

Lamar Institute of Technology
Dental Hygiene Program

DHYG 1260

Clinic Manual

Spring 2021

Taught by:
Lori Rogers, R.D.H., B. S.
larogers@lit.edu
(409) 839-2947



CLINICAL-INTRODUCTORY

TABLE OF CONTENTS

Dates to Remember	3
Course Description.....	4
Course Requirements.....	9
APPENDIX 1	12
SKILL EVALUATIONS.....	12
Anterior and Posterior Sickle Scalers	14
Patient Education Skill Evaluation (Three Sessions)	17
Instrument Sharpening Skill Evaluation	21
Using the Mirror and Explorer for Calculus Detection Skill Evaluation	23
Periodontal Debridement Skill Evaluation	26
Slow Speed Handpiece Use	31
APPENDIX 2	34
COMPETENCY EVALUATIONS	34
Instrument re-circulation and Clinic Readiness Competency Evaluation	36
Patient Assessment Competency Evaluation.....	39
Pedodontic Patient Competency Evaluation	41
APPENDIX 3.....	43
GUIDELINES FOR RADIOGRAPHIC REQUIREMENTS.....	44
APPENDIX 4.....	45
INTRODUCTORY CLINIC INFORMATION	456
APPENDIX 5.....	50
APPOINTMENT PLANNING	501
APPENDIX 6.....	61
GRADING CRITERIA FOR THE CLINICAL EVALUATION RECORD (CER)	612
APPENDIX 7.....	63
HARD DEPOSIT AND PERIODONTAL CLASSIFICATIONS	634
APPENDIX 8.....	667
INSTRUCTIONS FOR MID AND FINAL CLINIC COUNSELING	68
APPENDIX 9.....	71
STUDENT REQUIREMENT TRACKING SHEET.....	72
CHART AUDIT PROCEDURES.....	73

DATES TO REMEMBER:

1-18	MLK DAY/ NO SCHOOL
1-19	Screening day for T-TH clinic
1-20	Screening day for M-W clinic
3-8 thru 3-12	Mid Semester Counseling
3-15 to 3-19	Spring Break
4-14	No Clinic/FI Varnish Program
4-22	All x-ray requirements are due for both clinics
4-27	Last Clinic Day for T-TH (All Requirements Due)
5-3	Last Clinic Day for M-W (All requirements Due)
TBA	Clinic Cleanup
5-4 to 5-7	End of Semester Counseling week

***Deadline for completing all clinic requirements**

All clinic requirements **MUST** be met in order to complete this course. All requirements must be met by the **last clinic day**, Failure to complete minimal course requirements will result in an "F" being earned in DHYG 1260. Exclusion from this policy will be at the discretion of the faculty.

INTRODUCTORY CLINICAL DENTAL HYGIENE

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.

Clinic Goals

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

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

1. Demonstrate the ability to provide therapeutic dental hygiene care directed towards the treatment of oral disease at Introductory Clinic competency levels as noted in this manual.
2. Demonstrate modifications in dental hygiene care for patients with special needs.
3. Apply clinical, communication and patient management skills and didactic knowledge to assess needs, formulate, plan and evaluate a comprehensive dental hygiene treatment plan directed towards attaining and maintaining healthy periodontal tissues for individuals with normal gingiva to those with slight periodontal disease as measured by successful completion of two care plans.
4. Demonstrate the ability to use professional dental terminology in verbal and written communications.
5. Demonstrate the ability to maintain dental healthcare records according to industry and HIPAA standards.
6. React appropriately when confronted with a specific medical/dental emergency.
7. Function as a member of a dental health delivery team within the dental hygiene clinic.
8. Demonstrate observable behavior in clinic indicating personal knowledge of the concepts that are necessary to develop a professional and ethical value system for their personal practice of dental hygiene, with specific emphasis on patient rights, access to care and the legal responsibilities of the dental hygienist.

Prerequisites:

Admittance to the dental hygiene program and DHYG 1401, DHYG 1431, DHYG 1304, DHYG 1227, DHYG 1207

Co Requisites: DHYG 2301, DHYG 1219, DHYG 1235

Credit Hours:

2 Credits 8 Clinic/Lab Hours

Clinic Schedule:

Clinic meeting times:

Monday/Wednesday:	8:00 a.m. to 12:00 p.m.
Tuesday/ Thursday:	1:00 p.m. to 5:00 p.m.

Course Instructor:

Lori Rogers, RDH BS
Office: Multi-Purpose Building, Room 213
Phone: 409-839-2947
Office hours: Monday 1-3, Wednesday 1-3, Friday 9-10

Clinic Instructors:

Faculty Dentists	Faculty Instructors
Dr. Dave Carpenter DDS	Deborah Brown RDH MS
Dr. Sam Giglio DDS	Tami Browning RDH
Dr. Kristina Mendoza DDS	Michelle DeMoss RDH MS
Dr. William Middleton DDS	Rebecca Ebarb RDH BS
	Lisa Harrell RDH BS

Program/Course Policies:

1. Attendance Policy

Absenteeism

In order to ensure the students in the dental hygiene program achieve the necessary didactic and clinical competencies outlined in the curriculum, it is necessary that the student complete all assigned lecture classes, clinical and laboratory hours. It is the responsibility of the student to attend class, clinic or lab. The instructor expects the student to be present at each session.

If you are unable to attend lecture class, clinic or lab, **it is mandatory that you call the appropriate instructor prior to the scheduled class, clinic or lab time.** The student is responsible for all material missed at the time of absence. Extenuating circumstances will be taken into account. Extenuating circumstances might include: funeral of immediate family member, maternity, hospitalization, etc. If the student has a surgery, debilitating injury, or an extended illness, a doctor's release will be required before returning to clinic.

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

Fall/Spring Semesters:

Dental hygiene students will be allowed **two** absences in any lecture, clinic or lab. Absences must be accompanied by a written excuse on the next class day. In the event that a student misses class, clinic or lab beyond the allowed absences, the following policy will be enforced:

2 absences = verbal warning

3 absences = Beginning with 3 absences, 2 points will be deducted from the final course grade for each absence thereafter.

Tardiness

Tardiness is disruptive to the instructor and the students in the classroom. It is expected that students will arrive on time for class, clinic or lab, and remain until dismissed by the instructor. If tardiness becomes an issue, the following policy will be enforced:

Tardy 1 time = verbal warning/Tardy 2 times is considered an absence

***Students should plan on attending classes, labs and clinic sessions as assigned throughout the semester. Family outings, vacations and personal business should be conducted when school is not in session and will not be considered an excused absence.**

2. The Americans with Disabilities Act (ADA) The Americans with Disabilities Act of 1992 and Section 504 of the Rehabilitation Act of 1973 are federal anti-discrimination statutes that provide comprehensive civil rights for persons with disabilities. Among other things, these statutes require that all students with documented disabilities be guaranteed a learning environment that provides for reasonable accommodations for their disabilities. If you believe you have a disability requiring an accommodation, please contact the Special Populations Coordinator at (409) 880-1737 or visit the office of Student Services, Eagles Nest Building. You may also visit the online resource at <http://www.llit.edu/depts/stuserv/special/default.aspx>.

3. 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 Handbook. The LIT Catalog and Student Handbook may be accessed at lit.edu or obtained in print upon request at the Student Services Office. Please note that the LIT online version of the Catalog and Student Handbook supersedes all other versions of the same document.

4. Technical Requirements (for Blackboard)

The latest technical requirements including hardware, compatible browsers, operating systems, software, Java, etc. can be found online at

https://help.blackboard.com/enus/Learn/9.1_04/Student/015_Browser_Support_Policy.

A functional broadband internet connection, such as DSL, Cable or Wi-Fi is necessary to maximize the use of online technology and resources.

5. Starfish

LIT utilizes an early alert system called Starfish. Throughout the semester, you may receive emails from Starfish regarding your grades, attendance, or academic performance. Faculty members record student attendance, raise flags and kudos to express concern or give praise. You can make an appointment with faculty members and all staff through the Starfish homepage. You can also login to Blackboard or MyLIT and click the Starfish link to view academic alerts and detailed information. Starfish is used to help you be a successful student.



6. Electronic Devices

Electronic devices are a part of many individual's lives today. Devices such as tape recorders, radios,

cell phones, paging devices and laptop computers, however, may be distracting to faculty and classmates. Students, therefore must receive the instructor's permission to operate any electronic device in the classroom or clinic.

7. Academic Integrity

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 phones, smart watch/watch phone, laptop, tablet, electronic communication device (including optical), and earphones connected to or used as communication devices.

Uses of such devices during examinations will be considered academic dishonesty. The examination will be considered over and the student will receive a zero for the exam. Students with special needs and /or medical emergencies should communicate with the instructor regarding individual exceptions/provisions. It is the student's responsibility to communicate such needs to the instructor.

8. Mandatory Student Remediation

Remediation is mandatory in the event a student fails an exam. Remediation must be completed within 2 weeks of the failed exam.

Teaching Methodology:

1. One-on-one instruction
2. Demonstration
3. Individual practice
4. Observation and feedback

Required Texts:

1. Wilkins, E. (2020). *Clinical Practice of the Dental Hygienist* (13th ed.). Philadelphia: Lippincott Williams and Wilkins. ISBN: 978-1-4511-9311-4
2. Nield-Gehrig, J. (2017). *Fundamentals of Periodontal Instrumentation* (8th ed.). Philadelphia: Wolters Kluwer Health/ Lippincott Williams & Wilkins. ISBN: 9781496320209
3. Current Drug Reference Book (required for Pharmacology)

Required Materials:

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

Evaluation Criteria:

The requirements for each grade are specified on pages 8 and 9 of this manual. Each student must meet at least “minimal competency” at the “C” level. There are different levels of achievement designated for each letter grade. The responsibility for learning is in the hands of the student and the different levels of achievement are meant to identify those who strive for excellence in the clinical setting. Skill evaluations and competencies will receive a grade of A or U. Written Care Plans, Radiographic Evaluations, Professional Judgement and Ethical Behavior will receive a number grade.

* Skill Evaluations and Competencies: A=Acceptable, U=Not Acceptable (3 retakes allowed)

*Care Plans: Minimal Competency =75%

*Radiographic Evaluations: Minimal Competency = 80%

*Professional Judgement and Ethical Behavior: Minimal Competency = 38%

Course Requirements All course requirements must be completed successfully	LETTER GRADE				
	A	B	C Minimal competency	F minimal competency not met	
Competencies					
Instrument Recirculation and Clinic Readiness	Yes (one attempt)	yes	yes		
Patient Assessment	yes	yes	yes		
Pedodontic Patient	yes	yes	yes		
Written Evaluations					
Radiographic Evaluation (Standard films)	yes	yes	yes		
Radiographic Evaluation (Panoramic film)	yes	yes	yes		
Skill Evaluations					
Mirror and explorer for calculus detection	yes	yes	yes		
Sickle scaler	yes	yes	yes		
Universal curet	yes	yes	yes		
Periodontal Debridement	yes	yes	yes		
Using the slow speed handpiece	yes	yes	yes		
Instrument sharpening	yes	yes	yes		
Patient education (3 sessions)	yes	yes	yes		
Patient Requirements (Continued on next page...)					
	A	B	C		
Points in Class 1 and/or 2 patients	12	10	10		
Points in Class 3 patients	9	9	6		
Periodontal Stage Gingivitis	4	4	3		
Periodontal Stage 1	3	2	2		

* The student may choose which option to follow to obtain the correct number of points for the grade they want to achieve.

REQUIREMENTS <i>(Continued from previous page...)</i>	LETTER GRADE			
	A	B	C	F
Assessment Instruments: Med/dent history, oral exams, periodontal assessment, dental charting(one DC must be a child, primary or mixed dentition)	8	7	6	Minimal Competency not met
Polishing or biofilm free	8	7	6	
Full mouth radiographic surveys: 3 using digital radiography	3	3	3	
Bite-wing surveys: 3 using digital radiography	3	3	3	
Pedodontic or mixed full mouth survey* Digital or standard	1	1	1	
Pedodontic or mixed bite-wing survey* Digital or standard	1	1	1	
Panoramic radiograph	1	1	1	
Written care plans on designated patients	3	2	2	
Community Service hours[†] / minimum per semester (* temporarily waived due to COVID-19 restrictions)	3	3	3	
Professional Judgement and Ethical Behavior	Avg. 40%	Avg. 39%	Avg. 38%	

PROFESSIONAL JUDGEMENT AND ETHICAL BEHAVIOR

*During the semester you will be observed by the faculty on 6 separate clinic days. These will be on random dates. Faculty refer to this as pink sheet days. You will be evaluated on Professional Judgement and Ethical Behavior and given a score according to the grading rubric. You will receive a copy of the grading rubric for each observation day and feedback from the faculty. At the end of the semester you must have a minimal score of 38% as an average to complete requirements. *See the chart above.

***Important information regarding completing requirements:**

- * At least one survey (FMX or BWX) will be taken on a child patient/ the remaining survey may be taken on a pedodontic manikin. You will be allowed multiple attempts on the manikin. (FYI The manikin is not as easy as a real child patient)
- * Community Service hours are a clinic requirement and must be completed by the last clinic day. You are required to do a minimum of 3 hrs. each semester. The total hrs. required to graduate is 20. This means you have to do an additional 8 hrs. any time before graduation. You will be assigned 2 days of sterilization duty.

Dental Hygiene Care Plans

1. This semester's requirements include two (2) or three (3) acceptable (grade of 75 or better) dental hygiene care plans.
 - A. One for the patient who will be involved in the Patient Education Skill Evaluations.
 - B. One for a class 3 patient or instructor approved patient
 - C. One on a third patient if you are working towards a grade of "A" in this course (approved by an instructor).
2. *All care plans will be graded by the student's clinical advisor, unless otherwise indicated. All Care plans will be submitted online. Instructions are in Blackboard DHYG 1260.

APPENDIX 1

SKILL EVALUATIONS

Skill Evaluations

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

Time Allotment for Skill Evaluations

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

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

1. Using the Mirror and Explorer for calculus detection
2. Sickle Scalars
3. Universal Curet

***Students will be allowed 3 attempts at each skill evaluation or competency. After 3 unsuccessful completions the student will not be allowed to progress in the program.**

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

Anterior and Posterior Sickle Scalers

Patient Requirements

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

Student Instructions

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

Initial Use of the Sickle Scalers

General Management

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

Grasp

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

Fulcrum:

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

Instrument Positioning:

- Determines the correct working end and cutting edge.

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

Instrument Activation:

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

Instructor Instructions

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

LIT Dental Hygiene Program Skill Evaluation Sickle Scalers			
LIT Competency Statement	P12. Provide specialized treatment that includes preventive and therapeutic services designed to achieve and maintain oral health. a. Perform dental hygiene interventions to eliminate and/or control local etiologic factors to prevent and control caries, periodontal disease, and other oral conditions. b. Control pain and anxiety during treatment through the use of accepted clinical and behavioral techniques.		
Student		Date	
Instructor		Periodontal Stage	0 I II III IV
Patient		Prophy Class	1 2 3 4 5 6 7 8
		Grade	Not Acceptable Acceptable

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

Comments:

Patient Education Skill Evaluation (Three Sessions)

Patient Requirements

1. An RDH instructor MUST designate and/or approve your choice of patient for this evaluation.
2. Adult over the age of 18 (Or a patient approved by the clinic coordinator)
3. At least 16 teeth (An Instructor may approve a patient with fewer teeth if deemed appropriate).
4. Any prophy or periodontal classification is acceptable
5. The patient must present with educational needs that exceed simple homecare instructions consisting of brushing and flossing techniques. Some examples of this would be: the need for instruction with auxiliary aids to clean fixed bridges, extensive caries involvement, active periodontal disease (not gingival), and multiple small problems combined with a major lack of dental awareness, etc.

Student Instructions

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

Instructor Instructions

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

LIT Dental Hygiene Program Skill Evaluation Patient Education First Session			
LIT Competency Statements	P2. Assume responsibility for dental hygiene actions and care based on accepted scientific theories and research as well as the accepted standard of care. P4. Communicate effectively with individuals and groups from diverse populations both verbally and in writing. PC10. Diagnosis - Use critical decision making skills to reach conclusions about the patient's dental hygiene needs based on all available assessment data. PC11. Planning-Collaborate with the patient, and/or other health professional, to formulate a comprehensive dental hygiene care plan that is patient centered and based on current scientific evidence c. Establish a collaborative relationship with the patient in the planned care to include etiology, prognosis, and treatment alternatives. PC12. Implementation - Provide specialized treatment that includes preventive and therapeutic services designed to achieve and maintain oral health. a. Perform dental hygiene interventions to eliminate and/or control local etiologic factors to prevent and control caries, periodontal disease, and other oral conditions. PC13. Evaluation - Evaluate the effectiveness of the implemented clinical, preventive, and educational services and modify as needed. a. Determine the outcomes of dental hygiene interventions using indices, instruments, examination techniques, and patient self-report.		
Student		Date:	
Instructor		Periodontal Stage	0 I II III IV
Patient		Prophy Class	0 1 2 3 4 5 6 7 8
		Grade	Acceptable Not Acceptable

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

Comments:

LIT Dental Hygiene Program Skill Evaluation Patient Education Second Session			
LIT Competency Statements	P2. Assume responsibility for dental hygiene actions and care based on accepted scientific theories and research as well as the accepted standard of care. P4. Communicate effectively with individuals and groups from diverse populations both verbally and in writing. PC10. Diagnosis - Use critical decision making skills to reach conclusions about the patient's dental hygiene needs based on all available assessment data. PC 11.. Establish a collaborative relationship with the patient in the planned care to include etiology, prognosis, and treatment alternatives. PC12. Implementation - Provide specialized treatment that includes preventive and therapeutic services designed to achieve and maintain oral health. a. Perform dental hygiene interventions to eliminate and/or control local etiologic factors to prevent and control caries, periodontal disease, and other oral conditions. PC13.. Evaluation - Evaluate the effectiveness of the implemented clinical, preventive, and educational services and modify as needed. a. Determine the outcomes of dental hygiene interventions using indices, instruments, examination techniques, and patient self-report.		
Student		Date	
Instructor		Periodontal Stage	0 I II III IV
Patient		Prophy Class	0 1 2 3 4 5 6 7 8
		Grade	Acceptable Not Acceptable

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

Comments:

LIT Dental Hygiene Program Skill Evaluation Patient Education Third Session			
LIT Competency Statements	All previous statements and: PC13. b. Evaluate the patient's satisfaction with the oral health care received and the oral health status achieved. c. Provide subsequent treatment or referrals based on evaluation findings. d. Develop and maintain a health maintenance program.		
Student		Date	
Instructor		Periodontal Stage	0 I II III IV
Patient		Prophy Class	0 1 2 3 4 5 6 7 8
		Grade	Acceptable Not Acceptable

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

Instrument Sharpening Skill Evaluation

Patient Requirements

1. None.

Student Instructions

1. Evaluation may be done during non-productive (cancellation) time
2. You need to have dull instruments to sharpen
3. Schedule the skill evaluation on the clinic sign-up sheet
 - a. This evaluation may be done without signing up if an instructor is available
4. Review the following prior to the skill evaluation:

General Principles:

- Works in a well-lighted area.
- Holds instrument in stable position.
- Sits with both feet flat on the floor.
- Uses the light and magnifying glass (if necessary) to examine the cutting edge.

Grasp:

- Holds instrument with the appropriate grasp for the technique.
- Grasps stone with thumb (directed towards the student) contacting one side and three fingers positioned in a line on top of each other on the other side.

Positioning of Instrument:

- Positions face of instrument blade horizontal (parallel) to the floor.
- Places stone surface and face of the blade at a 90° angle to each other. (12 o'clock position, stone).
- Tilts top of stone out to achieve a clock position of 11:30 or 12:30 in relationship to the blade face depending on the cutting edge to be sharpened.
- Applies light-medium pressure on down stroke using one stroke per second
- Up stroke consists of very light contact to instrument edge without removing stone from blade in order to maintain a proper angulation.
- Demonstrates techniques to round the toe of a curet (stone at 2:00) and round the back of a curet.

Evaluation:

- Sharpened blade removes material from testing sticks with light pressure on stroke.
- Sharpened cutting edge does not reflect light when examined with magnifying glass and/or light source.
- Original form of the instrument is preserved

Instructor Instructions

1. Determine that the instruments are at least slightly dull.
2. Observe the student's sharpening technique on one anterior sickle scaler, a universal curet and either the Gracey 13/14, 15/16 or the 17/18.
3. Evaluate the instrument to determine if the cutting edge is sharpened and if the original shape of the instrument was maintained.
4. Record any feedback on the evaluation form.

LIT Dental Hygiene Program Skill Evaluation Instrument Sharpening			
LIT Competency Statements	PC2. Assume responsibility for dental hygiene actions and care based on accepted scientific theories and research as well as the accepted standard of care. PC6. Evaluate and utilize methods to ensure the health and safety of the patient and the dental hygienist in the delivery of dental hygiene.		
Student		Date	
Instructor		Periodontal Stage	N/A 0 I II III IV
Patient		Prophy Class	N/A 0 1 2 3 4 5 6 7 8
All three must be completed	Anterior sickle scaler Universal curet (SYG7/8 or SC13/14) Gracey – (one only)11/12, 13/14,15/16, 17/18	Grade	Acceptable Not Acceptable

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 as instructed	Yes		
4	Appropriate application of professional knowledge, judgment and skills by the student while providing patient care	Yes		
5	Demonstrate the ability to communicate professional knowledge verbally	No		
6	Use an accepted sharpening procedure	Yes		
7	Maintain the original design of the instrument	Yes		
8	Produce a sharp edge as determined by test stick and/or visual glare test	Yes		

Comments:

Using the Mirror and Explorer for Calculus Detection Skill Evaluation

Requirements

1. This skill evaluation will be done on a typodont

Student Instructions

Sign up in the skill evaluation calendar prior to the day you plan to attempt. No pre-op is performed prior to the evaluation.

1. At the beginning of clinic inform your pod instructor that you will be attempting the skill evaluation
2. Your instructor will give you a typodont to use.
3. You will need the calculus detection worksheet.
4. **Your instructor is allowed to remind you to check the working end of the explorer once if you are using the incorrect end. The second time you are told you will have failed the evaluation.**
8. Review the following prior to the evaluation:

Mirror

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

Explorer

Grasp

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

Fulcrum

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

Instrument Positioning

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

Instrument Activation

- Initiates vertical, oblique or horizontal strokes to the base of the sulcus/pocket from the stable fulcrum.
- Uses no independent finger motion.
- Rolls instrument between thumb and index finger to move the explorer obliquely/vertically along the buccal/labial or lingual surfaces.
- Rolls the instrument between index finger and thumb to maintain instrument adaptation when entering the interproximal areas.
- Uses correct wrist/arm/hand motion to produce vertical, oblique and/or horizontal strokes.
- Maintains the lower shank as close to parallel and possible to the long axis of the tooth.

- Instrument adaptation is maintained throughout exploring procedure (side of tip adapted to the tooth surface).
- Moves the instrument in the direction the tip faces.
- Uses short 2 mm overlapping strokes to explore the entire sulcus from the marginal gingiva to the epithelial attachment.
- Keeps explorer strokes within the sulcus.

Instructor Instructions

1. Give the student a prepared typodont.
2. Make sure they have a calculus detection sheet.
3. Observe the students as they explore all areas of the two quadrants identified for the skill evaluation and then compare the students' charting to the charting in the key. You may inform the student one time only to check their working end. **You will tell them this when they have completed an entire surface (either towards or away) without self-correcting.** The second time you have to tell them to check their working end **after they have completed an entire surface (either towards or away) without self-correcting,** they have failed the evaluation.
4. The student's technique must be satisfactory according to the stated criteria **and** they must have identified at least 80% of the agreed upon areas of calculus. In other words, the student may find 100% of the deposits but use an inappropriate technique and still fail the evaluation. The student may inaccurately note calculus on calculus free surfaces up to a maximum of 50%. After this, for every surface incorrectly identified with calculus one surface correctly identified will be dropped.
5. Record any feedback on the evaluation form

LIT Dental Hygiene Program			
Skill Evaluation			
Using the Mirror and Explorer for Calculus Detection			
LIT Competency Statement	9. Systematically collect, analyze, and record data on the general, oral, and psychosocial health status of a variety of patients. a. Select, obtain, and interpret diagnostic information recognizing its advantages and limitations. b. Recognize predisposing and etiologic risk factors that require intervention to prevent disease. f. Perform a comprehensive examination using clinical, radiographic, periodontal, dental charting, and other data collection procedures to assess the patient's needs. 13. Evaluate the effectiveness of the implemented clinical, preventive, and educational services and modify as needed. a. Determine the outcomes of dental hygiene interventions using indices, instruments, examination techniques, and patient self-report.		
Student		Date	
Instructor		Periodontal Stage	0 I II III IV
Typodont #		Prophy Class	0 1 2 3 4 5 6 7 8
		Grade	Acceptable Not Acceptable

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		
5	Maintain student records as instructed	No		
7	Demonstrate the ability to communicate professional knowledge verbally and in writing	No		
8	Choose the correct working end of the EXD 11/12 explorer	Yes		
9	Keep the lower shank as parallel as possible with the long axis of the tooth	No		
10	Use rotary motion and a walking stroke	No		
11	Effectively roll the instrument into the interproximal area and under the contact	Yes		
12	Maintain the tip one third of the instrument adapted to the tooth surface	Yes		
13	Use an effective mirror fulcrum	Yes		
14	Avoid resting the mirror on the attached gingiva	No		
15	Inaccurately identifies calculus free surfaces as having calculus 50%_____ # over_____ Total penalty _____	Yes		
16	Detect 80% of the calculus in the two quadrants	Yes		

Comments:

Periodontal Debridement Skill Evaluation

Patient Requirements

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

Student Instructions

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

Instructor Instructions

1. Identify an appropriate patient for the evaluation
 - a. The deposits may or may not be “clickable”, but should be distinct and easily detectable
 - b. The calculus deposits must have been agreed upon by two (2) instructors
2. Two (2) instructors will calculus chart the indicated quadrants and produce a guide for the student showing the location of each agreed upon deposit
 - a. There should be eight to no more than 10 deposits that the student will be required to remove completely for this evaluation
 - b. Use your professional judgment to determine which deposits will be counted while making up the guide form
3. Students sign-up for about 30 minutes of time on the clinic sign-up sheet or more if necessary
4. Observe the student’s scaling technique
5. Two (2) instructors will check scaling (**all surfaces of both quadrants**); remaining deposits agreed upon by both instructors’ will count as errors for this evaluation
6. All deposits not removed during the evaluation will count for the quadrant grade on the CER
7. Record any feedback on the evaluation form

LIT Dental Hygiene Program				
Skill Evaluation				
Periodontal Debridement (Two Quadrants Class 3 Patient)				
LIT Competency Statements	12. Provide specialized treatment that includes preventive and therapeutic services designed to achieve and maintain oral health. a. Perform dental hygiene interventions to eliminate and/or control local etiologic factors to prevent and control caries, periodontal disease, and other oral conditions. b. Control pain and anxiety during treatment through the use of accepted clinical and behavioral techniques. 13. Evaluate the effectiveness of the implemented clinical, preventive, and educational services and modify as needed. a. Determine the outcomes of dental hygiene interventions using indices, instruments, examination techniques, and patient self-report.			
Student		Date		
Instructor		Periodontal Stage	0 I II III IV	
Patient		Prophy Class	0 1 2 3 4 5 6 7 8	
	Start Time:	End Time:	Grade	Acceptable Not Acceptable
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
1	Utilize accepted infection control procedures		Yes	
2	Apply basic principles of dental hygiene instrumentation		Yes	
3	Maintain patient records as instructed		No	
4	Obtain informed consent prior to treatment		No	
5	Maintain student records as instructed		No	
6	Appropriate application of professional knowledge, judgment and skills by the student while providing patient care		Yes	
7	Demonstrate the ability to communicate professional knowledge verbally and in writing		No	
8	Removes indicated calculus from specified teeth leaving no more than 3 deposits		Yes	
9	Completes in a two hour time period		Yes	
Comments:				

Universal Curet Skill Evaluation

Patient Requirements

1. Adult over the age of 18
2. Prophy Class III and instructor approval
 - Rarely a Prophy Class II may be approved
3. Perio stage 1 or 2
4. Adequate calculus to observe both anterior and posterior instrumentation techniques

Student Instructions

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

Grasp

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

Fulcrum

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

Instrument Positioning

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

Instrument Activation

- Angulate the cutting edge correctly and lock the toe into the tooth.
- Tighten grasp and increases lateral pressure using thumb, index and/or middle finger.
- Initiate short, powerful 2 mm stroke in a coronal direction to remove deposit.
- Relax grasp, close blade, if necessary, and reposition blade to continue removing deposit with channel scaling strokes.
- Use correct wrist/arm/hand motion to produce vertical, oblique and/or horizontal strokes
- Use no independent finger motion.
- Pivot on fulcrum finger to adapt to facial or lingual surfaces.

- Roll the instrument between index finger and thumb to maintain instrument adaptation when entering the interproximal areas.
- Maintain the lower shank as close to parallel as possible with the long axis of the tooth.
- Move the instrument in the direction the tip faces.

Instructor Instructions

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

LIT Dental Hygiene Program			
Skill Evaluation			
Universal Curet			
LIT Competency Statements	12. Provide specialized treatment that includes preventive and therapeutic services designed to achieve and maintain oral health. a. Perform dental hygiene interventions to eliminate and/or control local etiologic factors to prevent and control caries, periodontal disease, and other oral conditions. b. Control pain and anxiety during treatment through the use of accepted clinical and behavioral techniques.		
Student		Date	
Instructor		Periodontal Stage	0 I II III IV
Patient		Prophy Class	0 1 2 3 4 5 6 7 8
		Grade	Acceptable Not Acceptable

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

Comments:

Slow Speed Handpiece Use

Patient Requirements

1. Adult over the age of 18
2. Any Prophy Class or Perio stage

Student Instructions

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

GRASP:

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

FULCRUM:

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

INSTRUMENT POSITIONING AND ACTIVATION:

- Obtain correct paste and apply to teeth.
- Direct cup occlusally to flare edge of cup into sulcular and proximal areas (especially on linguals).
- Maintain constant slow speed of angle.
- Continually moves cup on tooth.
- Use combination or roll/sweep stroke.
- Adapt edge of cup in anterior (fossae).
- Use overlapping strokes and light to medium pressure to effectively remove entire deposit.
- Use correct wrist/arm/hand motion to produce the desired stroke.
- Débride polishing cup of saliva before refilling.

USE OF AUXILIARY POLISHING INSTRUMENTS:

- Adapt toothbrush to occlusal pits and planes when indicated.
 - Adapt finishing strips to interproximal areas if indicated.
 - Adapt tape/floss to proximal surfaces.
7. Make sure you floss completely after you have used this instrument

Instructor Instructions

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

LIT Dental Hygiene Program Skill Evaluation Slow Speed Handpiece Use			
LIT Competency Statements	2. Assume responsibility for dental hygiene actions and care based on accepted scientific theories and research as well as the accepted standard of care. 11. Planning - Collaborate with the patient, and/or other health professionals, to formulate a comprehensive dental hygiene care plan that is patient-centered and based on current scientific evidence. c. Establish a collaborative relationship with the patient in the planned care to include etiology, prognosis, and treatment alternatives. 13. Evaluate the effectiveness of the implemented clinical, preventive, and educational services and modify as needed. b. Evaluate the patient's satisfaction with the oral health care received and the oral health status achieved.		
Student		Date	
Instructor		Periodontal Stage	0 I II III IV
Patient		Prophy Class	0 1 2 3 4 5 6 7 8
		Grade	Acceptable Not Acceptable

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

Comments:

APPENDIX 2

COMPETENCY EVALUATIONS

Competency Evaluations

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

Time Allotment for Competency Evaluations

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

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

Instrument Re-Circulation and Clinic Readiness Competency Evaluation

Student Instructions

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

10. The student will demonstrate effectiveness as a team member by performing the following for peers and faculty during scheduled sterilization time:
 - Assistant
 - Messenger
 - Supply retrieval
- Make sure your instructor is aware of the procedures you are completing, check with her throughout the session
- Make sure the instructor has your Competency form at the beginning of the session and that it is completed at the end of the session

Instructor Instructions

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

LIT Dental Hygiene Program Competency Evaluation Instrument Recirculation and Clinic Readiness			
LIT Competency Statements	1. Apply a professional code of ethics in all endeavors. 6. Evaluate and utilize methods to ensure the health and safety of the patient and the dental hygienist in the delivery of dental hygiene.		
Student		Date	
Instructor		Periodontal Stage	N/A
		Prophy Class	N/A
		Grade	Acceptable Not Acceptable

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

Comments:

Patient Assessment Competency Evaluation

Patient Requirements

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

Student Instructions

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

Instructor Instructions

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

LIT Dental Hygiene Program Competency Evaluation Patient Assessment			
LIT Competency Statement	9. Assessment – Systematically collect, analyze, and record data on the general, oral, and psychosocial health status of a variety of patients. a. Select, obtain, and interpret diagnostic information recognizing its advantages and limitations. b. Recognize predisposing and etiologic risk factors that require intervention to prevent disease. c. Obtain, review, and update a complete medical, family, social, and dental history. d. Recognize health conditions and medications that impact overall patient care. e. Identify patients at risk for a medical emergency and manage the patient care in a manner that prevents an emergency. f. Perform a comprehensive examination using clinical, radiographic, periodontal, dental charting, and other data collection procedures to assess the patient’s needs.		
Student		Date	
Instructor		Periodontal Stage	0 I II III IV
Patient		Prophy Class	0 1 2 3 4 5 6 7 8
	Start Time: Stop Time:	Start Time: Stop Time:	Grade Acceptable Not Acceptable

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

Pedodontic Patient Competency Evaluation

Patient Requirements:

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

Student Instructions:

- Must be scheduled in the skill evaluation book in the clinic with your Pod instructor.
- **Your Instructor MUST be present before you start the medical history for this patient.** The instructor will sign the history, release and HIPAA documents. **No other documents or procedures will be checked or signed until check out.**
- Obtain the correct paperwork for the child patient.
- **Have the parent sign the Informed Consent prior to any treatment.**
- Try to obtain a complete medical history prior to the child's appointment.
- **You have 2 hours to complete this patient, NOT including check out.** Any necessary radiographs may be taken at a date prior to the competency.
- 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.

Instructor Instructions:

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

LIT Dental Hygiene Program Competency Evaluation Pedodontic Patient			
LIT Competency Statements	9. Systematically collect, analyze, and record data on the general, oral, and psychosocial health status of a variety of patients. 10. Use critical decision making skills to reach conclusions about the patient's dental hygiene needs based on all available assessment data. 11. Collaborate with the patient, and/or other health professionals, to formulate a comprehensive dental hygiene care plan that is patient-centered and based on current scientific evidence. e. Obtain the patient's informed consent based on a thorough case presentation. 12. Provide specialized treatment that includes preventive and therapeutic services designed to achieve and maintain oral health. a. Perform dental hygiene interventions to eliminate and/or control local etiologic factors to prevent and control caries, periodontal disease, and other oral conditions. 13. Evaluate the effectiveness of the implemented clinical, preventive, and educational services and modify as needed.		
Student		Date	
Instructor		Periodontal Stage	0 I II III IV
Patient		Prophy Class	0 1 2 3 4 5 6 7 8
	Start Time:	Start Time:	Acceptable
	Stop Time:	Stop Time:	Not Acceptable

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

Comments:

APPENDIX 3

GUIDELINES FOR RADIOGRAPHS

Written Radiographic Evaluations

Radiographic Guidelines:

Grading Criteria:

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

Procedures:

1. Choose the appropriate radiographs needed for the patient. Select equipment accordingly.
2. Completed Surveys must be turned in within 1 week after the initial films have been taken or they may not be graded.
3. Retakes on all surveys must be completed on the 2nd appointment. Incomplete surveys will not be counted towards your requirements and will affect your Professional Judgment grade.
4. Surveys are to be completed before **the last clinic day**.
5. **All film released to the student must be accounted for. Unused or contaminated film must be returned to an instructor and noted in the grade book to avoid any suspicion of academic dishonesty.**
6. All surveys must be completed, critiqued and submitted online to be graded by an instructor. At that time, you will know how many retakes are needed. Retakes must be done regardless of whether or not the series is acceptable. You will only take radiographs the patient needs and you will take the type of radiographs that are best for your patient.

Written radiographic evaluations:

1. Two written Radiographic Evaluations are scheduled this semester.
 - Radiographic Evaluation (FMX)
 - Radiographic Evaluation (Panoramic)
2. Both written evaluations are scheduled online.
3. Radiographic evaluations are considered to be Competency Evaluations and must be successfully passed by achieving an **80%** or better.
4. Repeat evaluations will be given later in the semester for students whose first attempt was not successful. Remediation is mandatory.
5. The entire faculty will meet to consider the status of students in the DH program who are unsuccessful a second time.

APPENDIX 4

INTRODUCTORY CLINIC INFORMATION

Introductory Clinic Information

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

- **COVID 19 screening is mandatory for all patients prior to entering the clinic reception area at this time.**

I. Appointment book control

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

II. Cancellation Time (Non-productive Time)

1. It is your responsibility to explain the necessity of keeping scheduled appointments and of notifying you at least 24 hours in advance if your patient cannot keep the appointment. The maximum time allowed is 14 hours. After 14 hours the final grade drops by one letter grade.
2. Patients should be told they can leave messages for you by calling the Dental Hygiene Clinic number (880-8860).
3. Check your folder and the bulletin board regularly to receive messages.
4. Confirm all appointments 24 hours prior to the scheduled appointment time.
5. You should record any cancellations or missed appointments in the patient's progress notes and call log. The Dental hygiene program cannot be accused of abandoning a patient if there is a record of the missed or cancelled appointments. This patient will also be identified as non-compliant if they ever desire treatment at the LIT Dental Hygiene Clinic again.
6. Communication forms will be made for all patients and an entry of student/patient communication will be recorded for each contact. Contact with new patients who have no record yet will still be recorded on a communication form which will be kept in the student's file area in a folder especially labeled for that purpose. When the patient comes in for their first appointment this form will be placed in their patient folder.
7. You will be allowed to wait for 15 minutes for your patient in the receptionist's office. After that time, you will report to an instructor to be assigned work to do in your operatory. You may opt to go look for a patient but you must inform your Pod instructor. When you return you need to inform the same instructor if possible. If you have not found a patient you may be given an assignment to work on in your operatory.

III. **Patient Fees**

1. See Table below

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

2. Patient payment must be shown by written receipt **before** instructors will sign the patient's health history on the second visit, unless other arrangements have been made with the receptionist.
3. **Do not charge for screening appointments.**

IV. **Planning**

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

V. **Patient education, plaque and bleeding scores**

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

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

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

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

You are allowed to see two children this semester. Children must be accompanied by a **parent or legal guardian, no one else is allowed to sign the informed consent**. See the clinic coordinator if you have questions about parents staying for the entire appointment.

VIII. **LIT Appointment Policy**

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

IX. **Sterilization Duty**

Each student will be assigned to work in Sterilization approximately 2 times during the semester. This assignment is not optional. Students who schedule patients during their scheduled in-

session assignment will be required to reschedule their patients. Students who miss any part of their out-of-session assignments will be required to make up that session and an additional 4 hour session.

X. **Patient Transportation and Parking:**

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

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

XI. **Patient Records:**

All patient records are the property of the LIT Dental Hygiene Program. No patient records may leave the dental hygiene clinic.

XII. **Patient Confidentiality:**

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

XIII. **Instruments:**

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

XIV. **Patient Rights:**

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

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

XV. **Medically Compromised Patients:**

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

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

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

XVII. **Herpes Simplex Infection:**

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

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

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

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

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

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

APPENDIX 5
APPOINTMENT PLANNING

APPOINTMENT PLANNING

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

- I. Appointments
 - A. Appointments are usually made in intervals of 2 or 4 hours.
 - B. Appointments **must be** recorded in the office appointment book. Failure to record the appointment under other than extraordinary circumstances will result in an error under professional judgment and ethical behavior.
 - C. Appointment cards are available through the Dental Hygiene Clinic Receptionist. When you are making the initial appointment over the phone, it is an excellent idea to review the medical history. If the medical history contains questionable elements you will be able to obtain a medical release prior to the initial appointment. Examples would be: heart disease, history of latex allergy, uncontrolled high blood pressure or diabetes. It would also be a good idea to email the patient an appointment card with the time and date of their appointment and your name so that they know whom they have an appointment with. You can also send out medical history and treatment release forms to be completed by the patient.
 - D. Appointments **must be** confirmed 24 hours prior to the appointment time. We have had problems in the past with patients who cancel on short notice or just do not show up at all - even when confirmed. It is very helpful if you can have a few stand-by patients you can call on short notice. It is also very important your patients know how important they are to you, without them you will not become a hygienist. Take an interest in them. Please do not harass your patients by calling numerous times at all hours of the day and night. Every year at least several patients object to overzealous confirmation tactics.
 - E. Communications Log
Note every contact with your patient on the Communication Log in the record. This log is required and may prove to be very helpful when trying to sort out misunderstandings between patients, students and the clinic. Fill this out as completely as possible. Communication logs for patients who have not yet been in the clinic should be kept in a folder labeled "Communication Logs" and filed at the front of the student's file area in the file room.
 - F. You should locate your patient's chart prior to the day of the appointment.

- II. Pre-appointment preparation
 - A. Carry out all pre-appointment infection control procedures.
 - B. Pick up your patient's chart from the file cabinet.
 - C. Set up only those items necessary for the procedures to be performed during the appointment. You must plan ahead! For the first appointment you will need one instrument cassette, patient record forms, disclosing solution, mouth rinse, hand mirror, and disposables (gauze, etc.).
 - D. Your patient will call you to confirm they are in the parking area. You will Greet them outside and perform a COVID-19 screening. Full PPE is required.
 - E. Greet your patient and seat on time. If you are running behind schedule, please notify the patient and the clinic receptionist. She will need to know how long you will be delayed - be honest do not underestimate. If more than 15 minutes will be required, you should stop where you are with your current patient and start where you left off at their next appointment. Remember, it will take about 15 minutes to post and pre-op before you are able to seat your next patient.

- III. Fill out the CER
 - A. Account for clinic time by filling in the appropriate box in the top left corner of the CER. You will have a separate CER for each patient. You will also have a CER for the following occurrences.

Cancellation Time or Non-productive Time (CER #51 J)

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

Sterilization (CER #50 S)

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

Student Illness (CER #53I)

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

Screening (CER #52X)

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

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

C. Pat# / Code _____

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

* **REMEMBER, each patient has a separate CER.**

D. Student Name _____ (fill in student name)

E. Clinic I II III

Circle whichever clinic course you are in

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

Periodontal Stage/Grade

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

IV. Initial paper work and Histories

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

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

- drug card for OTC medication or herbal medications or supplements (herbal or others).
- (3) Drug cards accompany the medical/dental history on the second patient visit and will be reviewed by the instructor. The instructor will note the cards have been done by initialing the drug card space on the second sheet of the medical history.
- e. If the medical history indicates a consultation with an MD is required, the student will attempt to reach the MD by phone and FAX a Medical Release form to the MD for completion before the student can proceed with patient treatment.

FAX NUMBER 880-8081

- (1) At the discretion of the instructors and depending on the reason for the medical release the student may perform some limited procedures prior to receiving a medical release. An instructor will evaluate each patient and inform you what can be done.
 - (2) The best way to avoid wasted time is to obtain a preliminary medical history over the phone when making the initial appointment.
2. Patient Application for Treatment and Release Form. Have your patient read, sign and date this form. Your instructor will initial this form at the first appointment when the Medical/Dental history is reviewed. No other signatures are required during the semester in which the patient begins treatment. If seen in subsequent semesters, a new signature and initials must be obtained.
 3. LIT Appointment Policy form. Have your patient read and sign this form. Please ask if they have any questions, if so clarify the policy for them. Your instructor will initial the form. This form is signed once and does not have to be signed in subsequent semesters
 4. Fill out and explain all HIPAA Forms to the patient
 - a. Have the patient sign where indicated and give the patient a copy of the policy at LIT.
 5. The CER. The CER must be filled out as indicated previously including the start date for the Medical/Dental history.
- B. **The first appointment**
When you have completed all of the above you need to get an instructor to come to your chair to review the important points of the patient's medical/dental history. The instructor may comment or question you regarding any information contained or not contained on the form before placing the grade on the CER. The instructor will check and initial the patient release, appointment policy and HIPAA forms.
- C. For second and subsequent appointments the student will update the Medical/Dental history, note any changes by recording the number of the line item next to the signature line (or N/C if there have been no changes). If additional drugs have been added the student will follow the procedures noted above. The updated Medical/Dental history and other necessary forms will be given to an instructor for signatures.
- V. Oral Exam (Head and Neck and Intraoral exams)

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

A. Head and Neck Exam

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

B. Intraoral Exam

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

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

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

VI. Periodontal Assessment

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

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

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

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

B. Soft Tissue Examination

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

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

C. Radiographic Findings

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

1. Bring your CER to your instructor and he/she will procure needed supplies from the cabinet and record the patient's name and number along with number and type of radiographic imaging in the clinic grade book. The instructor will also initial the CER next to the proper radiographic procedure and place a start date in the appropriate column.
 2. Take the radiographs and process if necessary. Use the radiographs to fill in the radiographic findings portion of the periodontal assessment form and have this graded.
 3. The type of radiograph and the justification for exposure must be recorded on the progress notes on the date the radiographs are taken.
- D. Periodontal Condition
Determine the periodontal stage/grade and check off the appropriate box on the assessment form.
- E. Calculus Detection
Class 3 patients. The student will explore all surfaces for hard deposits and chart on the calculus detection form for each Class 3 patient. You are not required to do calculus charting on Class 1 and 2 patients.
- VII. Dental charting
- A. A complete dental charting will be accomplished for every patient. The information obtained from the chart will be used to determine biofilm retentive features and the predisposing factors on the periodontal assessment form. Findings will be recorded in Eagle Soft.
 - B. **Unless otherwise indicated radiographs must be utilized for dental charting.** The radiographs may be taken at the clinic or may be requested from the patient's dentist of record. If the latter is the case the radiographs will be returned after use.
 - C. You should fill out the progress notes for this patient up to the point of dental charting before the dentist is asked to check the patient. One of the following entries should be used:
"Dental charting with x-rays"
"Dental charting without x-rays"
 - C. **The dentist will evaluate your dental charting and will complete the following prior to leaving your area:**
 1. Grade the dental charting section of the CER
 2. Sign the patient's progress notes adjacent to the dental charting notation (make sure the entry states whether or not radiographs were used)
 - D. Referrals for dental treatment will be noted in the referral section on the informed consent document. The Dentist that clinic day must initial referrals or no referrals. It is your responsibility to write in the conditions the patient is being referred for.
 - E. It is your responsibility to ensure the dentist has the forms required and the proper signatures and grades are recorded. If these procedures are not completed correctly it will reflect on your professional judgment and ethical behavior grade.
- VIII. Plaque/Bleeding Score and Home Care Regimen Form

- A. Determine the plaque score by disclosing. The initial plaque score will be determined for all patients during their first or second visit and at **each subsequent visit**. Record the plaque and bleeding scores on this form.
- B. Each patient shall have an initial full mouth bleeding score recorded during the first or second visit and a partial score at every appointment thereafter. Determine the initial bleeding score for each patient by dividing the total number of bleeding points by the total number of possible bleeding points. Example follows:

$$\text{Number of bleeding points} / (\text{number of teeth present} \times 6 \text{ possible bleeding points})$$
$$28 \text{ bleeding points} / 168 \text{ possible} = .16 \text{ or } 16\% \text{ bleeding}$$

- C. On the first or second patient visit determine the patient's home care routine. Circle "baseline" under home care and record the information in the appropriate areas. At subsequent visits you can record your home care recommendations by circling "recommendations" and recording the information in the appropriate areas. Make sure you update this as necessary.
 - D. The plaque score and bleeding score should be noted in the progress notes on the date/s they are done.
- IX. Full Periodontal Charting will be used to determine the periodontal stage and grade if a patient Presents with certain abnormal findings. This includes one or more of the following: (pocket depths of 4mm or above, recession, furcation involvement, mobility, IZAG, frenal attachment involvement).
- A. The following information is recorded
 1. Pocket depths (6 readings for each tooth)
 2. Tissue heights (6 readings for each tooth)
 3. Determination of clinical attachment level (CAL) (6 readings per tooth)
 4. Mobility
 5. Sensitivity to percussion
 6. Suppuration
 7. Frenal problems, furcation involvement and IZAG
 - B. Instructors will check your periodontal assessment. The DDS is only allowed to check the radiographic portion of the assessment. If you do not have an instructor's signature for this assessment you will receive a U on this portion of the CER.
- X. Informed Consent / Care Plan and Risk Assessment Documents
- A. Informed Consent / Care Plan
 1. After completing and analyzing all baseline data the student will fill out an Informed Consent Document.
 2. **The student will present the document to an instructor prior to presenting it to the patient.**
 3. Fill out the referral section if any dental/medical referrals need to be made. Referrals are also recorded in the patient's progress notes. The dentist on duty must sign any referrals.

4. The instructor will sign the plan in the designated area and place a grade on the CER. The student will then verbally present and explain the plan to the patient and have the patient sign where indicated.
5. Give the patient the original and make a copy to keep in the patient's record.

XI. Dental Hygiene Care Plans

- A. Dental hygiene care planning and patient education will be accomplished on every patient during the course of treatment, written plans are required for the following:
 1. The patient you are using for the patient education skill evaluation
 2. Another patient approved by an instructor (preferably a class 3)
 3. If you are working towards a grade of "A" in this course, a third treatment plan needs to be done on another patient approved by an instructor.
- B. Data collection ends with the completion of all assessment forms. **You have 1 week from the date of the last assessment appointment to submit the written care plan to your clinical advisor. (all submissions must be online).**

XII. Patient Education

- A. Patient education will precede any scaling. Patient education WILL be done at **EVERY** appointment following determination of the plaque score. If appropriate patient education is not done the student will receive an "unsatisfactory" rating for Professional Behavior and Ethical Judgment.
- B. Record the patient's level of learning using the transtheoretical model in the progress notes in association with each patient education topic.

XIII. Scaling Procedures

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

- A. Start in one quadrant and use a systematic approach. Make sure you feel the deposits before you try to remove them. If you do not feel the deposits you cannot remove them! Get help from your instructor to identify deposits, if necessary. Trying to remove something you cannot feel is only going to cause tissue trauma and waste time. Unnecessary tissue trauma is counted as an error in scaling.
- B. At the beginning of the semester or when you have a difficult patient, you may ask an instructor to check your progress without grading you. We are here to help you learn, do not assume we know if you are having trouble or not. It is your responsibility to ask for assistance.
- C. When scaling in one quadrant is complete, ask for a scale check from an instructor. Only **the RDH instructors** are allowed to grade instrumentation, unless otherwise indicated.
- D. The instructor will check the areas scaled and indicate which areas still have deposits or which areas have tissue trauma. Record these areas in the comments area on the CER for that quadrant. The student is graded on the amount of deposit left and the presence of tissue trauma at this evaluation. Proceed to remove the remaining deposits identified by the instructor.
- E. Ask for a re-evaluation from an instructor and if the deposits have been removed the instructor will sign the re-evaluation column and the grade for the quadrant will be recorded. Continue with the next quadrant.

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

XIV. Polishing/Plaque Free

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

- A. Plaque Free (without prophy paste) *
 1. You will disclose your patient and proceed to remove all biofilm deposits using slow speed handpiece, brush, floss and instruments if necessary.
 2. Re-disclose the patient and have an instructor check when you have determined that all soft deposits are removed.
 3. The instructor will indicate any remaining areas. You will record these on the CER and remove them before asking for a re-evaluation.
- B. Polishing (using a prophy paste)
 1. Disclose the patient and remove all soft deposits and stain using slow speed handpiece, appropriate abrasive prophy paste (remember if you use medium or coarse you must follow with the medium and then fine pastes) brush, floss and instruments, if necessary.
 2. Disclose again and when you have determined the patient to be plaque free, have your instructor check.
 3. The instructor will indicate any areas that remain and you will remove these before asking for a re-evaluation.
- C. Children
Children up to the age of 10 will have a toothbrush prophy done unless there is stain present that cannot be scaled off or heavy plaque. Consult your pod instructor when in doubt.

XV. Fluoride Treatment

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

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

XVI. The last appointment

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

- A. Procedures are completed and you have a grade and instructors' initials on the CER.
- B. The last entry on the progress notes contains the following:
 1. Description of the patient's gingival/periodontal condition upon leaving
 2. Current learning level
 3. Referrals from the Informed Consent document for treatment needed or completed if not recorded previously

4. Recall frequency and date
 5. Patient's receipt number and payment information, if not recorded previously
- C. Have an instructor check your patient before he or she leaves

XVII. Completed Patient

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

- A. Comprehensive Care Grade-meaning all required treatment has been completed.
- B. The patient record must be complete
 1. All forms present in the correct order
 2. Radiographs must be present and placed into labeled coin envelope or saved on the computer. The progress notes should state where the films were sent if a patient requests them.
- C. Completed CER
- D. Payment receipt number, type (cash or credit card) and amount on CER
- E. Have the chart audited
 1. All charts must be organized according to the audit form, including those seen for radiographs only.
 2. Charts must be audited within one week of completion of treatment or receipt of a grade on the radiographs.

XVIII. Professional Behavior and Ethical Judgment

Demonstrating professional behavior and ethical judgement is an integral part of patient care. Student should exhibit a professional attitude and conduct themselves in a professional manner at all times. A dress code is stated in the student handbook and compliance is mandatory. A grade for professional behavior and ethical judgement will be given at 6 different times during the semester. The average of these must be 36 points or higher in order to meet minimal clinical requirements. The grade will reflect the students' performance in relation to punctuality, professional appearance, professional judgement, professional ethics, instrumentation skills, documentation, time management, infection control, organizational skills and patient rapport.

XIX. Patient Records

- A. **Patient records are NOT to leave the clinic area.**
- B. Follow the Chart Audit Form for record organization and writing progress notes

You must note when your patient cancels or fails to come for a scheduled appointment in the patient's progress notes.

XX. Chart Audit

- A. Random charts will be audited by your clinic advisor.
- B. Charts are to be audited as soon as you have finished all procedures and have received a grade on any radiographs taken. Turn in the CER only to your advisor.
- C. Patient charts must be refiled after use. Do not keep them in your mailbox. Your advisor will be ***extremely unhappy*** if this happens.
- D. See the Audit Checklist for more information.

APPENDIX 6

GRADING CRITERIA FOR THE CLINICAL EVALUATION RECORD (CER)

Grading Criteria

<u>Clinic Procedure</u>	<u>Satisfactory</u>
1. Medical/Dental History	2 errors
2. Oral Examination	3 errors
3. Periodontal Assessment (soft tissue)	3 errors
4. Periodontal Charting	6 errors
5. Radiographic Evaluation	3 errors
6. Informed Consent	4 errors
7. Dental Charting	5 errors
8. Scaling (per quadrant)	
A. Class I	2 errors
B. Class II	3 errors
C. Class III	4 errors
8. Tissue Trauma	counted as a scaling error
9. Polishing/Plaque Free	4 errors
10. Topical Fluoride Trays/Varnish	3 errors

*Failure to have faculty check patient will result in a "U".

11. Radiographs (3 improvable equal 1 retake)	
A. Adult BWX	5 improvable
Primary/mixed BWX (2 films)	3 improvable
B. Adult FMX	14 improvable
Primary/mixed FMX (8 films)	8 improvable
C. Panorex	2 improvable
13. Chart Audit	2 errors

*All CER forms must be kept in the cart under your name for Mrs. Haynes to access for grade input. Do not keep CER forms in the patient chart. File patient charts at the end of clinic. Never remove charts from the building.

APPENDIX 7

HARD DEPOSIT AND PERIODONTAL CLASSIFICATIONS

HARD DEPOSIT CLASSIFICATION SYSTEM

Class I: Any condition less than a Class II.

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

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

PERIODONTAL CLASSIFICATION SYSTEM

Periodontal Staging:

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

Grading:

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

APPENDIX 8

INSTRUCTIONS FOR MID AND FINAL CLINIC COUNSELING

INSTRUCTIONS FOR MID-SEMESTER CLINICAL COUNSELING

Student:

1. Check your computer grade printout for accuracy. Look at specific procedures and make sure you have the same number of satisfactory and unsatisfactory grades as the computer does. Check the number of complete and incomplete patients, the number of class 1's, 2's, and 3's, you have started and the periodontal case types against what you have recorded on your CER's. Be able to account for your clinic time as listed by clinic session. If you find errors make the corrections on the printout, do not change your CER's! You must be able to document any corrections you have made using CER's, x-ray critique sheets, skill evaluations, competency evaluations and your appointment book. Bring your corrected copy of the computer printout to the clinic counseling session. Check for systemic illnesses and make sure you have payment information if it is not already on the CER's.
2. Pull all of your patient records and CER's and bring them to your counseling appointment. Make sure they contain all of the proper forms and information.
3. Bring your Clinic Manual, including Skill and Competency evaluations and bring your appointment book.
4. Prepare a **typed** critique of your clinic performance thus far. What do you feel especially comfortable with, what areas do you feel that you need help with, etc.
5. Please bring the clinic requirement tracking form (from the clinic manual) with you to your counseling session. Make sure that you have recorded all of the correct information on this form.

Faculty

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

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

Please return the following:

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

INSTRUCTIONS FOR FINAL CLINIC COUNSELING

Student:

1. Check your computer grade printout for accuracy. Look at specific procedures and make sure that you have the same number of satisfactory grades as the computer does. Check the number of complete and incomplete patients, the number of Class 1's, 2's, and 3's that you have started and the periodontal classes recorded on the printout against what you have recorded on your CER's. Be able to account for your clinic time as listed by clinic session. If you find errors, make corrections on the printout; do not change your CER's! You must be able to document any corrections that you have made using CER's, x-ray critique sheets, skill evaluations, competency evaluations and your appointment book. Bring your corrected copy of the computer printout to the clinic counseling session.
2. Pull all of your patient records and CER's and bring them to your counseling appointment. Make sure the patient records have been audited by an instructor. Make a list of all patients that have not been completed and designate whether or not they will be returning in the fall for completion.
3. Bring your Clinic Manual, including skill and competency evaluations and bring your appointment book.
4. Prepare a **typed** critique of your clinic performance. What do you feel especially comfortable with, what areas do you feel that you need help with, etc. Did you utilize your time effectively? If you were not satisfied with your efforts, what might you do to correct the problem? Give this to your clinic counselor.
5. Please bring the clinic requirement tracking sheet on page 69 of the manual with you to the counseling session. Make sure that you have recorded all of the correct information on the form. If you have requirements that are not completed list these out and explain why they are not completed.
6. Check your CER's against your patient records for systemic conditions and handicapping conditions. Make sure these are circled on the CER.
7. There were 27 scheduled clinic sessions or 108 hours everyone should have. This includes 8 hrs of Sterilization. **Your total clinic time is what we must account for as 108 hours. Your clinical counselor will make sure you have done the assigned sterilization duty. You should have documented 8 hours of sterilization during clinic hours.**
8. Return dental materials key to Mrs. Harrell in a coin envelope with your name and drawer number on it.
9. Make sure you have all of your Community service hours documented. Keep a copy for yourself.

Faculty:

1. Record any skill evaluation, competency evaluation or treatment plan grades that have not been recorded on the clinic grade sheet.
2. Check the following on the computer printout for accuracy: Prophy/Periodontal Stage/Grade, number of requirements met, clinic time, etc. The time should include Sterilization hours.
3. Correct the CER's if necessary. The clinic receptionist will enter the corrections.
4. Check the student's patient records for audit signatures.
5. If radiographs are not documented on the student grade sheet, please enter them. Make sure the student can produce a CER and critique sheet for each survey. Question the student concerning any surveys that are not graded; we need to account for all radiographs taken. Have the student turn any ungraded surveys in to the first-year clinic coordinator or grade them yourself. If they are not completed just enter a U and initial the critique form.
6. Check the student's requirements against the requirement sheet in the manual. If the student has not completed requirements they should provide you with a list of incomplete requirements with reasons for not completing them.
7. Confirm completion of the proper number of prophy and periodontal class patients. Remember the student must have a 75% on the CER and must have passed at least 1 quadrant of scaling.
8. Check Community Service hours. They must have at least 3.
9. Write an entry in the student's counseling Notes for failure to complete requirements (any of the requirements).
10. Return the following to the clinic coordinator:
 - a. Computer printout with corrections
 - b. Written critiques
 - c. List of incomplete requirements
 - d. List of patients to be completed during the fall semester
 - e. CER's as corrected
 - f. Dental materials key should be given to Mrs. Harrell.

APPENDIX 9

STUDENT REQUIREMENT TRACKING SHEET

REQUIREMENT COMPLETION RECORD

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

PROPHY CLASS

Class I pts (completed) _____

Class II pts (completed) _____

Class III pts (completed) _____

PERIODONTAL STAGING/GRADING

Stage 1 (completed) _____

Stage 2 (completed) _____

REQUIREMENT	INDIVIDUAL PATIENT NUMBER							
3 FMX (digital)								
3 BWX (digital)								
1 PAN								
PEDO FMX (film or digital)								
PEDO BWX (film or digital)								
MED/DENT HISTORY								
HEAD & NECK/INTRAORAL EXAMS								
PERIODONTAL ASSESSMENT								
ADULT DENTAL CHARTING								
PRIMARY/MIXED DENTAL CHARTING								
PERIODONTAL CHARTING (1 QUAD)								
PLAQUE FREE/POLISHING								
WRITTEN CARE PLANS								
COMMUNITY SERVICE (3HR MIN)								
PROFESSIONAL JUDGEMENT SCORES								
CHART AUDIT SCORES								
RADIOGRAPHIC EVALUATIONS								

Chart Audit Procedure:

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

*You are allowed only 2 (U)-unsatisfactory chart audits for the semester. You will receive feedback on corrections. Beginning with the 3rd grade of (U) for the chart audit, one point will be deducted from the total of your Professional Judgement and Ethical Behavior scores. This will affect your overall average for this requirement and may lower your clinic grade. See page 10 /rubric for Professional Judgement and Ethical Behavior. Documentation is an integral part of standard dental hygiene care. The documents are legally binding and must be properly processed by the student. It is the student's responsibility to assure this is completed correctly according to LIT Dental Hygiene Program policies.