CLINICAL ADVANCED (DHYG 2262.7A1, DHYG 2262.7B1, DHYG 2272.7C1, DHYG 2262.7D1, DHYG 2262.7E1)

LAMAR INSTITUTE OF TECHNOLOGY

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

MODE OF INSTRUCTION
Face to Face

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

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

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

- The student will demonstrate the ability to provide therapeutic dental care directed toward the treatment of oral disease at appropriate competency levels.
- 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 advanced periodontitis.
- The student will accept responsibility to develop a professional and ethical value system while providing comprehensive dental hygiene services within the health care community.

INSTRUCTOR CONTACT INFORMATION

Instructor: Lisa Harrell, RDH, BS

Clinic faculty:

Michelle DeMoss, RDH, MS
Kristina Mendoza, RDH, DMD
Cynthia Thompson, RDH, BS
Lacey Blalock, RDH, BS
Tami Browning, RDH
Rebecca Ebarb, RDH, BS
Michelle Hidalgo, RDH
Leslie Carpenter, RDH, BS
Mary Dinh, RDH, BS
Debbie Brown, RDH, MS
William Nantz, DDS
Roland Williams, DDS
Terry German, DDS
Robert Wiggins, DDS
Harriett Armstrong, DDS
Joshua Seale, DDS

Email: lrharrell@lit.edu

Office Phone: (409) 247- 4884

Office Location: MPC 206

Office Hours: TBA

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

COURSE CALENDAR

DATE	TOPIC	READINGS (Due on this Date)	ASSIGNMENTS (Due on this Date)
Week 1	First week of Clinic		
Week 4	Progress Check Week		Check in with clinical advisor
Week 6	Radiographic Evaluation		Testing on Blackboard
Week 8	Mid-Semester Clinical Counseling		Check in with clinical advisor
Week 9	SPRING BREAK		NO CLINIC OR CLASSES
Week 10	Clinical Evaluation Testing		Test patient only on these days
Week 12	Progress Check Week		Check in with clinical advisor
	GOOD FRIDAY		NO CLINIC
Week 15	Last Tuesday Clinic		
	Last Wednesday Clinic		
	Last Thursday Clinic		
	Last Monday Clinic		
	Last Friday Clinic		This is a Tuesday for Friday people
	All requirements due		All requirements include all radiographs, retakes, and chart audits.
Week 16	Final Clinic Counseling Week		Check in with clinical advisor
Week 16	ADEX Clinical Testing Exam		
TBA	Clinic Clean Up and Check out		See posted schedule
TBA	Graduation!		

Approved: Initials/date

ATTENDANCE POLICY

Absenteeism

In order to ensure the students in the dental hygiene program achieve the necessary didactic and clinical competencies outlined in the curriculum, it is necessary that the student complete all assigned lecture classes, clinical and laboratory hours. It is the responsibility of the student to attend class, clinic or lab. The instructor expects each student to be present at each session.
It is expected that students will appear to take their exams at the regularly scheduled examination time. Make-up examinations will be given **only** if the absence is due to illness (confirmed by a physicians' excuse), a death in the immediate family, or at the discretion of the instructor.
If students are unable to attend lecture class, clinic or lab, it is **mandatory that you call the appropriate instructor prior to the scheduled class, clinic or lab time**. **An absence will be considered unexcused if the student fails to notify the course faculty prior to the start of class, clinic, or lab. Attendance through Blackboard Collaborate is considered an absence. The course instructor must be notified at least one hour prior to the beginning of class/lab if the student plans to attend through Blackboard Collaborate.** The student is responsible for all material missed at the time of absence. If a student is too ill to attend class, this will require an absence in clinic on the same day unless the student has Dr. permission to be on campus. Any other absence in clinic will be dealt with on an individual basis and must be discussed with the 2nd year clinic coordinator. Extenuating circumstances will be taken into account to determine if the absence is excused. Extenuating circumstances might include but are not limited to funeral of immediate family member, maternity, hospitalization, etc. If the student has surgery, a debilitating injury, or an extended illness, a doctor's release will be required before returning to clinic.

a. **Fall/Spring Semesters:**
   Dental hygiene students will be allowed **two excused absences** in any lecture, clinic or lab. Absences must be accompanied by a written excuse on the next class day. In the event that a student misses class, clinic or lab beyond the allowed absences, the following policy will be enforced:
   2 absences = notification in Starfish
   Beginning with the third absence, **2 points** will be deducted from the final course grade for each absence thereafter.
   Two (2) points will be deducted from the final course grade for each unexcused absence.

Tardiness

Tardiness is disruptive to the instructor and the students in the classroom. A student is considered tardy if not present at the start of class, clinic or lab. It is expected that students will arrive on time for class, clinic or lab, and remain until dismissed by the instructor. If tardiness becomes an issue, the following policy will be enforced:

Tardy 1 time = notification in Starfish
Tardy 2 times = is considered an unexcused absence. (See the definition of an unexcused absence)

If a student is more than 15 minutes late to any class period, it will be considered an unexcused absence.

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

DROP POLICY

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

STUDENT EXPECTED TIME REQUIREMENT

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

ACADEMIC DISHONESTY

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

TECHNICAL REQUIREMENTS

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

DISABILITIES STATEMENT

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

STUDENT CODE OF CONDUCT STATEMENT

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

note that the online version of the *LIT Catalog and Student Handbook* supersedes all other versions of the same document.

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

ADDITIONAL COURSE POLICIES/INFORMATION

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

Students are expected to complete examinations as scheduled. Make-up examinations will be given ONLY if the absence is due to illness (confirmed by a physicians' excuse), a death in the immediate family, or at the discretion of the Instructor. All make-up examinations must be taken within two (2) weeks from the scheduled exam date. All examinations will be kept on file by the Instructor. Students may have access to the examination by appointment during the Instructor's office hours. Exams may be reviewed up to two (2) weeks following the exam date. **You may not copy, reproduce, distribute or publish any exam questions**. This action may result to dismissal from the program. A grade of "0" will be recorded for all assignments due on the day of absences unless prior arrangements have been made with the Instructor.

Respondus Lockdown Browser and Respondus Monitor will be used for examinations therefore, a webcam is required to take the test. The student is required to show the testing environment at the beginning of the exam to assure the instructor that it is clear of any study materials. Failure to do so will result in a 10-point exam grade deduction.
If you need online assistance while taking the test, please call Online Support Desk at 409-951-5701 or send an email to lit-bbsupport@lit.edu.

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

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

Electronic Devices

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

Late coursework

Assignments, Quizzes and Tests must be completed by the due date. Late submissions or completion will not be accepted and will result in a zero for that assignment/quiz/test.

Remediation

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

*** Faculty has the authority to modify the above policies if unusual circumstances mandate a change. Please refer to the Student Handbook for a complete listing of program policies.**

COURSE REQUIREMENTS

See grading rubric on following page

COURSE EVALUATION

Each student must meet minimal competency for all requirements in order to pass DHYG 2262. Criteria for achieving a grade of "A", "B", "C", "D" or "F" can be found on page 8 and 9 of this syllabus. <u>All</u> 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 last week of clinic, **<u>this includes radiographs, retakes, and initial chart audits.</u>** Failure to complete chart audits by due date could result in receiving no credit for the patient. Failure to successfully complete all course requirements will result in receiving an "F" in DHYG 2262 and dismissal from the DH program. Exclusions from this policy will be dealt with at the discretion of the program faculty.

See grading rubric on the following page.

GRADING SCALE

	A	B	C	D/F
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 all requirements for a grade of "C".
Adult Patients (A)	8	8	8	
Geriatric Patients (G)	2	2	2	
Special Needs Patients	3	2	2	
Perio Stage	Stage I & II = 4 patients			
	Stage III & IV = 3 patients			
X-rays = Total #	4 FMX, 4 BWX, 1 PNX	4 FMX, 4 BWX, 1 PNX	4 FMX, 4 BWX, 1 PNX	
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	
Professional Judgment & Ethical Behavior	Average of 40	Average of 39	Average of 38	Average of below 38
Community service (optional)				
Cancellation	Over 20 hours of cancellation will lower Clinic grade by one letter grade			

Approved: Initials/date

	A	B	C	D/F
Treatment plans				
Nutritional Counseling	Passing on initial attempt (75% or higher)	Passing on second attempt	Passing on second attempt	
Periodontal Maintenance Patient	90 and above	86 – 89	85 or lower	
Written evaluations				
Radio- graphic Evaluation 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				
Clinical Evaluation	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 Teaching Using the Pod System
The Pod System will be utilized in the clinic setting to enhance student learning. The Pod system requires each clinical instructor be assigned to specific cubicles in order to create smaller groups within the clinic. Working in pods emphasizes one-on-one teaching, continuity of instruction and closer monitoring of student progression.

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. As stated in the Clinic Manual, documentation is an important part of professional judgement. Students are expected to create and maintain the patient record accurately, completely, and legibly. Three or more U's in chart audits will result in a one point deduction from the student's **Professional Behavior and Ethical Judgement** semester average.
The average 38 points must be obtained to meet minimal clinic requirements.

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 CERs will result in a one point deduction from the student's **Professional Behavior and Ethical Judgement** semester average.
Faculty has the authority to modify the above policies if unusual circumstances mandate a change. Please refer to the Student Handbook for a complete listing of program policies.

TEACHING METHODS

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

DENTAL HYGIENE STUDENT CER POLICY

- CERs can only be pulled by Clinic Admin or Clinic counselor.
- CERs are to remain in clinic office, unless in active use.
- If an instructor/ counselor wishes to remove CERs from the clinic office, they must check them out from the clinic admin.
- Patient CERs will be pulled daily by clinic admin for all patients listed in appt. book, and distributed to the students scheduled in clinic.
- Patient CERs must be turned back into clinic admin, by the student, at the end of each clinic session for grade entry.

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. Surveys must be critiqued within 1 week of the survey. (i.e., Survey taken on Tuesday morning = due by the following Monday). Surveys turned in after one week of taking may not be graded for credit.

- **All radiographs must be completed and submitted by last week of clinic**.
- 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.

Submitting Digital Critique Sheets

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

Radiographic Interpretation Evaluations

The student will be required to successfully complete one radiographic interpretation. This evaluation requires the student to identify landmarks, suspicious areas, restorations, unusual conditions and technique errors 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 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	Three (3) 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.**

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

*Dental hygiene students may treat ONE hygiene student or faculty/staff member per semester for requirements. 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 Clinical Evaluation test 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.
Sealants can **only** be placed after completion of **all** scaling, all quadrants have been graded on the CER and polishing/plaque free has been completed and graded. Pumice should be used after the polishing procedure only on the teeth to be sealed. Fluoride is placed after the sealants have been checked.

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 **Clinical Evaluation** patient. Only subgingival "clickable" calculus will be recorded for the calculus detection patients.

Periodontal Maintenance Patient/Patient Education Patient

The periodontal patient from the Fall semester will be utilized for one, formal Periodontal Maintenance patient education session and a post-care plan comparing all the patient's data and progress. The patient education competency will be conducted in the patient education room. The student will schedule the periodontal patient for a maintenance appointment. During the periodontal maintenance 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, CAL, furcation areas and mobility, bleeding score and plaque score. The patient education session will be done after all data collection, informed consent, and risk assessment have been completed. You will need to plan ahead for this session. 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 and/or introduce a supplemental oral hygiene aide (interproximal brush, etc.).

NOTE: If a student's periodontal patient from the Fall semester absolutely cannot return in the Spring for a periodontal maintenance, you must select another patient that will meet the requirements for this competency. The alternate patient will need to be approved by Mrs. DeMoss and MUST meet the following criteria: be a patient that was seen by the student in the Fall semester; have periodontitis; received chairside patient education (this should be done with all patients); and preferably be a good candidate to administer Arestin.
See page 26 for more detailed information regarding the Periodontal Maintenance Patient and 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 (A) patients, (19 years of age or older) either prophy Class I or Class II, and must be successfully completed in a 2 hour time segment or less. The student will class the patient their own patient. If a faculty screens and classes the patient, they will be ineligible as a Private Practice patient, however, the student will still get the points for the patient. **One of these patients needs to be a perio case type III or IV.** Documentation of the time will be recorded on the CER by an instructor and initialed.

- **The two hour time period includes all data collection, scaling, 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 Periodontal Charting

The student will complete one periodontal charting using the EagleSoft software. The student will use their Periodontal patient from the Fall/Spring Periodontal Maintenance. The student will use the **pre- and post- full** periodontal charting from the perio patient's chart from **Fall semester** and transfer the periodontal charting information to the computer using the EagleSoft software. The student will print the comparison chart of all periodontal findings to use in the patient education session. A copy of the printed periodontal comparison chart will be turned into Mrs. DeMoss with the patient chart, after Periodontal Maintenance is completed. A PowerPoint of the steps for this evaluation has been provided on Blackboard. The evaluation form is found in this syllabus on page 38.

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 and former patient education patients may not be used for the nutritional counseling session. Each student must complete all required forms (same as used for the Personal Food Diary Project). The student will bring the patient in the clinic on their clinic day for a one-on-one counseling session in the patient education room. If the student has finished treatment on this patient, the patient must be willing to return for the counseling session. All completed clinical forms will be turned in at the time of the counseling session. The written summary will be due by 12:00 pm the next school day after the session. The summary should be emailed to the instructor who listened to the counseling session.
Evaluation criteria are outlined on the Nutritional Counseling Evaluation form found at the end of this syllabus. A grade of at least 75% must be obtained to be considered acceptable.

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 documented including: 4mm or greater pockets, recession, furcation and mobility. When any of these abnormal conditions are found, all of the following must be documented for that **specific zone** of the tooth: pocket depth, tissue height (TH), and CAL. Each patients' periodontal classification should then be determined using clinical attachment loss (CAL) as the first indicator, radiographic bone loss is used second; this will help determine the most accurate periodontal diagnosis. The exception to this is the 2nd year periodontal patient, in which all readings must be documented for each tooth.

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 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, 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 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 CER grade. (IE. areas 29D, 30M and 25L were found on initial checking of scaling which makes 3 errors. When the instructor checks after spot removal, the area on 29D is still present. This student would then have 4 errors on this patient.)

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 on any type of patient as long as there are no contraindications on the medical history. Students will only be graded on the use of the Ultrasonic on patients prophy class IV and above, unless otherwise documented by an instructor. Usage of the Ultrasonic scaler that is contraindicated on a patient will receive an Unsatisfactory grade on the Professional Judgement form for that day and no credit for the patient.

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 and will receive a U in Comprehensive Care.

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

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.

- 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 prophy class re-evaluated by an instructor. This must be done during or after the completion of one quadrant. Patient classification will not be changed if more than one quadrant has been scaled.

Patient Dismissal

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

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

Progress Checks and Clinical Advising

Students must meet with assigned instructor on the designated dates. 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 complete random chart audits on all students throughout the semester. Students are still required to complete a chart audit checklist and have each chart ready for potential audit within one week of completing the patient. After patient completion and student self-audit, student must submit a digital copy of the CER into the DHYG 2262 Blackboard submission link. This **must** be done within one week of completing the patient, in order for the faculty advisor to monitor patient completion and randomize audits. When a chart audit is found with errors, the student will receive an "unacceptable" on the CER. Receiving unacceptable grades on CER will affect the patients overall CER grade. This may determine whether the student will get credit for the patient.
Three or more U's in chart audits will result in a one point deduction from the student's **Professional Behavior and Ethical Judgement** semester average. A student with three or more "unacceptable" chart audits will need to schedule a time with their clinical advisor to have all patient files audited. The student will remain with the instructor while the charts are audited.

Sterilization Duty

Each student is assigned 6 clinic sessions of sterilization. Students are expected to arrive 15 minutes before the clinic session begins to help assist in getting clinic ready. Upon arrival, students on sterilization duty must sign in at the clinic front office. The penalty for arriving later than 15 minutes prior to the beginning of clinic will result in an additional sterilization duty done outside of the students assigned clinic day. This will be scheduled with the 2nd year clinic coordinator. Students are not to use assigned sterilization time for personal business, such as auditing charts, studying, sharpening instruments, or computer/phone use. The penalty for conducting personal business during sterilization duty is an extra 4 hours of sterilization duty outside of the student's regular clinic day.

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

Special Needs Patients

Please refer to the clinic manual for guidelines on patients with special needs and considerations.

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

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

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

GRADE/QUADRANT

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

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

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

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

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

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

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

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

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

Approved: Initials/date

STUDENT AND FACULTY ACADEMIC AND CLINICAL COUNSELING ASSIGNMENTS

Harrell	Mendoza	DeMoss
Ali	Gier	Melancon
Bhakta	Hodges	Merkelz
Bragg	Jones	Miller
Byrd	Lanier	Nicholson
Castillo	LeDoux	Potato
Clark	Luu	Tan
Diaz	Maredia	Verdinez
Espinoza	Medina	Woods
Garcia	Sifuentes	

PROGRESS CHECKS

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 4
Week 12

MID-SEMESTER CLINICAL COUNSELING
Week 8

FINAL CLINICAL COUNSELING
Week 15

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

Chart Audits will be completed by the student after patient care is completed. These will be randomly checked by the faculty advisor. However, it is the responsibility of the student to make sure that charts are accurate and ready for audit.

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

INSTRUCTIONS FOR MID-SEMESTER CLINICAL COUNSELING

STUDENTS:

1. Bring your CER's, x-ray critique sheets, appointment book, skill evaluation grade sheets (unless already submitted in Blackboard).
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.

Approved: Initials/date

INSTRUCTIONS FOR FINAL CLINICAL COUNSELING

STUDENTS:

1. Bring your CER's, x-ray critique sheets, appointment book, skill evaluations not in Blackboard- 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 Clinic Administrative Associate at Clinic Clean-up.

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 (A) (completed) ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Adolescent Patients (Y) (completed) ___ ___ ___ ___ ___
Geriatric Patients (G) (completed) ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Special Needs Patients (completed) ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

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

CLINICAL EVALUATION COMPETENCY

Clinical Evaluation Competencies will be scheduled on TBA.

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

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

- **CALCULUS DETECTION**: Each tooth has four surfaces: mesial, distal, facial and lingual. A qualifying surface is a tooth surface upon which there is "clickable" subgingival calculus. A 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 Clinical Evaluation patient as part of the evaluation. The student will chart **6 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.

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

On the day of the Clinical Evaluation Competency exam, the student will review the medical/dental history and obtain all necessary signatures before beginning.

The 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-in by one faculty.

Anesthesia may be used on this examination.

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

The student 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 prophy 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.

<table>
<tr><td colspan="5">LIT Dental Hygiene Program
CLINICAL EVALUATION COMPETENCY</td></tr>
<tr><td colspan="5">DHYG 2262</td></tr>
<tr><td>LIT Competency Statement</td><td colspan="4">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.</td></tr>
<tr><td>Student</td><td></td><td>Date:</td><td colspan="2"></td></tr>
<tr><td>Instructor</td><td></td><td>Perio Stage</td><td colspan="2">H G I II III IV</td></tr>
<tr><td>Patient</td><td></td><td>Prophy Class</td><td colspan="2">0 1 2 3 4 5 6 7 8</td></tr>
<tr><td colspan="2">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.</td><td>Grade</td><td colspan="2">☐ Acceptable
☐ Unacceptable</td></tr>
</table>

	Seventy five percent (75%) is needed to be acceptable.	Possible Points	Points Earned
1	Case Selection (current FMX or pano, appropriate anesthesia, complete exam in 2 hours)	3	
2	Surface Selection requirements (12 clickable surfaces, no Class 3 furcation or mobility, ortho bands, or 6mm+ pockets)	5	
3	Calculus detection: 12 surfaces of calculus (3 teeth) (1 pt each)	12	
4	Periodontal Probing measurement exercise: 12 pockets (2 teeth) ($^1/_2$ 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 Final case presentation: Clean pt napkin, mouth rinsed, tray & instruments clean & tidy.	4	
	TOTAL POINTS EARNED	100	

COMMENTS:

Approved: Initials/date

PERIODONTAL MAINTENANCE 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 periodontal maintenance appointment. At this appointment, you will be reviewing all the patient data collection and updating it where applicable. You will perform plaque and bleeding indices, gingival index, and 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 periodontal maintenance post-care plan comparing your findings from last semester to this semester. You will discuss the relationships of your findings to the patient's state of periodontal disease progression. Care plan template and rubric are on pages 31-33.

All post-care plans are to be turned in to Mrs. DeMoss through DHYG 2262 Blackboard, within 72 hours of completing patient treatment. Student will also submit the patient chart with periodontal charting comparison print-out to Ms. DeMoss for grading.

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.) Student may introduce a supplemental OH aide, if indicated.
9. Student stresses the patient's responsibility for home/self-care in partnership with the clinician.
10. Student discusses current concepts of dental practice as well as basic principles of dental disease as they apply to the patient's needs. Instructions are individualized with the use of available visual aids, pamphlets and models.
11. The level of information is appropriate for the learning level of the individual.

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

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

The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.		Critical Error	Yes	No
1	Utilize accepted infection control procedures	Yes		
2	Apply basic and advanced principles of dental hygiene instrumentation	N/A	N/A	N/A
3	Maintain clinic and laboratory records	Yes		
4	Identifies patient needs, reviews goals, and identifies progress towards goals with patient	Yes		
5	Student reviews previous topics to verify patient understanding	Yes		
6	Assists patient in evaluating home care and modifies as needed	Yes		
7	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:				:

Approved: Initials/date

<u>PERIODONTAL MAINTENANCE POST-CARE PLAN TEMPLATE</u>
Patient Name____ Age_____
Date of initial exam ___________ Date post-perio (fall semester) ______
Date of periodontal maintenance visit(s)_____________________

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

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

____

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

a. Prophy Class _____ Periodontal Stage & Grade______
b. Gingival Description:
c. Plaque Index: Appt 1_____ 2_____
d. Gingival Index: ______
e. Bleeding Index: Appt 1_____ 2_____
f. Comparison of indices from last semester to now & relationship to perio:

____

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

____

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

Appt 2: (if needed)

____

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

____

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

---

9. Assessment of Changes and Goal Progress:

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

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

Approved: Initials/date

DATE________________________
NAME____

PERIODONTAL MAINTENANCE POST-CARE PLAN EVALUATION

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

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

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

Approved: Initials/date

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

Late submissions will not be accepted.
Comments:

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.
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 stoke a millimeter or so longer.
22. *Executes a controlled shaving stroke with moderate length.
23. *Demonstrates many, multidirectional strokes; covering the entire root surface.
24. Pivots on fulcrum and rolls instrument between thumb and index finger to adapt to the tooth surface.

<u>EVALUATION BY FACULTY</u>

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

LIT Dental Hygiene Program

ROOT DEBRIDEMENT COMPETENCY

DHYG 2262

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

	The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.	Critical Error	Yes	No
1	Utilize accepted infection control procedures	Yes		
2	Apply basic and advanced principles of dental hygiene instrumentation	Yes		
3	Maintain clinic and laboratory records	Yes		
5	Utilizes 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:

Geriatric Patient Competency Evaluation
Patient Requirements:

- 60 years of age or older, no exceptions.

Student Instructions:

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

Instructor Instructions:

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

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

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

COMMENTS:

Approved: Initials/date

LIT Dental Hygiene Program **EagleSoft Software Periodontal 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	☐ Acceptable ☐ Unacceptable

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

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

The student, in accordance with the standards set forth by the ADA and the Dental Hygiene Program, has demonstrated the following criteria.		Errors	A	U
1	Correctly charted 6 probe depths per tooth from the 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:

Approved: Initials/date

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.

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

D. The Fermentable Carb Analysis Worksheet is to be typed and placed directly with each Day of Food Diary that it corresponds to. Ex. Day 1 of Food Diary has a corresponding Ferm Carb Worksheet. Label Both as Day 1, Day 2 etc.
E. Average the three days on the last day. You will need the average**.**

3. LIT Caries Risk Assessment

- Fill out the assessment

4. Written Summary: Total of 1 page

- 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. 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

<u>Evaluation</u>

Place the competed project in a binder or folder in a daily order below. The binder or folder will 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 will be emailed to the faculty who listened to the session. Ten percent will be deducted from the total grade of the project for each day (except weekends) that it is late.

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

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

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

PATIENT NAME: ______________________________

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

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

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

Approved: Initials/date

Food Diary Form

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

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

Carbohydrate Intake Analysis Worksheet

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

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

____ + _____ + _____ = _______/3=______

Approved: Initials/date

Patient Nutritional Counseling Skill Evaluation

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

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

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

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

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

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