

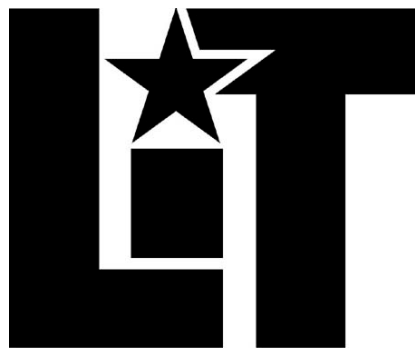
**Lamar Institute of
Technology**

DHYG 2262

Course Syllabus

Spring 2021

Taught by:
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(409) 880-8856
MPC 214



CLINICAL-ADVANCED

TABLE OF CONTENTS

DATES TO REMEMBER	3
PREREQUISITES.....	4
COURSE DESCRIPTION	4
CLINIC GOALS.....	4
CREDIT HOURS.....	4
CLINIC SCHEDULE.....	4
INSTRUCTOR	4
COURSE POLICIES	5
DISABILITIES STATEMENT.....	7
PROFESSIONAL BEHAVIOR AND ETHICAL JUDGMENT	16
TEACHING METHODS.....	7
EVALUATION CRITERIA.....	7
REQUIREMENTS FOR GRADES.....	9
RADIOGRAPHIC INFORMATION.....	11
PATIENT POINT REQUIREMENTS	11
PATIENT SELECTION.....	12
SPECIAL PATIENTS	13
PRIVATE PRACTICE PATIENTS	14
EAGLESOFT PROBING.....	13
NUTRITIONAL COUNSELING PATIENT.....	14
GENERAL CLINICAL INFORMATION.....	15
CLINICAL GRADING CRITERIA FOR SATISFACTORY ON “CER”	21
STUDENT & FACULTY CLINICAL COUNSELING ASSIGNMENTS.....	23
PROGRESS CHECK	23
INSTRUCTIONS FOR MID-SEMESTER CLINICAL COUNSELING	24
INSTRUCTIONS FOR FINAL CLINICAL COUNSELING	25
REQUIREMENT COMPLETION RECORD.....	26
MOCK BOARD EVALUATION	27
PATIENT EDUCATION COMPETENCY EVALUATION CHECKLIST:.....	30
PATIENT EDUCATION SESSION COMPETENCY	30
CRITERIA FOR ROOT DEBRIDEMENT COMPETENCY	34
ROOT DEBRIDEMENT COMPETENCY.....	36
CRITERIA FOR GERIATRIC COMPETENCY.....	37
GERIATRIC COMPETENCY.....	38
EAGLESOFT PROBE CHARTING.....	39
NUTRITION CASE HISTORY	40

Clinical-Advanced (DHYG 2262)
Spring 2021
DATES TO REMEMBER

See addendum

Clinical-Advanced (DHYG 2262)
Spring 2021

PREREQUISITES: DHYG 1301, 1431, 1304, 1227, 1235, 1219, 1339, 2301, 1207, 1260, 1311, 2261, & 2331

CO-REQUISITE: DHYG 2153 & 1315

COURSE DESCRIPTION

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

CLINIC GOALS

- I. The student will demonstrate the ability to provide therapeutic dental care directed toward the treatment of oral disease at appropriate competency levels.
- II. The student will use didactic knowledge, communication, and patient management skills to assess, plan, and evaluate a comprehensive dental hygiene care program directed towards healthy periodontium for individuals with moderate and advance periodontitis.
- III. The student will function as a member of a dental health delivery team within the dental hygiene clinic.
- IV. The student will accept responsibility to develop a professional and ethical value system while providing comprehensive dental hygiene services within the health care community.

CREDIT HOURS

2 semester hours
12 lab hours

CLINIC SCHEDULE

4:00 pm-8:00 pm - Monday
8:00 am-12:00 pm – Tuesday/Thursday/Friday
1:00 pm-5:00 pm - Wednesday

INSTRUCTOR

Renee Sandusky, RDH, BS Second-Year Clinic Coordinator
Office 214 Multipurpose Building
(409) 880-8856

OFFICE HOURS

Monday 9:00-10:00, 3:00-4:00
Tuesday 1:00-3:00, Wednesday 11:00-12:00, Thursday 10:00-2:00

CLINICAL FACULTY

Renee Sandusky, R.D.H., B.S.	Dr. W. Nantz
Debbie Brown, R.D.H., M.S.	Dr. R. Williams
Michelle DeMoss, R.D.H., M.S.	Dr. T. German
Lisa Harrell, R.D.H., B.S.	Dr. R. Wiggins
Kristina Mendoza, R.D.H. D.M.D.	Dr. J. Porter
Rose Rayner, R.D.H., B.S.	Dr. H. Armstrong
Rebecca Ebarb, R.D.H., B.S.	
Katie Ferguson, R.D.H., B.S.	
Tami Browning, R.D.H.	

STAFF

Deborah Haynes

COURSE POLICIES

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 all assigned clinic sessions.

If students are unable to attend clinic, it is **mandatory that you call the appropriate instructor prior to the scheduled clinic time**. The student is also responsible for contacting their patient's at the time of absence.

Extenuating circumstances will be taken into account. Extenuating circumstances might include, but are not limited to: funeral of immediate family member, maternity, hospitalization, etc. If the student has surgery, a debilitating injury, or an extended illness, a doctor's release will be required before returning to clinic.

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

Dental hygiene students will be allowed to make-up a missed clinic session for illness when the student presents a doctor's excuse to the 2nd year clinic coordinator. Absences are strongly discouraged throughout the semester. If a student is too ill to come to class, that will require an absence for clinic on the same day. Any other absence in clinic will be dealt with on an individual basis and must be discussed with the 2nd year clinic coordinator.

Tardiness

Tardiness is not acceptable in the clinic. It is expected that students will arrive on time for clinic and remain until dismissed by the instructor. If tardiness becomes an issue, the student will be required to meet with the 2nd year clinic coordinator.

If a student is tardy for their assigned sterilization duty, they will be assigned one extra sterilization duty during the semester outside of their regular scheduled clinic.

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

Technical Requirements (for Blackboard)

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

Clinical-Advanced (DHYG 2262)

Spring 2021

[https://help.blackboard.com/en-](https://help.blackboard.com/en-us/Learn/9.1_2014_04/Student/015_Browser_Support/015_Browser_Support_Policy)

[us/Learn/9.1_2014_04/Student/015_Browser_Support/015_Browser_Support_Policy](https://help.blackboard.com/en-us/Learn/9.1_2014_04/Student/015_Browser_Support/015_Browser_Support_Policy). A functional broadband internet connection, such as DSL, cable, or WiFi is necessary to maximize the use of the online technology and resources.

Supplemental Instruction

You will be assigned a clinical advisor for the semester. If you are in need of supplemental instruction, please see your clinical advisor or the clinical coordinator for assistance.

Starfish

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



Disabilities Statement

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 in Student Services, Cecil Beeson Building. You may also visit the online resource at <http://www.lit.edu/depts/stuserv/special/defaults.aspx>

Student Code of Conduct Statement

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

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.

Clinical-Advanced (DHYG 2262)
Spring 2021

Working in pods emphasizes one-on-one teaching, continuity of instruction and closer monitoring of student progression. **PROFESSIONAL BEHAVIOR AND ETHICAL JUDGMENT**

PROFESSIONAL BEHAVIOR AND ETHICAL JUDGMENT

Demonstrating professional behavior and ethical judgment is an integral component of patient care. A student should exhibit a professional attitude and conduct themselves in a professional manner at all times. A professional dress code is stated in the student handbook and compliance with this code is expected. This grade will reflect the student's performance in relation to punctuality, professional appearance, professional judgment, professional ethics, instrumentation skills, documentation, time management, infection control, organizational skills, and patient rapport. The average 38 points must be obtained to meet minimal clinic requirements.

Comprehensive Care Grade on CER

Students are expected to perform comprehensive care on all patients. Not taking retakes, prewriting charts, not doing the plaque or bleeding score, not doing diagnosed sealants, not completing post-calculus evaluation are some examples of behaviors that will result in an unacceptable grade in this area. Four or more U's in Comprehensive Care on clinic CERs will result in a one point deduction from the student's **Professional Behavior and Ethical Judgement** semester average.

Additional Policies: Refer to the student handbook for a comprehensive listing of program policies.

TEACHING METHODS

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

EVALUATION CRITERIA

Each student must meet minimal competency for all requirements in order to pass DHYG 2262. Criteria for achieving a grade of "A", "B", "C", "D" or "F" can be found on page 8 and 9 of this syllabus. All criteria must be met in each grading category in order to achieve the desired grade. (EXAMPLE: If all criteria except one are met for a grade of "B" then the student would receive a grade of "C".) These criteria place the responsibility for learning in the hands of the student and are meant to identify those who strive for excellence in the clinical setting.

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

All course work must be successfully completed and turned in by **April 29, 2021**, **this includes radiographs, retakes, and community service.** All initial chart audits must be completed by **April**

Clinical-Advanced (DHYG 2262)
Spring 2021

29 by 10:00 am. Failure to complete chart audits by due date could result in receiving no credit for the patient. Failure to successfully complete all course requirements will result in an "F" being awarded in DHYG 2262 and dismissal from the DH program. Exclusions from this policy will be dealt with at the discretion of the program faculty.

REMEDIATION

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

REQUIREMENTS FOR GRADE

	A	B	C	D/F
Requirements			Minimal Competency	
Total Patient Points	48 Total points 22 points in Class III and above	45 Total points 19 points in class III and above	42 Total points 16 points in class III and above	Does not meet <u>all</u> requirements for a grade of "C".
Adult Patients	8	8	8	
Geriatric Patients	2	2	2	
Special Needs Patients	3	2	2	
Perio Stage	Stage I & II = 4 patients			
	Stage III & IV = 4 patients			
X-rays = Total #	4 FMX, 4 BWX, 1 PNX	4 FMX, 4 BWX, 1 PNX	4 FMX, 4 BWX, 1 PNX	
	Sensors must be utilized for 2 of the dBWX & dFMX	Sensors must be utilized for 2 of the dBWX & dFMX	Sensors must be utilized for 2 of the dBWX & dFMX	
Calculus detection	1 patient/ IV or V	1 patient/ IV or V	1 patient/ IV or V	
Eagle Soft Probe Chart	1 Probe chart	1 Probe chart	1 Probe chart	
Private practice patients	6 patients	5 patients	4 patients	
Sealants	4 patients	3 patients	2 patients	
Ultrasonic patients	12 quadrants	10 quadrants	8 quadrants	

Clinical-Advanced (DHYG 2262)
Spring 2021

		A	B	C	D/F
Professional Judgment & Ethical Behavior		Average of 40	Average of 39	Average of 38	Average of below 38
Community service		3 hrs/semester	3 hrs/semester	3 hrs/ semester	
Cancellation		Over 20 hours of cancellation will lower grade by one letter grade			
Treatment plans					
Nutritional Counseling		Passing on initial attempt (75% or higher)	Passing on second attempt	Passing on second attempt	
Perio Case Follow Up		90 and above	86 – 89	85 or lower	
Written evaluations					
Radio-graphic (FMX)	90%	Passing evaluation on initial attempt	Passing evaluation on second attempt	Passing evaluation on second attempt	Does not meet all requirements for a grade of “C”.
Clinical Competency					
Mock Board		Meet minimal competency on any 3 evals on initial try.	Meet minimal competency on any 2 evals on initial try.	Meet minimal competency	Does not meet all requirements for a grade of “C”.
Root Debridement		See above	See above	See above	
Geriatric Patient		See above	See above	See above	
Patient Education		See above	See above	See above	

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

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

Clinical-Advanced (DHYG 2262)

Spring 2021

RADIOGRAPHIC INFORMATION

A student must demonstrate minimal competency by exposing acceptable quality radiographic surveys. Regardless of requirements, the student will take all necessary radiographs based on patient needs. Surveys will be graded as either satisfactory or unsatisfactory by Dr. Mendoza or the Second-Year Clinic Coordinator. Surveys must be critiqued within 1 week of the survey. (i.e. Survey taken on Tuesday morning = due by the following Monday) Surveys turned in after one week of taking may not be graded for credit.

- **All radiographs must be completed and graded by April 29, 2021 by 10:00am.**
- The student who is treating the patient must take the patient's radiographs even if the radiographs are not needed for requirements.
- Radiographs may be taken outside of the student's clinic time if it is during a second-year clinic. **Radiographs may not be taken during lunch, before clinic, during 1st year clinic, or after clinic hours.**
- All surveys taken and the justification for each patient exposure must be documented in the progress notes. (Example: FMX-patient has numerous suspicious areas).
- Only technique errors, bone loss, calculus, suspicious areas and those areas requiring referral should be documented on the radiographic critique sheets. Only note existing conditions such as missing teeth if it aids in grading the radiographs.
- **IF A PATIENT CANNOT RETURN FOR RETAKES, THAT PARTICULAR SURVEY WILL NOT BE ACCEPTED AS A COMPLETED SURVEY.** Therefore, it is advisable to discuss this with your patient before the need arises. If the patient cannot return, it must be documented on the Communication Log and in the progress notes.
- **Any patient wanting their radiographs sent to their DDS, must have the retakes taken in order to send a diagnostic survey.**
- Not taking retakes on a patient will affect your Comprehensive Care grade on your CER, which in turn, affects your overall grade for that patient.
- Two of the digital BWX surveys and two of the digital FMX surveys must be taken with sensors. However, sensor technology may be used more than the minimal requirement. The survey taken will depend on the patient's needs.
- A digital critique sheet will be submitted to dhcritique@lit.edu for grading purposes.

Radiographic Interpretation Evaluations

The student will be required to successfully complete one radiographic interpretation. Students will be tested only on the Full Mouth Radiographic Survey this semester. This evaluation requires the student to identify landmarks, suspicious areas, restorations, unusual conditions and technique errors which are pointed out by the instructor on the exam. The date for the evaluation will be **TBA**. A score of **90%** or higher is required for successful completion of this evaluation. Failure to meet this score on the second try may result in dismissal from DHYG 2262.

PATIENT POINT REQUIREMENTS

Prophylaxis points

Total patient points will be dependent on the grade the student is striving to attain. The number of points required for specific grades can be found in the course syllabus. All patients must be

Clinical-Advanced (DHYG 2262)
Spring 2021

completed at minimal competency. Minimal competency will be reflected by **85%** of the CER grades being “satisfactory”. A minimum of two (2) quadrants must be satisfactorily scaled in order to receive partial point credit for incomplete patients. **ALL PATIENTS ARE EXPECTED TO BE COMPLETED.** Incomplete patients will adversely affect the final clinic grade of the student. Cases of incomplete patients will be addressed on an individual basis and action on these cases will be at the discretion of the faculty.

- **PROPHYLAXIS POINTS AND PERIODONTAL CASE TYPES WILL BE AWARDED ONLY AT COMPLETION OF COMPREHENSIVE TREATMENT (i.e., all indicated treatment must be completed at minimal competency).**
- **SERVICES RENDERED TO PATIENTS WILL BE CONDUCTED BY ONE (1) STUDENT (i.e., Mary and Susie cannot earn credit for Miss Smith who is a class VIII) unless preapproved by the instructor.**

Patient Point Value

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

Periodontal Case Type: Patient selection must include the following perio case type for all students.

Stage Type I & II	Four (4) patients required
Stage Type III & IV	Four (4) patients required

Patient Selection

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

*Dental hygiene students may treat ONE hygiene student or faculty/staff member per semester for requirements. Also, remember that DH students, faculty and staff who are patients are not exempt from payment of customary charges. **THESE PATIENTS WILL ONLY BE USED TO COUNT FOR POINTS, X-RAY REQUIREMENTS, OR SEALANT REQUIREMENTS.**

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

*Each student may choose to waive the fee for one patient per semester.

SPECIAL PATIENTS

The student will be required to complete several special patients in this course. They will include a mock board patient and private practice patients.

Pit and Fissure Sealant Patients

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

Calculus Detection Patient

One class IV or V patient will be utilized to chart calculus. The calculus detection will require a special form for recording the findings and two instructors will check the calculus detection. The calculus detection should be done on your Mock Board patient. Only subgingival "clickable" calculus will be recorded for the calculus detection patients.

Periodontal Patient/Patient Education Patient

The periodontal patient from the Fall semester will be utilized for one, formal follow-up patient education session and a follow up care plan comparing all the patients data and/or progress. *The patient education competency will be conducted in the patient education room.* The student will schedule the periodontal patient for a recall appointment. During the recall appointment the student will first perform the following: intra/extra oral exam, periodontal assessment, dental charting, recording of probing depths of 4 mm and higher, recession, furcation areas and mobility, bleeding score and plaque score. The patient education session will be done after all data collection has been completed. The student will then scale all four quadrants, plaque free, administer Arestin if indicated, and give a fluoride treatment. During the patient education session, the student will assist the patient in evaluating his/her progress toward specified goals set in the Fall. The student will provide the patient with a copy of the comparison probe chart from the pre and post periodontal charting completed in the Fall using the Eagle Soft software program. The student will assist the patient in determining further steps that may need to be taken to reach the stated goals and modify home care techniques.

NOTE: If a student's periodontal patient from the Fall semester absolutely cannot return in the Spring for periodontal maintenance and re-evaluation you must select another patient that will meet the requirements for this competency. The patient selected **MUST** meet the following requirements: be a patient that was seen by the student in the Fall semester; have periodontitis; had chairside patient education (this should have been done with all patients); and preferably be a good candidate to administer Arestin. Please inform your Periodontology instructor of these changes.

Clinical-Advanced (DHYG 2262)
Spring 2021

See page 28 for more detailed information regarding the Patient Education Competency Evaluation.

PRIVATE PRACTICE

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

Patient Criteria for Private Practice Patients

Private practice patients should be adult patients, (19 years of age or older) either prophylaxis class I or class II, and must be successfully completed in a 2 hour time segment or less. The student will class the patient. **One of these patients needs to be a perio case type III or IV.** Documentation of the time will be recorded on the CER by an instructor and initialed.

- **The two hour time period includes all data collection, oral prophylaxis, patient education, and plaque free. Radiographs and medical history are not included in the 2 hour time period.**
- **An instructor and dentist will check patient at completion of all data collection, oral prophylaxis and plaque free but before fluoride treatment.**
- The student should class these patients themselves and begin treatment. **Informed consent should be signed by the patient and student before any scaling is initiated.** Failure to do so may result in the loss of patient points for the student.
- Faculty will sign the Informed Consent after all paperwork has been checked.
- The student is responsible for informing their pod instructor of their intent to do private practice. The students start and finish times are to be written on the CER by an instructor and initialed.

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

EAGLESOFT PROBE CHARTING

The student will complete one probe charting using the EagleSoft software. The student will use their Perio patient from the Fall for this patient. The student will use the pre and post full periodontal charting from the perio patient's chart from Fall semester and transfer the charting information to the computer using the EagleSoft software. The student will print the comparison chart of CAL's to use in the patient education session. The post probe chart will be printed from the computer and turned in with the patient's chart to the student's advisor for grading to satisfy this requirement. A PowerPoint of the steps for this evaluation has been provided on Blackboard. The evaluation form is found in this syllabus on page 35.

Clinical-Advanced (DHYG 2262)
Spring 2021

Nutritional Counseling Patient

Counseling patients about the relationship between their diet and dental health is an integral part of total patient care. Students enrolled in General and Dental Nutrition learned many nutritional principles. This semester the student will have the opportunity to apply the learned nutritional principles in a practical setting. Each student will identify a caries susceptible patient for nutritional counseling based on specific needs and the LIT Caries Risk Assessment. Relatives or the former patient education patient and perio patient may not be used as the subject of the nutritional counseling session. Each student must complete all required forms (same as used for the Personal Food Diary Project). The student will bring the patient in the clinic on their clinic day for a one-on-one counseling session in the patient education room in the clinic. If the student has finished treatment on this patient, the patient must be willing to return for the counseling session. All completed clinical forms will be turned in at the time of the counseling session. The written summary will be due by 12:00 pm the next school day after the session. The summary can be emailed to the Clinic Coordinator (rssandusky@lit.edu) and state who listened to the counseling session.

Evaluation criteria are outlined on the Nutritional Counseling Evaluation form found on page 36 of this syllabus. A grade of at least 75% must be obtained to be considered acceptable.

Clinical-Advanced (DHYG 2262)

Spring 2021

PROFESSIONAL BEHAVIOR AND ETHICAL JUDGMENT

Demonstrating professional behavior and ethical judgment is an integral component of patient care. A student should exhibit a professional attitude and conduct themselves in a professional manner at all times. A professional dress code is stated in the student handbook and compliance with this code is expected. A professional behavior and ethical judgment grade will be during selected clinic sessions. This grade will reflect the student's performance in relation to punctuality, professional appearance, professional judgment, professional ethics, instrumentation skills, documentation, time management, infection control, organizational skills, and patient rapport. The average of 38 points must be obtained to meet minimal clinic requirements.

Comprehensive Care Grade on CER

Students are expected to perform comprehensive care on all patients. Not taking retakes, prewriting charts, not doing the plaque or bleeding score, not doing diagnosed sealants, not completing post-calculus evaluation are some examples of behaviors that will result in an unacceptable grade in this area. Three or more U's in Comprehensive Care on clinic CER's will result in a one point deduction from the student's **Professional Behavior and Ethical Judgement** semester average.

GENERAL CLINICAL INFORMATION

Vital Signs

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

Extra Oral and Intra Oral Examination

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

Periodontal Assessment/Periodontal Charting

Record findings on Periodontal Assessment form as indicated. The student will conduct a periodontal assessment of all patients during data collection. Students are to record tissue architecture, color, consistency, margins, papillae shape, surface texture, suppuration and all radiographic findings. The periodontal charting (see below) is also a part of the Periodontal Assessment. Upon completion of the Periodontal Assessment data collection, a Periodontal Stage and Grade should be assigned to the patient.

Periodontal Charting

A periodontal assessment of all patients will be conducted by the student during data collection. All abnormal conditions should be noted including 4mm or greater pockets, recession, furcation and mobility. When any of these abnormal conditions are present, the following must all be documented for

Clinical-Advanced (DHYG 2262)

Spring 2021

that tooth: pocket depth, tissue height (TH), and CAL. Each patients' periodontal classification should be determined using clinical attachment loss (CAL) as the first indicator, radiographic bone loss is used second; this will help determine the most accurate periodontal diagnosis. The exception to this is the perio patient, in which all readings must be documented.

Dental Charting

Chart existing restorations, suspicious areas, missing teeth, fixed bridges, needed sealants, and positive findings that affect the periodontal condition (overhangs, rotations, abfractions). A dentist must evaluate dental charting. Any referrals should be noted on the informed consent and in the progress notes. Have your progress notes and Informed Consent with referrals ready for the D.D.S. to sign at the time the D.D.S. is checking your patient.

Informed Consent

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

Risk Assessments

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

Plaque and Gingival Bleeding Indices

Plaque scores and bleeding indices utilizing indicator teeth are to be taken on all patients. Bleeding and plaque scores are to be taken on patients at every appointment. Chair-side patient education is expected at every appointment before scaling. Failure to take these scores and/or record them in the progress notes may result in an Unacceptable score on the Professional Judgment form or on Comprehensive Care on the CER.

Grading of Data collection

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

Evaluation of Scaling Procedures

Evaluation criteria for scaling includes: calculus removal, stain removal, smooth root surfaces, and tissue trauma. Prophy class IV and below require one instructor to evaluate scaling for credit. Significant tissue trauma will be noted on the CER and may be reflected in the patient grade. Prophy class V or higher requires an evaluation from two instructors. Errors will be recorded under comments on the CER. Errors documented for scaling must be re-scaled by the student and re-checked by one instructor. An instructor must sign in the appropriate box on the CER indicating that the areas have

Clinical-Advanced (DHYG 2262)

Spring 2021

been rechecked to receive credit for patient points. **It is the responsibility of the student to see that all procedures are appropriately signed off by an instructor.**

- Areas identified by faculty as still remaining after the rescale will be counted as additional errors against the student and will be reflected in the student grade. (IE. areas 29D, 30M and 25L were found on initial checking of scaling which makes 3 errors. When the instructor checks after spot removal, the area on 29D is still present. This student would then have 4 errors on this patient.)

Ultrasonic Scaling

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

Post Calculus

All patients class V and above must be scheduled two weeks after prophylaxis for re-evaluation (Post Calculus). The student is expected to thoroughly explore, re-scale needed areas, and have the treatment evaluated by an instructor. Only one instructor will check post calculus evaluation. In the event the patient does not return for the post calculus evaluation, the student will not get full patient points for this patient.

EagleSoft Software Program

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

Patient Selection

It is advised to select a variety of patients to enhance clinical experience. On prophy class V and above remember to consider the amount of root debridement indicated on those patients and the time required for post-calculus evaluation.

- *Patients who have been designated as special patients (i.e. Perio, Recall, Mock Board) in the past three years at LIT will not be good candidates as special patients for you.
- DH students, faculty, DDS, or RDH may not be utilized for special patients or for evaluations.

Clinic Time

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

Clinical-Advanced (DHYG 2262)
Spring 2021

Patient Dismissal

Patients must be evaluated by an instructor before dismissal at each appointment. An instructor must see the patient even if no clinical procedures were completed.

Non-productive Clinic Time

Students are allowed twenty (20) hours of non-productive time without grade penalty. **If the student accumulates more than twenty hours of non-productive clinic time, the final letter grade in DHYG 2262 will be lowered by one letter.** Students are expected to have a patient in their chair through the completion of the semester. The student is to remain in their cubicle even when the patient cancels or no shows. It should be documented on the back of the Cancellation CER what activities the student participated in during this time. The Cancellation CER time should be signed by the pod instructor at the end of clinic. If the student leaves the clinic for any reason, the student must notify a clinic instructor before leaving. The student may wait in the clinic office for 15 minutes before going to their cubicle. Completion of the student requirements is not an excuse for non-productive time. It is to the student's benefit to continue practicing clinical skills throughout the semester. Approved non-productive time (cancellation) learning activities may include, but are not limited to:

- Completing assignments through Dentalcare.com
- Critiquing radiographs
- Practicing the use of the Intraoral Camera techniques on a typodont
- Instrument sharpening
- EagleSoft probe charting
- EagleSoft dental charting
- Practicing sensor radiographs on the DXTRR manikin

Intraoral Camera

An intraoral camera is available for use by the student. It is not a requirement to use it, however, it is highly recommended that the student become familiar with this tool. The intraoral camera is often used in private practice and the Dental Hygienist may be expected to use it. You may want to use the camera on a patient during clinic, however, time may be an issue due to patient schedules. Cancellation time is a good time to practice with the intraoral camera on a typodont or another student.

Progress Checks and Clinical Advising

Students must meet with assigned instructor on the dates outlined on page 3 of this syllabus. Students must bring CER's, appointment book, radiograph critique sheets, and completed competencies to all progress checks. Students should also be able to discuss how many points they have started and completed, how many radiographs they have completed, etc. Be prepared coming to your appointed time.

Chart Audits

Chart audits will be randomized for students this semester. Faculty advisors will do a random chart audit on all students throughout the semester. When a chart audit is found with errors, the student will receive of "unacceptable" on the CER. Receiving 'unacceptable' grades on CER will affect the patients overall CER grade. This may determine whether the student will get credit for the patient.

Clinical-Advanced (DHYG 2262)

Spring 2021

Student with repeated “unacceptable” chart audits, will need to schedule a time with their clinical advisor to have all patient files audited. The student will remain with the instructor while the chart is audited.

Sterilization Duty

Each student is assigned 6 clinic sessions of sterilization. Students are expected to arrive 15 minutes before the clinic session begins to help assist in getting clinic ready. The penalty for arriving later than 15 minutes prior to the beginning of clinic will result in an additional sterilization duty done outside of the students assigned clinic day. This will be scheduled with the 2nd year clinic coordinator. The penalty for computer use/phone use during sterilization duty is an extra 4 hours of sterilization duty outside of the student’s regular clinic day. The only exception to this rule is if the student is processing digital x-rays.

Competencies

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

End of clinic procedures

At the end of clinic, each student will remain in their cubicle until dismissed. CER’s and progress notes will be checked for completion of information, time entries, signatures, and signed by the pod instructor. No one will be dismissed until all students CER’s and progress notes have been checked for completeness.

CLINICAL GRADING CRITERIA FOR SATISFACTORY ON “CER”

	S	U
1. Medical/Dental History	no errors	1 or more
2. Head/Neck & Oral Exam	0-1 errors	2 or more
3. Periodontal Assessment	0-1 errors	2 or more
4-5. Dental Charting	0-1 errors	2 or more
6. Informed Consent	0-3 errors	4 or more
7. Risk Assessment	0-3 errors	4 or more
7. Periodontal Charting (per quad)	0-3 errors	4 or more
8-11. Ultrasonic Scaling - More than two calculus deposits, stain and/or plaque remaining per quadrant will result in a “U”. 0-2 deposits-“S”.		
12-15. Scaling - Errors include evaluation of: rough tooth surfaces, tissue trauma, and calculus.		

GRADE/QUADRANT

Class I	1 surface	2 or more
Class II	2 surface	3 or more
Class III	3 surfaces	4 or more
Class IV	4 surfaces	5 or more
Class V	5 surfaces	6 or more
Class VI	6 surfaces	7 or more
Class VII	7 surfaces	8 or more
Class VIII	8 surfaces	9 or more
16. Polishing Plaque Free (surfaces/mouth) 0-2 surfaces 3 or more		
17. Fluoride Treatment - Failure to remove most dental plaque, dry teeth prior to application, place saliva ejector, stay with patient the entire time, give appropriate patient instruction nor check tissue response will result in a “U”.		
18. Tissue Trauma (surfaces/mouth) 0-2 surfaces 3 or more surfaces		
19. Pit and Fissure - Proper occlusion maintained, no evidence of voids in sealant, cannot be displaced with explorer, somewhat high but other criteria satisfactory = “S”. Voids in sealant material or is removed with explorer = “U”.		

Clinical-Advanced (DHYG 2262)

Spring 2021

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

	<u>S</u>	<u>U</u>
Class V	4	5 or more
Class VI	5	6 or more
Class VII	6	7 or more
Class VIII	7	8 or more

21. **Post-op Perio Charting**- Use criteria for #7.

Acceptable

- | | |
|-------------------------------|---|
| 22. Radiographs-BWX | Equivalent to 4 improvable |
| 23. Radiographs-FMX | Equivalent to 12 improvable |
| 24. Radiographs-PNX | 2 improvable |
| 25. Comprehensive Care | no errors/patient 1 or more errors/patient |
| 26. Chart Audit | no errors/patient 1 or more errors/patient |

STUDENT AND FACULTY ACADEMIC AND CLINICAL COUNSELING ASSIGNMENTS

Mendoza	Sandusky	Brown	Ferguson
Blalock	Hardy	Escareno	Abshire
Gallegos	Harkins	Landry	Caswell
Johle	Immel	Mallett	Free
Palombo	Mendez	Matthews	Sizemore
Stollsteimer	Nguyen	Rangel	
Trinh	Rodriguez	Torres	
	Self	Wilson	
	Smith	Wolford	
	Stephens		

PROGRESS CHECK

Listed below you will find the weeks of progress checks. Students must meet with their clinical advisors to report on their progress in clinic. Please be prepared to discuss how many points have been started, patient issues, what requirements are met, etc. CER's, radiographic critique sheets, and requirement completion forms should be brought to each progress check.

Week of February 15
Week of April 12

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

MID-SEMESTER CLINICAL COUNSELING

Week of March 8

FINAL CLINICAL COUNSELING

Week of May 3

Chart Audits will be completed as the patient care is completed. These will be checked as the patient is completed. However, it is the responsibility of the student to make sure that chart audits are completed in a timely manner.

- CHARTS THAT ARE NOT AUDITED WITHIN ONE WEEK OF COMPLETION OF PATIENT CARE MAY RESULT IN PENALTIES INCURRED BY THE STUDENT.
- These penalties could mean that the student may not use that patient toward meeting requirements for DHYG 2262.

Clinical-Advanced (DHYG 2262)

Spring 2021

INSTRUCTIONS FOR MID-SEMESTER CLINICAL COUNSELING

STUDENTS:

1. Bring your CER's, x-ray critique sheets, appointment book, skill evaluation gradesheets, etc., for documentation.
2. Look over your print out/time sheet for any errors or discrepancies **prior** to your appointment.
3. Bring your corrected copy of the computer print-out. Be able to document any errors with CER's.

FACULTY:

1. Document grades and patient #/codes on the grade sheets on the "R" Drive grade book.
2. Check grade book on the "R" Drive for the following:
 - a. Accuracy
 1. Check to see that patients listed on grade sheet on "R" Drive are completed.
 2. Check on student progress toward successful completion of clinic requirements.
 - b. Check proficiency in each skill areas.
 - c. Check accuracy of clinic time.
 - d. Corrections to CER-s should be done on the "R" drive.
 - e. Make any notations on the student's counseling notes tab.
3. Return to me the following:
 - a. Requirement tracking sheet.

Clinical-Advanced (DHYG 2262)

Spring 2021

INSTRUCTIONS FOR FINAL CLINICAL COUNSELING

STUDENTS:

1. Bring your CER's, x-ray critique sheets, appointment book, skill evaluations, etc., for documentation. Know how many points you have finished for clinic.
2. Bring your corrected copy of the computer print-out. Be able to document any errors with CER's.
3. Provide a written list of incomplete patients from this semester and the reason the patient was incomplete.

FACULTY:

1. Document grades and patient #/codes on the grade sheets on the "R" Drive grade book.
2. Collect written critique from student, list of incomplete patients.
3. Check grade book on the "R" Drive for the following:
 - a. Accuracy
 1. Check to see that patients listed on grade sheet on "R" Drive are completed.
 2. Check to see if any clinic requirements were successfully completed.
 - b. Check proficiency in each skill areas.
 - c. Check accuracy of clinic time.
 - d. Check accuracy of clinic time. Students should have a total of 156 hours of clinic time. Students should have 24 hours of sterilization.
 - e. Corrections to CER-s should be done on the "R" drive.
4. Return to me the following:
 - a. Requirement tracking sheet.
 - b. List of incomplete patients.
 - c. Instrument key and locker key should be given to Mrs.Haynes at Clinic Clean-up.

Clinical-Advanced (DHYG 2262)
 Spring 2021

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 Case Types

Class I pts (completed) _____
 Class II pts (completed) _____
 Class III pts (completed) _____
 Class IV pts (completed) _____
 Class V pts (completed) _____
 Class VI pts (completed) _____
 Class VII pts (completed) _____
 Class VIII pts (completed) _____

Periodontal Case Types

Case Type I (completed) _____
 Case Type II (completed) _____
 Case Type III (completed) _____
 Case Type IV (completed) _____

Adult Patients (completed) _____

Adolescent Patients (completed) _____

Geriatric Patients (completed) _____

Special Needs Patients (completed) _____

FMX							
BWX							
PNX							
Digital Radiograph (FMX)							
Digital Radiograph (BWX)							
Sensor Radiograph (BWX)							
Sensor Radiograph (FMX)							
Calculus Detection							
EagleSoft Probe Charting							
Private Practice							
Pit & Fissure Sealants							
Ultrasonic Instrumentation							
Radiographic Eval – FMX (90%)							
Patient Nutritional Counseling							
Mock Board Comp							
Root Debridement Comp							
Geriatric Patient Comp							
Patient Ed Comp							
Professional Judgment Average							
Community Service							

MOCK BOARD EVALUATION

Mock Board evaluations will be scheduled on March 24th and March 25th, 2021. Students will be assigned to one of these dates by the instructor.

The following pages contain criteria, instructional information, and evaluation forms for the Mock Board Evaluation. The student will have two hours to complete this evaluation. A 75% or higher must be achieved to pass this competency.

Criteria for Mock Board Evaluation

Student is responsible for patient selection using the following criteria.

- **CALCULUS DETECTION:** Each tooth has four surfaces: mesial, distal, facial and lingual. A qualifying surface is a tooth surface upon which there is “clickable” subgingival calculus. A clinic calculus detection will be completed prior to the examination to qualify the patient. During the evaluation, 3 teeth will be assigned at check-in for calculus detection during the evaluation.
- **PATIENT REQUIREMENTS:** Patient should be a Prophy Class IV or V. The patient should have a minimum of 12 “clickable” surfaces on a minimum of 6 teeth in one quadrant plus 2 posterior teeth from another quadrant. Eight (8) of the twelve (12) qualifying surface must be on posterior teeth.
- **DEFINITION OF QUALIFYING SUBGINGIVAL CALCULUS:**
 - Distinct and easily detectable
 - Definite “jump” or bump felt with an explorer with one or two strokes
 - Interproximal deposit felt from lingual and/or buccal
 - Ledges and/or ring deposits
- **EXEMPTIONS:** Calculus surfaces located on supra erupted or partially erupted third molars. A third molar is considered erupted if the occlusal plane of the third molar is in alignment with the occlusal plane of the rest of the teeth. A third molar with tissue covering the tooth, even though it is in the occlusal plane is also exempt.
- **QUALIFYING SURFACES:** The twelve qualifying surfaces must be on natural teeth and must not have the following: Class III furcations, Class III mobility, retained deciduous teeth or orthodontic bands. (Bonded lingual arch wires are acceptable.) Surfaces with greater than 6-millimeter pockets are discouraged.
- **ULTRASONIC USE:** The use of ultrasonics will be allowed on this examination
- **PERIODONTAL PROBING:** Two teeth designated by an instructor at check-in will be probed for measurements on the lingual surfaces and will be done on the Mock Board patient as part of the evaluation. The student will chart 3 pocket depths per tooth. The student will record the pocket depths in ink. The tooth numbers, which the student probes, must be recorded on the form.

Clinical-Advanced (DHYG 2262)
Spring 2021

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

On the day of the Mock Board evaluation, the student will review the medical/dental history and obtain all necessary signatures before beginning.

The forms that will be utilized for this evaluation will be the Evaluation Station Form and the Progress Form. It is advised that the student look over these forms before the evaluation. The student will have a current FMX or Panorex on the view box or on the computer.

The cubicle number will serve as the candidate number. After the medical/dental history is signed, the student will wait in the clinic office while the patient is examined by an instructor to determine that the patient still qualifies and assign two teeth in which the student will probe and three teeth in which the student will calculus detect as part of the evaluation. The patient will be checked by one faculty.

Anesthesia may be used on this examination.

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

The student must read the assignment sheet carefully to determine which teeth to probe, which teeth to calculus detect and which teeth to scale. The probing, calculus detection, scaling, and supragingival deposit removal is included in the two hour time limit. The student is advised to use the entire two hours.

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

Mock Board evaluations will be scheduled on March 24th and March 25th, 2021. Students will be assigned to one of these dates by the instructor.

Clinical-Advanced (DHYG 2262)
Spring 2021

LIT Dental Hygiene Program MOCK BOARD COMPETENCY			
DHYG 2262			
LIT Competency Statement	P2. Assume responsibility for dental hygiene actions and care based on accepted scientific theories and research as well as the accepted standard of care. PC 12. Provide specialized treatment that includes preventive and therapeutic services designed to achieve and maintain oral health. a. Perform dental hygiene interventions to eliminate and/or control local etiologic factors to prevent and control caries, periodontal disease, and other oral conditions. b. Control pain and anxiety during treatment through the use of accepted clinical and behavioral techniques. PC 13. Evaluate the effectiveness of the implemented clinical, preventive, and educational services and modify as needed. a. Determine the outcomes of dental hygiene interventions using indices, instruments, examination techniques, and patient self-report.		
Student		Date:	
Instructor		Perio Stage	H G I II III IV
Patient		Prophy Class	0 1 2 3 4 5 6 7 8
The following criteria will be used to determine a competency of 75% or higher on this evaluation. Failure to achieve a 75% will result in a retest.		Grade	<input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable

Seventy five percent (75%) is needed to be acceptable.		Possible Points	Points Earned
1	Case Selection	3	
2	Surface Selection requirements	5	
3	Calculus detection: 12 surfaces of calculus (3 teeth) (1 pt each)	12	
4	Periodontal Probing measurement exercise: 6 pockets (2 teeth) (1 pt each)	6	
5	Calculus removal (12 surfaces) (5.5 points each)	66	
6	Tissue management (1 pt deducted for each site of minor tissue trauma)	3	
7	All surfaces free of biofilm and extrinsic stain	1	
8	All surfaces free of supragingival and subgingival calculus	4	
	TOTAL POINTS EARNED	100	

COMMENTS:

FOLLOW UP APPOINTMENT WITH PERIODONTAL PATIENT

During the Fall semester, a periodontal patient was completed in the clinic setting. This patient had a care plan, formal patient education sessions, and was tracked on their progress throughout their treatment. This semester, the patient will return for a follow-up appointment. At this appointment, you will be reviewing all the patients' data collection and updating it where applicable. You will perform plaque and bleeding indices, gingival index, and a comparison periodontal charting.

Page 12 of this syllabus also specifies the procedures to be completed. Be thorough in the documentation and/or updates on this patient. At the conclusion of the treatment and after the patient education session, you will write a follow-up periodontal maintenance care plan comparing your findings from last semester to this semester. You will find the worksheet and rubric on pages 30-33.

All follow up care plans are to be turned in to Mrs. DeMoss within 72 hours after the data collection and patient education session are complete.

PATIENT EDUCATION COMPETENCY EVALUATION CHECKLIST:

Patient Education: This skill evaluation will be conducted in the patient education room.
See page 12 for more information regarding the patient education patient.

Session:

1. Utilizes time effectively and efficiently.
2. Uses current infection control procedures
3. Preparation of operatory is appropriate for procedure and effective instructional materials are present.
4. Professional behavior and ethical judgment demonstrated by;
 - providing for patient comfort
 - providing proper patient communication
 - accepting constructive criticism
 - adapting to new situations
 - instilling confidence in the patient
 - explaining procedures to the patient
 - exhibiting self-confidence to perform procedure
5. Student reviews progress towards ALL short and long term goals with patient from the Fall semester.
6. Student assists patient in evaluating his/her own oral condition and relates goals and methods of evaluation to the oral conditions present. (Patient carries out home regimen and the student discloses the patient.)
7. The student provides the patient with a comparison probe chart of CAL's generated by EagleSoft software. The probe chart from the Fall will be utilized to generate this form.
8. Modifies patient's technique in the patient's mouth. Evaluate technique by having patient demonstrate technique and re-disclose patient. Modify areas where indicated. (Based on plaque/bleeding scores.)
9. Student stresses the patient's responsibility for home/self-care in partnership with the clinician.
10. Student discusses current concepts of dental practice as well as basic principles of dental disease as they apply to the patient's needs. Instructions are individualized with the use of available visual aids, pamphlets and models.

Clinical-Advanced (DHYG 2262)

Spring 2021

11. The level of information is appropriate for the learning level of the individual.
12. The patient is involved in the learning process by answering questions, stating opinions or performing skills, etc., throughout the session.
13. The information and discussion follow a logical sequence starting with background knowledge and a review of what the patient is already aware of before advancing to new topics or more in-depth information.
14. The student actively searches for opportunities to provide positive reinforcement and provides that reinforcement.
15. Student reviews methods that are used to evaluate progress.
16. Student determines patient current oral health status by comparing to last semester and determines an appropriate recall interval based on information collected.

Clinical-Advanced (DHYG 2262)
Spring 2021

LIT Dental Hygiene Program			
<u>PATIENT EDUCATION SESSION COMPETENCY</u>			
DHYG 2262			
LIT Competency Statement	P2. Assume responsibility for dental hygiene actions and care based on accepted scientific theories and research as well as the accepted standard of care. P4. Communicate effectively with individuals and groups from diverse populations both verbally and in writing HP5. Promote the values of oral and general health and wellness to the public and organizations within and outside the profession. PC10. Use critical decision making skills to reach conclusions about the patient's dental hygiene needs based on all available assessment data. PC11c. Establish a collaborative relationship with the patient in the planned care to include etiology, prognosis, and treatment alternatives.		
Student		Date:	
Instructor		Perio Stage	H G I II III IV
Patient		Prophy Class	0 1 2 3 4 5 6 7 8
Any critical error results in a score of 'Not Acceptable' and the student must repeat the competency.		Grade	<input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable

The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.		Critical Error	Yes	No
1	Utilize accepted infection control procedures	Yes		
2	Apply basic and advanced principles of dental hygiene instrumentation	N/A	N/A	N/A
3	Maintain clinic and laboratory records	Yes		
4	Identifies patient needs, reviews goals, and identifies progress towards goals with patient	Yes		
5	Student reviews previous topics to verify patient understanding	Yes		
6	Assists patient in evaluating home care and modifies as needed	Yes		
7	Provided the patient with a comparison probe chart.	Yes		
8	Demonstrates oral hygiene procedures	No		
9	Emphasizes patient responsibility in oral health care partnership	Yes		
10	Individualizes instruction based on patient need and learning level	Yes		
11	Involves patient and provides positive reinforcement	No		
12	Determines recall schedule based on data collected from appointment	No		
Comments:				

PERIODONTAL MAINTENANCE CARE PLAN

Patient Name _____ Age _____
Date of initial exam _____ Date patient completed last semester _____
Date of periodontal maintenance visit(s) _____

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

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

3. Oral and Dental Examination Updates: (lesions noted, facial form, habits and awareness, consultation) and (caries, attrition, midline position, mal-relation of groups of teeth, occlusion, abfractions) Compare to last semester and note any changes or updates.

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

- a. Case Classification _____ Periodontal Case Type _____
- b. Gingival Description:

- c. Plaque Index: App't 1 _____ 2 _____
- d. Gingival Index: _____
- e. Bleeding Index: App't 1 _____ 2 _____
- f. Evaluation/Comparison of Indices:

- g. Periodontal Chart: (Periodontal Maintenance probe depth and recession data)

5. Treatment Plan: (Include assessment of patient needs and patient education plan)

App't 1:

App't 2: (if needed)

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

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

8. Assessment of Changes: (including plaque control, bleeding tendency, gingival health, probing depths, patient oral hygiene habits)

9. Self-Assessment: What did you feel that you did well with the patient? What improvements could be done? Were there any particular topics that you would have addressed differently? How?

PERIODONTAL MAINTENANCE CARE PLAN EVALUATION

LIT Dental Hygiene Competency	P3	<ul style="list-style-type: none"> Continuously perform self-assessment for lifelong learning and professional growth Systematically collect, analyze, and record data on the general, oral, psychosocial health status of a variety of patients. Use critical decision-making skills to reach conclusion about the patient’s dental hygiene needs based on all available assessment data. Provide specialized treatment that includes preventive and therapeutic services designed to achieve and maintain oral health. Evaluate the effectiveness of the implemented clinical, preventive, and educational services and modify as needed.
	PC9	
	PC10	
	PC12	
	PC13	

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

Topic area	Points	Excellent 5	Good 4	Fair 3	Unacceptable 2
Medical History		Identifies <u>many</u> systemic conditions altering treatment, steps taken to avoid medical problem, effect on dental hygiene diagnosis and/or care. Relates <u>many</u> medical history findings to periodontal disease: its progression, healing, and prevention	Identifies <u>several</u> systemic conditions altering treatment, steps taken to avoid medical problem, effect on dental hygiene diagnosis and/or care. Relates <u>several</u> medical history findings to periodontal disease: its progression, healing, and prevention	Identifies at least one <u>relevant</u> systemic condition altering treatment, steps taken to avoid medical problem, effect on dental hygiene diagnosis and/or care. Relates <u>at least one relevant</u> medical history finding to periodontal disease: its progression, healing, and prevention	<u>Fails</u> to identify any relevant systemic conditions altering treatment, steps taken to avoid medical problem, effect on dental hygiene diagnosis and/or care. <u>Fails</u> to relate any medical history finding to periodontal disease: its progression, healing, and prevention
Dental History		Identifies <u>many</u> elements of the dental history, its effect on dental hygiene diagnosis and/or care. Relates <u>many</u> dental history findings to periodontal disease: its progression, healing, and prevention	Identifies <u>several</u> elements of the dental history, its effect on dental hygiene diagnosis and/or care. Relates <u>several</u> dental history findings to periodontal disease: its progression, healing, and prevention	Identifies at least one <u>relevant</u> element of the dental history, its effect on dental hygiene diagnosis and/or care. Relates <u>at least one relevant</u> dental history finding to periodontal disease: its progression, healing, and prevention	<u>Fails</u> to identify any elements of the dental history, its effect on dental hygiene diagnosis and/or care. <u>Fails</u> to relate any medical history finding to periodontal disease: its progression, healing, and prevention
Oral and Dental Exams		Identifies <u>many</u> findings of the oral and dental exams, steps taken to avoid a medical problem, effect on dental hygiene diagnosis and/or care. Relates <u>many</u> exam findings to periodontal disease: its progression, healing, and prevention	Identifies <u>several</u> findings of the oral and dental exams, steps taken to avoid a medical problem, effect on dental hygiene diagnosis and/or care. Relates <u>several</u> exam findings to periodontal disease: its progression, healing, and prevention	Identifies at least one <u>relevant</u> finding of the oral and dental exams, steps taken to avoid a medical problem, effect on dental hygiene diagnosis and/or care. Relates <u>at least one</u> exam finding to periodontal disease: its progression, healing, and prevention	<u>Fails</u> to identify any finding on the oral and dental exams, steps taken to avoid a medical problem, effect on dental hygiene diagnosis and/or care. <u>Fails</u> to relate any exam finding to periodontal disease: its progression, healing, and prevention
Periodontal Exam					
Gingival Exam & Dental Indices		Describes <u>many</u> characteristics of the gingival exam by quadrant. Evaluates <u>many</u> of the indices and relates to periodontal disease	Describes <u>several</u> characteristics of the gingival exam by quadrant. Evaluates several of the indices and relates to periodontal disease	Describes <u>at least one</u> characteristic of the gingival exam by quadrant. Evaluates one index and relates to periodontal disease	<u>Fails</u> to describe any characteristics of the gingival exam by quadrant. <u>Fails</u> to evaluate any index and relate to periodontal disease

Clinical-Advanced (DHYG 2262)
Spring 2021

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

Late submissions will not be accepted.

Comments:

CRITERIA FOR ROOT DEBRIDEMENT COMPETENCY

- On this competency evaluation, the student must use the following instruments:
 - Anterior Gracey 1/2
 - Mesial Gracey 11/12 or 15/16
 - Distal Gracey 13/14 or 17/18
- This patient must be a Class III or higher and a perio case type III or higher.
- An instructor will select 2-3 teeth to be evaluated on during this competency evaluation.
- If the patient is a Class IV or higher, the ultrasonic may be used prior to beginning this competency.
- * = designates an advanced skill using the gracey curet

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

GENERAL MANAGEMENT

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

ACTIVATES ROOT DEBRIDEMENT STROKES

12. Holds curet in the modified pen grasp.
13. *Establishes a stable fulcrum (intra or extraoral).
14. *Determines correct working end of curet.

Clinical-Advanced (DHYG 2262)
Spring 2021

15. Places curette on the surface to be smoothed making sure the blade is flush against the tooth surface.
16. Inserts the tip under the free gingival to the epithelial attachment, being sure to keep blade angulation at 0 degrees.
17. *Establishes working angulation (45-90 degrees) with lower shank parallel to tooth surface.
18. Uses a light exploratory stroke coming back to the free gingival margin to confirm the confines of the pocket and topography of the root surface.
19. Applies lateral pressure against tooth with thumb and index finger.
20. *Demonstrates instrumentation of a furcation and/or concavity adjacent to the furcation
21. *Activates a series of moderate to light pull or push-pull strokes, starting with a short stroke and making each successive overlapping stroke a millimeter or so longer.
22. *Executes a controlled shaving stroke with moderate length.
23. *Demonstrates many, multidirectional strokes; covering the entire root surface.
24. Pivots on fulcrum and rolls instrument between thumb and index finger to adapt to the tooth surface.

EVALUATION BY FACULTY

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

Clinical-Advanced (DHYG 2262)
Spring 2021

LIT Dental Hygiene Program			
<u>ROOT DEBRIDEMENT COMPETENCY</u>			
DHYG 2262			
LIT Competency Statement	P2 Assume responsibility for dental hygiene actions and care based on accepted scientific theories and research as well as the accepted standard of care. PC12 Provide specialized treatment that includes preventive and therapeutic services designed to achieve and maintain oral health. a. Perform dental hygiene interventions to eliminate and/or control local etiologic factors to prevent and control caries, periodontal disease, and other oral conditions. b. Control pain and anxiety during treatment through the use of accepted clinical and behavioral techniques. PC13 Evaluate the effectiveness of the implemented clinical, preventive, and educational services and modify as needed. a. Determine the outcomes of dental hygiene interventions using indices, instruments, examination techniques, and patient self-report.		
Student		Date:	
Instructor		Perio Stage	H G I II III IV
Patient		Prophy Class	0 1 2 3 4 5 6 7 8
Any critical error results in a score of 'Unacceptable' and the student must repeat the competency.		Grade	<input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable

The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.		Critical Error	Yes	No
1	Utilize accepted infection control procedures	Yes		
2	Apply basic and advanced principles of dental hygiene instrumentation	Yes		
3	Maintain clinic and laboratory records	Yes		
5	Utilizes perio charting and radiographs for pocket depth and topography	Yes		
6	Explains procedure and rationale to their patient	Yes		
7	Utilizes sharp and correctly contoured instruments	No		
8	Obtains calculus removal on selected teeth without excessive tissue trauma	Yes		
9	Insures patient's comfort with appropriate anesthesia	Yes		
10	Demonstrates professional conduct and ethical judgment	Yes		
Comments:				

Clinical-Advanced (DHYG 2262)

Spring 2021

Geriatric Patient Competency Evaluation

Patient Requirements:

- 60 years of age or older, no exceptions.

Student Instructions:

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

Instructor Instructions:

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

Clinical-Advanced (DHYG 2262)
Spring 2021

LIT Dental Hygiene Program Competency Evaluation Geriatric Patient			
DHYG 2262			
LIT Competency Statement	PC9. Systematically collect, analyze, and record data on the general, oral, and psychosocial health status of a variety of patients. PC10. Use critical decision making skills to reach conclusions about the patient's dental hygiene needs based on all available assessment data. PC11. Collaborate with the patient, and/or other health professionals, to formulate a comprehensive dental hygiene care plan that is patient-centered and based on current scientific evidence. e. Obtain the patient's informed consent based on a thorough case presentation. PC12. Provide specialized treatment that includes preventive and therapeutic services designed to achieve and maintain oral health. a. Perform dental hygiene interventions to eliminate and/or control local etiologic factors to prevent and control caries, periodontal disease, and other oral conditions. PC13. Evaluate the effectiveness of the implemented clinical, preventive, and educational services and modify as needed.		
Student		Date:	
Instructor		Perio Stage	H G I II III IV
Patient		Prophy Class	0 1 2 3 4 5 6 7 8
Any critical error results in a score of 'Not Acceptable' and the student must repeat the competency.		Grade	<input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable

The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.		Critical Error	Yes	No
1	Utilize accepted infection control procedures	Yes		
2	Apply basic and advanced principles of dental hygiene instrumentation	No		
3	Maintain clinic and laboratory records	Yes		
4	Obtain a complete medical/dental history and release	Yes		
5	Explains procedure and rationale to their patient	Yes		
6	Perform an adequate oral assessment and record the information properly	No		
7	Present the patient with an appropriate informed consent/risk assessment which the patient, student, & faculty sign before treatment starts	Yes		
8	Obtains removal of calculus	Yes		
9	Selects appropriate polishing agent and uses sound polishing technique	Yes		
10	Flosses all interproximal surfaces	Yes		
11	Achieves an 85% or higher on the CER for this patient	Yes		
12	List any treatment modifications required or considered for this patient: You may use the back of this form. Submit to your clinical counselor with the chart audit.	Yes		

Clinical-Advanced (DHYG 2262)
Spring 2021

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

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

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

The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.		Errors	A	U
1	Correctly charted 6 probe depths per tooth from the pre and post-periodontal charting. (recorded as PD in EagleSoft)			
2	Correctly charted 6 tissue heights per tooth from the pre and post-periodontal charting. (recorded as GM in EagleSoft)			
3	Correctly charted any Furcations from the pre and post-periodontal charting. (recorded as FG in EagleSoft)			
4	Correctly charted any Mobility from the pre and post-periodontal charting. (recorded as MOB in EagleSoft)			
5	Correctly charted 6 bleeding points per tooth tooth from the pre and post-periodontal charting.			
6	Provided instructor with a copy of the probe chart printed from EagleSoft and the patient's chart.			
COMMENTS:				

Nutritional Counseling Project

PATIENT ASSESSMENT INSTRUCTIONS

Objectives

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

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

Procedure (All required form may be found on Blackboard)

- Fill out the LIT Caries Risk Assessment
- Type Food Diary and Carbohydrate Intake Analysis in Syllabus
- Counseling Session will be done with a patient
- Type Written Summary Report (one page)
- Place all forms in a binder or folder.

1. Food Diary Form

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

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

2. Fermentable Carbohydrate Analysis Worksheet

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

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

Clinical-Advanced (DHYG 2262)
Spring 2021

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

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

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

3. LIT Caries Risk Assessment

- Fill out the assessment

4. Written Summary: Total of 1 page

- A brief written summary of the counseling session will be due to the instructor the day after the counseling session is completed. You may email the summary to the faculty who listened to the session or to the Clinic Coordinator (rssandusky@lit.edu). State which faculty listened to your counseling session. The summary should include information from the session that identifies eating habits and nutritional choices that impact the patient's oral health. It should also include healthy options given to the patient to improve their oral health. The summary should conclude with statements addressing what was learned from the nutritional counseling session, what you did that was good about the session, and how you could improve. One statement should include what the patient learned and one should include what the student learned.
- **Professionalism**
Edit your paper.
 - Grammar/spelling
 - Completeness—did you turn in all parts of the assignment? Neatness
 - Accuracy—correct values and calculations, information presented, appropriate dental terms
 - Logic of conclusions and appropriateness of recommendations—your conclusions must be consistent with the evidence, and your recommendations must be in line with current nutrition knowledge

Evaluation

Place the completed project in a binder or folder in a daily order below. The binder or folder will be turned in at the time of the nutritional session. Your written summary should be compiled and turned in by 12:00 P.M. on the DAY FOLLOWING YOUR NUTRITIONAL COUNSELING SESSION. It can be emailed to the faculty who listened to the session or to the Clinic Coordinator (lrharrell@lit.edu) if needed. Ten percent will be deducted from the total grade of the project for each day (except weekends) that it is late.

Clinical-Advanced (DHYG 2262)
Spring 2021

- Place report in a binder in the following order:
 - o LIT Caries Risk assessment
 - o Food diaries in a daily order
 - o Carbohydrate intake analysis behind each corresponding day (average all days on the last day)
 - o Written report

You are graded on the written summary and oral counseling. See page 46-47 for Nutritional Skill Evaluation Rubric.

Clinical-Advanced (DHYG 2262)

Spring 2021

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

PATIENT NAME: _____

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

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

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

Clinical-Advanced (DHYG 2262)
 Spring 2021
Food Diary Form

FOOD DIARY				
Day _____				
TIME	PLACE	FOOD EATEN	AMOUNT EATEN	HOW PREPARED
Instructions: 1. List <i>everything</i> you eat or drink on 3 consecutive, typical days. 2. Use 2 weekdays and 1 weekend day. 3. Include extras such as chewing gum, sugar and cream in coffee, or mustard on a sandwich.				

Clinical-Advanced (DHYG 2262)
Spring 2021

Patient Nutritional Counseling Skill Evaluation

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

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

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

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

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

Clinical-Advanced (DHYG 2262)
Spring 2021

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