasp
20. *Establishes an intra- or extra- oral fulcrum

Adaptation

21. *Uses appropriate power to remove deposits
22. Adapts the insert under the tissue correctly
23. *Point of insert is directed away from tooth; point is never in direct contact with tooth surface
24. Applies side of dull instrument tip to calculus, stain, or plaque.
25. Working end is parallel to the tooth/root surface
26. Applies instrument in continuous wet field, releasing at intervals to aid in water control
27. Keeps steady pressure on foot control
28. *Keeps tip moving constantly using strokes that are light, smooth, precise and overlapping

Evaluation

29. Removes all supragingival and subgingival deposits.

LIT Dental Hygiene Program

ULTRASONIC INSTRUMENTATION SKILL EVALUATION

DHYG 2261

LIT Competency Statement	P2 Assume responsibility for dental hygiene actions and care based on accepted scientific theories and research as well as the accepted standard of care. PC12 Provide specialized treatment that includes preventive and therapeutic services designed to achieve and maintain oral health. a. Perform dental hygiene interventions to eliminate and/or control local etiologic factors to prevent and control caries, periodontal disease, and other oral conditions. b. Control pain and anxiety during treatment through the use of accepted clinical and behavioral techniques. PC13 Evaluate the effectiveness of the implemented clinical, preventive, and educational services and modify as needed. a. Determine the outcomes of dental hygiene interventions using indices, instruments, examination techniques, and patient self-report.

Student			Date:		
Instructor		Circle one:	Healthy gingiva	Gingivitis	Perio Stage ____
Patient			Prophy Class	0 1 2 3 4 5 6 7 8	
Any critical error results in a score of 'Unacceptable' and the student must repeat the competency.			Grade	☐ Acceptable ☐ Unacceptable	

	The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.	Critical Error	Yes	No
1	Utilize accepted infection control procedures	Yes		
2	Apply basic principles of dental hygiene instrumentation	Yes		
3	Maintain clinic and laboratory records	No		
4	Identifies information which may contraindicate treatment	Yes		
5	Explains procedure and rationale to their patient	Yes		
6	Properly demonstrates assembly of the ultrasonic unit	Yes		
7	Demonstrates proper grasp and fulcrum	No		
8	Selected appropriate insert for task	Yes		
9	Used overlapping strokes, kept tip moving at all times	Yes		
10	Obtains removal of calculus without excess trauma (passes quadrant)	Yes		
11	Demonstrates professional conduct and ethical judgment	Yes		

Comments:

PATIENT EDUCATION COMPETENCY CHECK LIST

This skill evaluation will be conducted in the patient education room.

First Session:

1. Utilizes time effectively and efficiently.
2. Uses current infection control procedures
3. Preparation of operatory is appropriate for procedure and effective instructional materials are present.
4. Professional behavior and ethical judgment demonstrated by;
   - providing for patient comfort
   - providing proper patient communication
   - accepting constructive criticism
   - adapting to new situations
   - instilling confidence in the patient
   - explaining procedures to the patient
   - exhibiting self-confidence to perform procedure
5. Student reviews **ALL** short and long term goals with patient
6. Student assists patient in evaluating his/her own oral condition and relates goals and methods of evaluation to the oral conditions present. (Patient carries out home regimen and discloses.)
7. Demonstrates new oral hygiene procedure(s) or modifies patient's technique on typodont and in the patient's mouth. Evaluate technique by having patient demonstrate technique and re-disclose patient. Modify areas where indicated. (Based on plaque/bleeding scores.)
8. Student stresses the patient's responsibility for self-care in partnership with the clinician.
9. Student discusses current concepts of dental practice as well as basic principles of dental disease as they apply to the patient's needs. Instructions are individualized with the use of available visual aids, pamphlets and models.
10. The level of information is appropriate for the learning level of the individual.
11. The patient is involved in the learning process by answering questions, stating opinions or performing skills, etc., throughout the session.
12. The information and discussion follow a logical sequence starting with background knowledge and a review of what the patient is already aware of before advancing to new topics or more in-depth information.
13. The student provides only small units of instruction at any one time and should expand on this information throughout the dental hygiene appointment.
14. The student actively searches for opportunities to provide positive reinforcement and provides that reinforcement.
15. Student reviews methods that will be used to evaluate progress and states which information etc. will be covered in the next session.

Second Session:

Same as session one

Third Session:

Same as sessions one and two EXCEPT -----

16. Student assists the patient in evaluating his/her progress towards ALL specified goals. The student assists the patient in determining further steps that may need to be taken to reach the stated goals. (referrals, etc.)
17. The student and patient determine a continuing care (recall) schedule that meets the needs of the patient.

LIT Dental Hygiene Program

PATIENT EDUCATION SESSION 1 COMPETENCY EVALUATION

DHYG 2261

LIT Competency Statement	P2. Assume responsibility for dental hygiene actions and care based on accepted scientific theories and research as well as the accepted standard of care. P4. Communicate effectively with individuals and groups from diverse populations both verbally and in writing HP5. Promote the values of oral and general health and wellness to the public and organizations within and outside the profession. PC10. Use critical decision-making skills to reach conclusions about the patient's dental hygiene needs based on all available assessment data. PC11c. Establish a collaborative relationship with the patient in the planned care to include etiology, prognosis, and treatment alternatives.

Student			Date:		
Instructor		Circle one:	Healthy gingiva	Gingivitis	Perio Stage ____
Patient			Prophy Class	0 1 2 3 4 5 6 7 8	
Any critical error results in a score of 'Unacceptable' and the student must repeat the competency.			Grade	☐ Acceptable ☐ Unacceptable	

The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.		Critical Error	Yes	No
1	Utilize accepted infection control procedures	Yes		
2	Apply basic and advanced principles of dental hygiene instrumentation	N/A	N/A	N/A
3	Maintain clinic and laboratory records	Yes		
4	Identifies patient needs and reviews goals with patient	Yes		
5	Assists patient in evaluating home care and modifies as needed	Yes		
6	Demonstrates new oral hygiene procedures	Yes		
7	Emphasizes patient responsibility in oral health care partnership	No		
8	Individualizes instruction based on patient need and learning level	Yes		
9	Involves patient and provides positive reinforcement	No		
10	Concludes with review of session and previews future session	No		

Comments:

LIT Dental Hygiene Program

PATIENT EDUCATION SESSION 2 COMPETENCY EVALUATION

DHYG 2261

LIT Competency Statement	P2. Assume responsibility for dental hygiene actions and care based on accepted scientific theories and research as well as the accepted standard of care. P4. Communicate effectively with individuals and groups from diverse populations both verbally and in writing HP5. Promote the values of oral and general health and wellness to the public and organizations within and outside the profession. PC10. Use critical decision-making skills to reach conclusions about the patient's dental hygiene needs based on all available assessment data. PC11c. Establish a collaborative relationship with the patient in the planned care to include etiology, prognosis, and treatment alternatives.

Student			Date:		
Instructor		Circle one:	Healthy gingiva	Gingivitis	Perio Stage ____
Patient			Prophy Class	0 1 2 3 4 5 6 7 8	
Any critical error results in a score of 'Unacceptable' and the student must repeat the competency.			Grade	☐ Acceptable ☐ Unacceptable	

	The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.	Critical Error	Yes	No
1	Utilize accepted infection control procedures	Yes		
2	Apply basic and advanced principles of dental hygiene instrumentation	N/A	N/A	N/A
3	Maintain clinic and laboratory records	Yes		
4	Identifies patient needs and reviews goals with patient	Yes		
5	Assists patient in evaluating home care and modifies as needed	Yes		
6	Demonstrates new oral hygiene procedures	Yes		
7	Emphasizes patient responsibility in oral health care partnership	Yes		
8	Individualizes instruction based on patient need and learning level	Yes		
9	Involves patient and provides positive reinforcement	No		
10	Concludes with review of session and previews future session	No		

Comments:

LIT Dental Hygiene Program

PATIENT EDUCATION SESSION 3 COMPETENCY EVALUATION

DHYG 2261

LIT Competency Statement	P2. Assume responsibility for dental hygiene actions and care based on accepted scientific theories and research as well as the accepted standard of care. P4. Communicate effectively with individuals and groups from diverse populations both verbally and in writing HP5. Promote the values of oral and general health and wellness to the public and organizations within and outside the profession. PC10. Use critical decision-making skills to reach conclusions about the patient's dental hygiene needs based on all available assessment data. PC11c. Establish a collaborative relationship with the patient in the planned care to include etiology, prognosis, and treatment alternatives.

Student			Date:		
Instructor		Circle one:	Healthy gingiva	Gingivitis	Perio Stage ____
Patient			Prophy Class	0 1 2 3 4 5 6 7 8	
Any critical error results in a score of 'Unacceptable' and the student must repeat the competency.			Grade	☐ Acceptable ☐ Unacceptable	

	The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.	Critical Error	Yes	No
1	Utilize accepted infection control procedures	Yes		
2	Apply basic and advanced principles of dental hygiene instrumentation	N/A	N/A	N/A
3	Maintain clinic and laboratory records	Yes		
4	Identifies patient needs and reviews goals with patient	Yes		
5	Assists patient in evaluating home care and modifies as needed	Yes		
6	Demonstrates new oral hygiene procedures	No		
7	Emphasizes patient responsibility in oral health care partnership	Yes		
8	Individualizes instruction based on patient need and learning level	Yes		
9	Involves patient and provides positive reinforcement	No		
10	Concludes with review of session, determines continuing care (recall) schedule, and review referrals	Yes		

Comments:

Adolescent Patient Competency Evaluation

Patient Requirements:

- 11 to 17 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 for this competency.

Student Instructions:

- The instructor will sign the history, release and HIPAA documents prior to starting the time. **No procedures will be checked or signed until check out.**
- Instructors will not watch you do the medical history but there must be no errors.
- Obtain the correct paperwork for the adolescent patient.
- **The parent MUST sign the Informed Consent prior to any treatment.** Instructors will sign the Informed Consent when all paperwork is checked.
- Try to obtain a complete medical history prior to the adolescent's appointment.
- **You have 2 hours to complete this patient.** The only procedures that may be done prior to the appointment are the medical/dental history, have the patient classed, and any necessary radiographs. If radiographs need to be taken on the day of the appointment, it will not be a part of the time of the competency.
- The fluoride treatment is not included in this competency evaluation
- Record detailed patient education information and **recommendations made to the parent** in the progress notes.
- Make sure you follow the format for the evaluation; if you have questions you must ask them prior to the start of the appointment.
- Keep in mind when scheduling this patient, that the appointment may be longer than 2 hours to allow for all grading of the data collection and scaling to be completed, whether radiographs will be taken on the day of the evaluation, and if there are needed sealants.

Instructor Instructions:

- Approve the patient for the competency evaluation and sign the appropriate paperwork. No other paper work will be checked or signed until check out.
- Observe the student at intervals appropriate to the criteria on the evaluation
- Check all paperwork and evaluate all procedures when the student is finished. Sign Informed Consent, checking for any referrals, sign CER for all checked examinations and/or scaling quadrants, and sign for plaque free/polishing.
- Complete the written competency evaluation form when the student is finished

LIT Dental Hygiene Program

Adolescent Patient Competency

DHYG 2261

LIT Competency Statement	PC9 Systematically collect, analyze, and record data on the general, oral, and psychosocial health status of a variety of patients. PC10 Use critical decision-making skills to reach conclusions about the patient's dental hygiene needs based on all available assessment data. PC11 Collaborate with the patient, and/or other health professionals, to formulate a comprehensive dental hygiene care plan that is patient-centered and based on current scientific evidence. e. Obtain the patient's informed consent based on a thorough case presentation. PC12 Provide specialized treatment that includes preventive and therapeutic services designed to achieve and maintain oral health. a. Perform dental hygiene interventions to eliminate and/or control local etiologic factors to prevent and control caries, periodontal disease, and other oral conditions. PC13 Evaluate the effectiveness of the implemented clinical, preventive, and educational services and modify as needed.

Student			Date:		
Instructor		Circle one:	Healthy gingiva	Gingivitis	Perio Stage ____
Patient			Prophy Class	0 1 2 3 4 5 6 7 8	
Any critical error results in a score of 'Unacceptable' and the student must repeat the competency.			Grade	☐ Acceptable ☐ Unacceptable	
Start time:			Stop time:		

The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.		Critical Error	Yes	No
1	Utilize accepted infection control procedures	Yes		
2	Apply basic and advanced principles of dental hygiene instrumentation	Yes		
3	Maintain clinic and laboratory records	Yes		
4	Obtain a complete medical/dental history and release	Yes		
5	Explains procedure and rationale to their patient	Yes		
6	Perform an adequate oral assessment and record the information properly	No		
7	Present the parent/guardian with an appropriate informed consent which the parent/guardian **signs** before treatment starts	Yes		
8	Obtains removal of calculus	Yes		
9	Selects appropriate polishing agent and uses sound polishing technique	Yes		
10	Flosses interproximal surfaces of all teeth	Yes		
11	Complete all identified procedures in two hours.	Yes		

Comments:

EAGLESOFT DENTAL CHARTING

A complete dental charting will be performed using EagleSoft dental charting software on one patient this semester. The purpose of this evaluation is to give the student experience in charting in a dental software program.

Patient Selection
The patient selected for this skill evaluation must be approved by your clinic counselor. The patient should have a variety of conditions/restorations to chart in EagleSoft for a thorough experience. You should verify in EagleSoft that the patient has not previously had a dental charting performed.

Instructions
This evaluation may be completed at any time once the dental charting has been graded by a DDS in clinic this semester. Instructions on how to use EagleSoft dental charting can be found uploaded in Blackboard. Once you have completed the charting, the patients' chart must be turned in, along with the skill evaluation grade sheet, to your clinic counselor.

All of the following should be charted:

- Restorations
- Missing teeth
- Impacted teeth
- Sealants – existing or needed
- Caries – chart as proposed treatment
- Torsoversions
- Attrition
- Abfractions
- Lingual arch wires
- Periapical pathology
- Open contacts
- Decalcification

LIT Dental Hygiene Program **EagleSoft Software Dental Charting Skill Evaluation**					
DHYG 2261					
LIT Competency Statement	PC9Assessment – Systematically collect, analyze, and record data on the general, oral, and psychosocial health status of a variety of patients.				
Student			Date:		
Instructor		Circle one:	Healthy gingiva	Gingivitis	Perio Stage ____
Patient			Prophy Class	0 1 2 3 4 5 6 7 8	
More than 2 errors in one category is unacceptable. All conditions should be charted according to the patient's dental chart using LIT dental charting guidelines.			Grade	☐ Acceptable ☐ Unacceptable	

Acceptable = 0-2 U's in total categories. **Unacceptable = 3 or more U's in total categories.**

The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.		Errors	A	U
1	Correctly charted all existing restorations.			
2	Correctly charted all missing teeth.			
3	Correctly charted all suspicious areas as determined by DDS.			
5	Correctly charted impacted (fully or partially) and supernumerary teeth.			
6	Correctly charted attrition, abfractions, fractures, and decalcifications.			
7	Correctly charted all periapical pathology.			
8	Correctly charted all existing and needed sealants.			
9	Correctly charted watch areas as determined by DDS.			
10	Correctly charted open contacts and rotated teeth.			
11	Correctly charted removable (full or partial) appliances and lingual arch wires.			
12	No more than 4 errors listed in the EagleSoft progress notes.			
Comments:				

Special Needs Patient Evaluation

Patient Requirements:

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

Student Instructions:

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

Instructor Instructions:

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

LIT Dental Hygiene Program

Special Needs Patient Evaluation

DHYG 2261

LIT Competency Statement	P2 Assume responsibility for dental hygiene actions and care based on accepted scientific theories and research as well as the accepted standard of care. PC10 Use critical decision-making skills to reach conclusions about the patient's dental hygiene needs based on all available assessment data. b. Identify patient needs and significant findings that impact the delivery of dental hygiene services.				
Student			Date:		
Instructor		Circle one:	Healthy Gingiva	Gingivitis	Perio Stage ____
Patient			Prophy Class	0 1 2 3 4 5 6 7 8	
If 'Unacceptable' grade is achieved, the student will need to designate another patient to complete this evaluation. Must achieve a minimum score of 75% to obtain 'Acceptable'.			Grade	☐ Acceptable ☐ Unacceptable	

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

The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.

1.	**MEDICAL KNOWLEDGE:** Describe the patient's special need or needs. Address the importance of obtaining a thorough medical history before treating the patient. Identify the patients Activity of Daily Living (ADL/IADL) classification level.
2.	**ASSESSMENT SKILLS:** Explain and describe any treatment modifications that you had to consider, plan for, or prepare for prior to treatment. Explain and describe any treatment modifications that you had to perform during treatment. What were the outcomes of your expectations? Be specific and thorough in your answer.
3.	**MEDICATION MANAGEMENT**: How did you inquire about a patient's medications (if applicable), and why is it crucial for dental hygiene care? What oral manifestations from medications were noticed during treatment?
4.	**EMERGENCY PREPAREDNESS:** How would you prepare for and/or respond to a medical emergency during a dental hygiene appointment if this patient presented one? What signs/symptoms would you be looking for?
5.	**PATIENT COMMUNICATION:** What patient education topics did you address with this patient? What specific items did you need to address due to the patient's special need?

EAGLESOFT SOFTWARE PERIODONTAL CHARTING

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

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

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

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

This semester, the initial full periodontal charting from the periodontal patient will be used. Use the date from the first quadrant of periodontal charting to create a periodontal chart. All 4 quadrants of the periodontal chart will be entered under the initial date the periodontal chart was created. This periodontal chart will be used in the patient education session next semester with the periodontal maintenance patient.

All bleeding points, furcation areas, inadequate zones of attached gingiva, mobility and percussion should also be included in the charting in EagleSoft.

The EagleSoft Software Periodontal Charting grade form should be placed in the patients' chart and turned in to your clinical counselor for grading.

LIT Dental Hygiene Program

EagleSoft Software Periodontal Charting Grade Form

DHYG 2261

LIT Competency Statement	**PC9. Systematically collect, analyze, and record data on the general, oral, and psychosocial health status of a variety of patients.**

Student		Date:	
Instructor		Perio Stage	H G I II III IV
Patient		Prophy Class	0 1 2 3 4 5 6 7 8
		Grade	☐ Acceptable ☐ Unacceptable

More than 6 errors in one category are unacceptable. All conditions should be charted according to the patient's dental chart using LIT dental charting guidelines.

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

The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.		Total Errors	Initial periodontal charting	
			A	U
1	Correctly charted 6 probe depths per tooth from the pre- and post-periodontal charting. (recorded as PD in EagleSoft)			
2	Correctly charted 6 tissue heights per tooth from the pre- and post-periodontal charting. (recorded as GM in EagleSoft)			
3	Correctly charted any Furcations from the pre- and post-periodontal charting. (recorded as FG in EagleSoft)			
4	Correctly charted any Mobility from the pre- and post-periodontal charting. (recorded as MOB in EagleSoft)			
5	Correctly charted 6 bleeding points per tooth from the pre- and post-periodontal charting.			
6	Provided instructor with the patient's chart and this form.			
7	All corrections were made and resubmitted for grading within 1 week			

Comments/Feedback: