# 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
Rebecca Ebarb, RDH, BS
Michelle Hidalgo, RDH
Leslie Carpenter, RDH, BS
Ronnie Cruz, RDH, BS
Renee Sandusky, RDH, BS
William Nantz, DDS
Roland Williams, DDS
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Robert Wiggins, DDS
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Office Phone: (409) 247- 4884

Office Location: MPC 206


Office Hours: Mondays 9:00 am – 10:30 am; Tuesdays 12:30 pm – 2:30 pm; Wednesdays 11:30 am – 12:30 pm; Thursdays 10:00 am – 2:00 pm

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

**COURSE CALENDAR**

| DATE | | ADDITIONAL INFORMATION |
|---|---|---|
| | | |
| Week 1 | First Day of Clinic | |
| Week 2 | TMOM Pre-Screening Day | Friday – 1:00 pm – 5:00 pm |
| | | |
| Week 4 | TDHA/SCADHA Conference | San Marcos, TX |
| Week 4 | Progress Check Week | Check in with clinical advisor |
| Week 6 | NO CLINIC (FRIDAY) | TMOM Event – Lumberton, TX |
| Week 6 | Radiographic Evaluation | Testing on Blackboard |
| | | |
| Week 7 | Mid-Semester Clinical Counseling | Check in with clinical advisor |
| | SPRING BREAK | NO CLINIC OR CLASSES |
| Week 8 | Clinical Evaluation Testing | Test patient only on these days |
| | NO CLINIC | Good Friday Holiday |
| | | |
| Week 10 | MANIKIN TESTING | NO PATIENTS SCHEDULED |
| Week 10 | Progress Check Week | Check in with clinical advisor |
| Week 13 | Last Tuesday Clinic | |
| Week 13 | Last Wednesday Clinic | |
| Week 13 | Last Thursday Clinic | |
| Week 14 | NATIONAL BOARD EXAM – ALL STUDENTS | Peason Vue Professional Center – Houston NW Center |
| Week 14 | Last Monday Clinic | |
| Week 14 | Friday Clinic | This is a Tuesday (8:00 am – 12:00 pm) |
| Week 14 | Last Friday Clinic | This is a Wednesday (1:00 pm – 5:00 pm) |
| Week 14 | All requirements due by 12:00 pm | All requirements include all radiographs, retakes, and chart audits. |
| Week 15 | Final Clinic Counseling Week | Check in with clinical advisor |
| **MAY** | | |
| Week 15 | ADEX Clinical Testing Exam | LIT Clinic |
| Week 16 | Clinic Clean Up and Check out | Duties and instructions TBD |



Approved: Initials/date

**ATTENDANCE POLICY**

***Absenteeism***

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

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

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

Dental hygiene students are required to makeup all excused absence clinic sessions and must be scheduled with the clinic coordinator.

If a student has an unexcused absence, they will receive a written disciplinary action form which will be placed in the student's permanent record and a Professional Judgement and Ethical Behavior form will be given which may affect the students overall Professional Judgement and Ethical Behavior average.

Any unexcused absence will be added to Cancellation time Clinical Evaluation Record (CER) and the student will lose that clinic time.

***Tardiness***

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

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

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

**DROP POLICY**

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

**STUDENT EXPECTED TIME REQUIREMENT**

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

**ACADEMIC DISHONESTY**

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

**TECHNICAL REQUIREMENTS**

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

**DISABILITIES STATEMENT**

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

**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**

***Assignment and Examination Policy***

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

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

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

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

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

***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 clinic. Texting on cell phones will not be allowed during clinic.

***Late coursework***
Assignments 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/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 7 and 8 of this syllabus. All criteria must be met in each grading category in order to achieve the desired grade. (EXAMPLE: If all criteria, except one, are met for a grade of "B" then the student would receive a grade of "C".) These criteria place the responsibility for learning in the hands of the student and are meant to identify those who strive for excellence in the clinical setting.

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

All course work must be successfully completed and turned in by April 25 at 12:00 PM, **this includes radiographs, retakes, and initial chart audits.** Failure to complete chart audits by due date could result in receiving no credit for the patient. Failure to successfully complete all course requirements will result in receiving an "F" in DHYG 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 |
|---|---|---|---|---|
| **Grading Scale Requirements (GSR)** | | | Minimal Competency | |
| Total Patient Points (GSR 1) | 48 Total points<br>22 points in Class III and above | 45 Total points<br>19 points in Class III and above | 42 Total points<br>16 points in Class III and above | Does not meet <u>all</u> requirements for a grade of "C". |
| Adult Patients (A) (GSR 2) | 8 | 8 | 8 | |
| Geriatric Patients (G) (GSR 3) | 2 | 2 | 2 | |
| Assessment Data: Med/dent history, oral exams, periodontal assessment, dental charting, polishing/plaque free (GSR 4) | 12 | 11 | 10 | |
| Full Periodontal Charting (GSR 5) | 1 | 1 | 1 | |
| Special Needs Patients (GSR 6) | 3 | 2 | 2 | |
| Periodontal Stage Category (GSR 7) | Stage I & II = 4 patients | | | |
| | Stage III & IV = 3 patients | | | |
| Perio Grade Category (GSR 8) | Grade A & B = 4 patients | | | |
| | Grade C = 1 patient | | | |
| Radiographic Surveys = Total # (GSR 9) | 4 FMX, 4 BWX,<br>1 PNX | 4 FMX, 4 BWX,<br>1 PNX | 4 FMX, 4 BWX,<br>1 PNX | |
| | *3 FMX & 3 BWX with Sensor<br>*1 BWX w/NOMAD & bisecting angle | *3 FMX & 3 BWX with Sensor<br>*1 BWX w/NOMAD & bisecting angle | *3 FMX & 3 BWX with Sensor<br>*1 BWX w/NOMAD & bisecting angle | |

| | | A | B | C | D/F |
|---|---|---|---|---|---|
| Calculus detection (GSR 10) | | 1 patient/IV or V<br>Pass 1st attempt | 1 patient/IV or V<br>Pass 2nd attempt | 1 patient/IV or V<br>Pass 2nd attempt | |
| Eagle Soft Probe Chart (GSR 11) | | 1 Probe chart<br>Pass 1st attempt | 1 Probe chart<br>Pass 2nd attempt | 1 Probe chart<br>Pass 2nd attempt | |
| Private practice patients (GSR 12) | | 6 patients | 5 patients | 4 patients | |
| Sealants (GSR 13) | | 4 patients | 3 patients | 2 patients | |
| Ultrasonic quadrants (GSR 14) | | 12 quadrants | 10 quadrants | 8 quadrants | |
| Professional Judgment & Ethical Behavior (GSR 15) | | Average of 40 | Average of 39 | Average of 38 | Average of below 38 |
| Community service (GSR 16) | | 5 hours | 4 hours | 3 hours | |
| Cancellation (GSR 17) | | Over 20 hours of cancellation will lower Clinic grade by one letter grade | | | |
| **Treatment plans** | | | | | |
| Nutritional Counseling (GSR 18) | | Passing on initial attempt (75% or higher) | Passing on second attempt | Passing on second attempt | |
| Periodontal Maintenance Patient (GSR 19) | | 90 and above | 86 – 89 | 85 or lower | |
| **Written evaluations** | | | | | |
| Radiographic Evaluation (GSR 20) | 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*** | Meet minimal competency on any all evals. on initial try. | Meet minimal competency on any 4 evals on initial try. | Meet minimal competency | Does not meet all requirements for a grade of "C". |
|---|---|---|---|---|
| Clinical Evaluation **(GSR 20)** | See above | See above | See above | |
| Root Debridement (GSR 21) | See above | See above | See above | |
| Geriatric Patient (GSR 22) | See above | See above | See above | |
| Patient Education | See above | See above | See above | |
| Manikin Mock Board | 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.

**Grading Scale Requirements (GSR) Defined:**

**GSR 1: Total Patient Points**

The total points required for each grade category is defined in the previous table. Total patient points will be dependent on the grade the student is striving to attain. Each student must ensure that they are obtaining the total points required, as well as, the number of points designated for Class 3 and higher patients. The remainder of the points can be obtained in any prophy classification points that the student desires. In order for the student to be awarded the points for the patient, the patient must be completed at a competency level of 85% or higher on the Clinical Evaluation Record (CER).
A minimum of two (2) quadrants must be satisfactorily scaled and graded (all spot checks done) in order to receive 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 by receiving an Unsatisfactory in the Comprehensive Care grade on the CER. Cases of incomplete patients will be addressed on an individual basis and action on these cases will be at the discretion of the faculty.

**Patient Point Value**

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

**GSR 2: Adult Patients**

Each student is required to see a minimum of 8 adult patients this semester. An adult patient is defined

as a patient between the ages of 19 – 59. In order for the student to be awarded credit for an adult patient, the patient must be completed at a competency level of 85% or higher on the Clinical Evaluation Record (CER) (see criteria under GSR 1).

**GSR 3: Geriatric Patients**

Each student is required to see a minimum of 2 geriatric patients this semester. A geriatric patient is defined as a patient that is age of 60 and older. In order for the student to be awarded credit for a geriatric patient, the patient must be completed at a competency level of 85% or higher on the Clinical Evaluation Record (CER) (see criteria under GSR 1).

**GSR 4: Assessment Data**

**Medical/Dental History**

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

**Vital Signs**

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

**Extra Oral and Intra Oral Examination**

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

**Periodontal Assessment**

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

- Plaque scores are a part of the Periodontal Assessment. Plaque scores are to be performed on each patient at every appointment. The patient should only brush prior to a plaque score being taken if they have not brushed within 4 hours prior to the appointment. After the plaque score is taken, this gives the student the opportunity to provide education to the patient using a toothbrush and interdental aids. Plaque scores will be randomly checked by faculty in clinic or during chart audits.

- Bleeding scores are a part of the Periodontal Assessment. Bleeding scores are to be obtained on each patient at every appointment. On the initial appointment, a bleeding score should be charted and calculated during the probing of the tissues. On subsequent appointments, the 6 indicator teeth may be used to calculate the bleeding score. The bleeding score gives the student the opportunity to provide education to the patient. Calculation of bleeding scores will be randomly checked by faculty in clinic or during chart audits.

**Dental Charting**

A thorough dental charting is an integral part of the dental hygiene education process. It not only supports clinical decision-making but also contributes to effective communication, legal documentation, and ongoing patient care. Developing proficiency in dental charting is essential for dental hygiene students to provide quality oral health care and contribute to overall patient well-being. The student is expected to use the radiographs and do a visual examination of the patients' dentition. The student is to chart using the Initial Dental Charting Form. List all of the radiographic findings (missing teeth, restorations, suspicious areas, periapical pathologies) and all the clinical findings (missing teeth, restorations, sealants, suspicious areas, rotations, abfractions, attrition, overhangs)
A dentist must evaluate the initial dental charting first. Once the initial dental charting has been checked by the dentist, the student must use the Dental/Periodontal Chart form to shade in the dental charting. Any dental hygiene faculty can check the dental charting shading in clinic. The shading must be done prior to scaling.

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

**Plaque Free/polishing**

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

**GSR 5: Full Periodontal Charting**

A complete periodontal charting must be done on the Periodontal Maintenance patient which includes 6-point pocket depths, 6-point gingival margin measurements, clinical attachment loss calculations, mobility, furcation involvement and bleeding points. This charting will allow for a complete evaluation of the periodontal patients' progress toward optimal oral health.

**GSR 6: Special Needs Patients**

Special Needs patients are defined as patients whose medical, physical, psychological, or social situations may make it necessary to modify procedures in order to provide dental hygiene treatment for that individual. Special needs patients may have mobility issues, be mentally disabled, immunocompromised, have a complex medical problem, or be a child with behavioral or emotional conditions. (See *Clinical Practice of the Dental Hygienist* by Wilkins for a list of special needs patients). The Special Needs Patient Evaluation will be completed after the appointment and turned in to the clinical advisor. Each student is required to complete a minimum of 2 Special Needs Patient Evaluations this semester. However, if the student is striving for an 'A' in clinic, then they will need to complete a minimum of 3 Special Needs Patient Evaluations this semester. In order for the student to be awarded credit for a Special Needs patient, the patient must be completed at a competency level of 85% or higher on the Clinical Evaluation Record (CER).

Be thorough in your assessment of the patient and their condition(s) they present. The Special Needs Patient Evaluation directions and form are included in the Appendix section of this syllabus on pages 52-53.

**GSR 7: Periodontal Staging Category**

Each student must see a minimum of 4 patients in the Periodontal Staging Category 1 & 2. Each student must also see a minimum of 3 patients in the Periodontal Staging Category 3 & 4. In order for the student to be awarded credit for a Periodontal Stage category, the patient must be completed at a competency level of 85% or higher on the Clinical Evaluation Record (CER).

**GSR 8: Periodontal Grading Category**

Each student must see a minimum of 4 patients in the Periodontal Grading Category A & B. Each student must also see a minimum of 1 patient in the Periodontal Grading Category C. In order for the student to be awarded credit for a Periodontal Grade category, the patient must be completed at a competency level of 85% or higher on the Clinical Evaluation Record (CER).

**GSR 9: Radiographic Surveys**

A student must demonstrate minimal competency by exposing acceptable quality radiographic surveys. Regardless of requirements, the student will take all necessary radiographs based on patient needs. Surveys will be graded as either satisfactory or unsatisfactory. Each student must complete a minimum of 4 acceptable full mouth surveys, 4 acceptable bitewing surveys, and 1 acceptable panorex survey. Each survey must be critiqued, retakes taken, and a final grade given to be considered complete. Students are given unlimited attempts to satisfy this requirement with no penalty on another patient. Surveys must be critiqued within 1 week of the survey. (i.e., Survey taken on Tuesday morning = due by the following Monday). Surveys turned in after one week of taking may not be graded for credit.

- **All radiographs must be completed and submitted by April 25 by 12:00 pm**.
- The student who is treating the patient must take the patient's radiographs even if the radiographs are not needed for requirements.
- Retakes must be done at the next appointment after the survey has been graded.
- Radiographs may be taken outside of the student's clinic time if it is during a second-year clinic. **Radiographs may not be taken during lunch, before clinic, during 1st year clinic, or after clinic hours.**
- All surveys taken and the justification for each patient exposure must be documented in the progress notes. (Example: FMX-patient has numerous suspicious areas).
- Technique errors, restorations, bone loss, calculus, suspicious areas and those areas requiring referral should be documented on the radiographic critique sheets. Only note existing conditions such as missing teeth if it aids in grading the radiographs.
- **IF A PATIENT CANNOT RETURN FOR RETAKES, THAT PARTICULAR SURVEY WILL NOT BE ACCEPTED AS A COMPLETED SURVEY.** Therefore, it is advisable to discuss this with your patient before the need arises. If the patient cannot return, it must be documented on the Communication Log and in the progress notes.
- **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. (Ex: Subj Line: Harrell)

**GSR 10: Calculus Detection**

Calculus detection is considered a basic skill. Each student must successfully complete one calculus detection on their Clinical Evaluation patient or a Class IV or V patient. The student will be graded on their calculus detection skills and must detect 80% of the calculus charted by 2 instructors in 2 quadrants. Only subgingival "clickable" calculus will be recorded for the calculus detection patients. The student will be given 2 attempts to successfully complete this requirement. If the student is striving for an 'A' in clinic, this requirement must be passed on the first attempt.

**GSR 11: EagleSoft Periodontal Charting**

The student will complete one periodontal charting using the EagleSoft software. The student will use their Periodontal patient from the Fall semester. 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 PowerPoint of the steps for this evaluation has been provided on Blackboard. The evaluation form is found in this syllabus on page 44.

**GSR 12: Private Practice Patients**

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) or Geriatric (G) 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 the patient 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.

**GSR 13: Sealant Patients**

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

area of the CER. Teeth that are sealed will be verified by the tooth number on the CER and in the progress notes. Once the designated sealants have been placed, the sealed teeth should be marked with a blue 'S' on the dental charting. The D.D.S. should award a grade on the CER after checking the sealant placement.

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

**GSR 14: Ultrasonic Quadrants**

The number of graded and acceptable ultrasonic quadrants will depend on the grade the student is striving to achieve. This information can be found in the table above. Students must have the ultrasonic quadrant checked prior to any hand scaling. If hand scaling has begun, then the quadrant is no longer eligible for an ultrasonic grade.

The Ultrasonic scaler may be used on 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.

**GSR 15: Professional Judgement & Professionalism**

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.

**GSR 16: Community Service**

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

**GSR 17: Cancellation**

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
- Chart audits
- Practicing the use of the Intraoral Camera techniques on a typodont
- Instrument sharpening
- EagleSoft probe charting
- EagleSoft dental charting
- Practicing sensor or NOMAD radiographs on the DXTRR manikin
- Study for National Board exam

**GSR 18: 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. 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 into 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 or to their clinical counselor.
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.
Instructions, forms, and grade sheet can be found on pages 45-51.

**GSR 19: 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, a full periodontal charting recording all probing depths (6 points), gingival margin measurements (6 points), CAL (6 points), 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 review with the patient with 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 or your clinical counselor 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 pages 31-37 for more detailed information regarding the Periodontal Maintenance Patient and Patient Education Competency Evaluation.

**GSR 20: Radiographic Evaluation**

The student will be required to successfully complete one radiographic interpretation. This evaluation requires the student to identify landmarks, suspicious areas, restorations, unusual conditions and technique errors on periapical, bitewing, and panoramic images. The evaluation will be taken in the clinic Blackboard course and Respondus Lockdown Browser will be used. The date for the evaluation will be **Feb 29 – March 1**. A score of **90%** or higher is required for successful completion of this evaluation. If a student is unsuccessful on the first attempt, they are required to meet with the clinic coordinator for remediation before a 2nd attempt can be scheduled. The student will have 2 attempts to successfully complete this requirement. Failure to meet this score on the second try may result in dismissal from DHYG 2262.

**GSR 21: Clinical Competencies**

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

- **Clinical Evaluation Competency – pages 28-30**
- **Root debridement Competency – pages 38-40**
- **Patient Education Competency – page 33**
- **Geriatric Patient Competency – pages 41-42**
- **Manikin Mock Board Competency – pages 55-56**

**ADDITONAL CLINIC INFORMATION**

**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. 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.



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- **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.

**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. There will be no sharing of patients for points.

**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.

**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

**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 or student 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; therefore, patients must be in the appointment book prior to the beginning of clinic.
- Patient CERs must be turned back into clinic admin, by the student, at the end of each clinic session for grade entry.
- Any CER with a new entry must be placed in the designated CER holding area.

**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.



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**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.

**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, periodontal 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 requires 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.)

**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.

**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.

**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.

**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.

- **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.**

**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.

**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. All students are expected to assist others at the end of clinic prior to removing PPE. No one will be dismissed until all students CER's and progress notes have been checked for completeness and all students have performed post-op procedures.



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**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 |



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## PROGRESS CHECKS/CLINICAL COUNSELING

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

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

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

Listed below you will find the weeks of progress checks. Students must meet with their clinical advisors to report on their progress in clinic. Students must bring their CER's and clinical requirement tracking chart **(pages 25-27)** to each appointment filled in with current information. Please be prepared to discuss how many points have been started, patient issues, what requirements are met, etc.

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



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**DATES FOR PROGRESS CHECK/CLINICAL COUNSELING**

**Week of February 5**
**Week of April 8**

***MID-SEMESTER CLINICAL COUNSELING***
**Week of March 4**

***FINAL CLINICAL COUNSELING***
**Week of April 29**

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

**STUDENT AND FACULTY ACADEMIC AND CLINICAL COUNSELING ASSIGNMENTS**

| Harrell | Mendoza | DeMoss |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**INSTRUCTIONS FOR MID-SEMESTER CLINICAL COUNSELING**

**STUDENTS:**

1. Bring your CER's, appointment book, and clinic requirement tracking chart.
2. Check Blackboard to be sure it is updated with all completed information.
3. Look over your print out/time sheet for any errors or discrepancies **prior** to your appointment.
4. Bring your corrected copy of the computer print-out. Be able to document any errors with CER's.

**FACULTY:**

1. Document and verify grades and patient #/codes in 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. Check Blackboard gradebook for the following:
    a. Accuracy
        1. Check to see that all completed patient CER's have been uploaded
        2. Check on Skill evaluation and Competency uploads are complete.



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4. Fill out tracking requirement sheet on the 'R' drive > gradebook > 2nd yr gradebook

## INSTRUCTIONS FOR FINAL CLINICAL COUNSELING

**STUDENTS:**

1. Bring your CER's, appointment book, and completed skill evaluations. 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.
4. Turn in instrument locker key and lock from locker to Clinic Admin.

**FACULTY:**

1. Document grades and patient #/codes on the grade sheets on the "R" Drive grade book.
2. Collect list of incomplete patient from student.
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 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. Check Blackboard for accuracy.
    a. Check to see that all completed patient CER's have been uploaded
    b. Check on Skill evaluation and Competency uploads are complete.

5. Fill out tracking requirement sheet on the 'R' drive > gradebook > 2nd yr gradebook
6. Collect list of incomplete patients.
7. Remind student to turn in locker and key from instrument locker.



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# APPENDIX

| REQUIREMENT TRACKING RECORD | 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 | |
| **POINTS STARTED (I AND II)** | | | | |
| **POINTS FINISHED (I AND II)** | | | | |
| **POINTS STARTED (III AND ABOVE)** | | | | |
| **POINTS FINISHED (III AND ABOVE)** | | | | |
| **ADULT PATIENTS** | **8 patients**<br>1. | **8 patients**<br>2. | **8 patients**<br>3. | <br>4. |
| | 5. | 6. | 7. | 8. |
| **GERIATRIC** | **2 patients**<br>1. | **2 patients**<br>2. | **2 patients** | |
| **MEDICAL/DENTAL HISTORY** | **12 patients** | **11 patients** | **10 patients** | |
| **ORAL EXAMS** | **12 patients** | **11 patients** | **10 patients** | |
| | **12 patients** | **11 patients** | **10 patients** | |



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| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **PERIODONTAL ASSESSMENTS** | | | | | | | | | |
| **DENTAL CHARTING** | **12 patients** | | | **11 patients** | | | **10 patients** | | |
| | | | | | | | | | |
| | | | | | | | | | |
| **POLISHING/PLAQUE FREE** | **12 patients** | | | **11 patients** | | | **10 patients** | | |
| | | | | | | | | | |
| | | | | | | | | | |
| **FULL PERIODONTAL CHARTING** | **1 patient** | | | **1 patient** | | | **1 patient** | | |
| | 1. | | | | | | | | |
| **SPECIAL NEEDS** | **3 patients** | | | **2 patients** | | | **2 patients** | | |
| | 1. | | | 2. | | | 3. | | |
| **PERIODONTAL STAGING CATEGORY** | **Stage I or II** | | | **4 patients** | | | | | |
| | | | | 1. | 2. | 3. | 4. | 5. | |
| | **Stage III or IV** | | | **3 patients** | | | | | |
| | | | | 1. | 2. | 3. | | | |
| **PERIODONTAL GRADING CATEGORY** | **Grade A or B** | | | **4 patients** | | | | | |
| | | | | 1. | 2. | 3. | 4. | | |
| | **Grade C** | | | **1 patient** | | | | | |
| | | | | 1. | | | | | |
| **RADIOGRAPHS (TOTAL)** | **4 FMX, 4 BWX, 1 PANOREX (document when the survey is complete & graded)** | | | | | | | | |
| **FMX** | 1. (Sensor) | 2. (Sensor) | 3. (Sensor) | 4. | | | | | |
| **BWX** | 1. (Sensor) | 2. (Sensor) | 3. (Sensor) | 4. (NOMAD) | | | | | |
| **PANOREX** | 1. | | | | | | | | |
| **CALCULUS DETECTION** | **1 patient (Clinical Evaluation patient)** | | | | | | | | |
| | 1. | | | | | | | | |
| **EAGLESOFT PROBE CHARTING** | **1 patient (Periodontal patient from Fall semester)** | | | | | | | | |
| | 1. | | | | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **PRIVATE PRACTICE PATIENTS** | **6 patients** | | | **5 patients** | | | **4 patients** | | | | | |
| | **1.** | **2.** | | **3.** | **4.** | | **5.** | **6.** | | | | |
| **SEALANT PATIENTS** | **4 patients** | | | **3 patients** | | | **2 patients** | | | | | |
| | **1.** | **2.** | | **3.** | | | **4.** | | | | | |
| **ULTRASONIC QUADRANTS** | **12 quadrants** | | | **10 quadrants** | | | **8 quadrants** | | | | | |
| | **1.** | **2.** | **3.** | **4.** | **5.** | **6.** | **7.** | **8.** | **9.** | **10.** | **11.** | **12.** |
| **PROFESSIONAL JUDGEMENT & ETHICAL BEHAVIOR** | **Average of 40** | | | **Average of 39** | | | **Average of 38** | | | **Average below 38** | | |
| | | | | | | | | | | | | |
| **COMMUNITY SERVICE** | **5 hours** | | | **4 hours** | | | **3 hours** | | | | | |
| | **1 hour** | **2 hours** | | **3 hours** | | | **4 hours** | | | **5 hours** | | |
| **CANCELLATION TIME** | **Up to 20 hours before penalty occurs** | | | | | | | | | | | |
| | **Hrs/date** | **Hrs/date** | **Hrs/date** | **Hrs/date** | **Hrs/date** | **Hrs/date** | **Hrs/date** | **Hrs/date** | **Hrs/date** | **Hrs/date** | | |
| | **Hrs/date** | **Hrs/date** | **Hrs/date** | **Hrs/date** | **Hrs/date** | **Hrs/date** | **Hrs/date** | **Hrs/date** | **Hrs/date** | **Hrs/date** | | |
| **NUTRITIONAL COUNSELING PLAN (75% or higher)** | **Passing on initial attempt** | | | **Passing on 2nd attempt** | | | **Passing on 2nd attempt** | | | | | |
| | **Pass** | **Fail** | | **Pass** | | | **Fail** | | | | | |
| **PERIODONTAL MAINTENANCE PATIENT TREATMENT PLAN** | **90 and above** | | | **86-89** | | | **85 or below** | | | | | |
| | **Grade:** | | | | | | | | | | | |
| **CLINICAL COMPETENCIES** | **Meet minimal competency on all evaluations on initial attempt** | | | **Meet minimal competency on 4 evaluations on initial attempt** | | | **Meet minimal competency 3 evaluations on initial attempt** | | | **Does not meet all requirements for a 'C'** | | |
| **CLINICAL EVALUATION** | **Pass on initial attempt (date):** | | | **Pass on 2nd attempt (date):** | | | | | | | | |
| **ROOT DEBRIDEMENT** | **Pass on initial attempt (date):** | | | **Pass on 2nd attempt (date):** | | | | | | | | |
| **GERIATRIC PATIENT** | **Pass on initial attempt (date):** | | | **Pass on 2nd attempt (date):** | | | | | | | | |
| **PATIENT EDUCATION** | **Pass on initial attempt (date):** | | | **Pass on 2nd attempt (date):** | | | | | | | | |
| **MANIKIN MOCK BOARD** | **Pass on initial attempt (date):** | | | **Pass on 2nd attempt (date):** | | | | | | | | |



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**** All Clinical Competencies must be passed in order to meet requirements. Student will be given 2 attempts. If not successful on the 1st attempt, the student must schedule a remediation session with an instructor.**

## CLINICAL EVALUATION COMPETENCY

**Clinical Evaluation Competencies will be scheduled on March 20th and March 21st.**

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. The student has 2 attempts 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 calculus detection will be completed prior to the examination to qualify the patient by the student and by 2 dental hygiene faculty.

- **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; 2 posterior teeth from another quadrant may be added if needed. 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 unless contraindicated.

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. The student must detect 80% of the agreed-upon surfaces found by the 2 faculty members. Only the surfaces agreed upon by the two (2) instructors will be used in qualification and evaluation.



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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 student should use current radiographs and the periodontal charting during the evaluation.

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. 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 is advised to use the entire two hours to complete the evaluation. If a break is needed, get a 'stop time', and upon return, have your time restarted.

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, 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.



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| LIT Dental Hygiene Program<br>**CLINICAL EVALUATION 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.<br>PC 12. Provide specialized treatment that includes preventive and therapeutic services designed to achieve and maintain oral health.<br>a. Perform dental hygiene interventions to eliminate and/or control local etiologic factors to prevent and control caries, periodontal disease, and other oral conditions.<br>b. Control pain and anxiety during treatment through the use of accepted clinical and behavioral techniques.<br>PC 13. Evaluate the effectiveness of the implemented clinical, preventive, and educational services and modify as needed.<br>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'. The student has 2 attempts on this competency. | | Grade | ☐ Acceptable<br>☐ 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 | Utilizes proper infection control procedures | Yes | | |
| 2 | Applies basic and advanced principles of dental hygiene instrumentation | Yes | | |
| 3 | Demonstrates proper use of the ultrasonic scaler | Yes | | |
| 4 | Obtains informed consent prior to treatment; maintains clinical records | Yes | | |
| 5 | Explains procedure and rationale of procedure to the patient | Yes | | |
| 6 | Procedures are carried out in an efficient and systematic manner | No | | |
| 7 | Utilizes periodontal charting and radiographs during procedure | No | | |
| 8 | Removes calculus without excessive tissue trauma | Yes | | |
| 9 | Demonstrates professional conduct and ethical judgement during treatment | Yes | | |
| | | | | |

**COMMENTS:**



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**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 15 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 34-37.

All post-care plans are to be turned in to your clinical counselor 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 their clinical counselor for grading.

**PATIENT EDUCATION COMPETENCY EVALUATION CHECKLIST:**

***Patient Education****: This skill evaluation will be conducted in the patient education room.*
See page 15 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. A review of previous topics is discussed to check the patient's understanding and knowledge retention 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.)
   - Do not have the patient brush prior to the patient education session unless the patient has not brushed within 4 hours of the appointment.
   - If the patient has not brushed 4 hours prior to the appointment, let the patient brush with no assistance, take the plaque score, and give any instruction in the patient education room.)
7. The student will review with the patient the comparison probe chart of CAL's and probing depths generated by EagleSoft software. The probe chart from the Fall will be utilized to generate this form. The periodontal chart completed this semester should also be used for comparison of identifying areas of health or areas that need attention.



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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<br><br>**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.<br>P4. Communicate effectively with individuals and groups from diverse populations both verbally and in writing<br>HP5. Promote the values of oral and general health and wellness to the public and organizations within and outside the profession.<br>PC10. Use critical decision-making skills to reach conclusions about the patient's dental hygiene needs based on all available assessment data.<br>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<br>☐ 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 | Reviews the comparison probe chart with the patient. | 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

**PERIODONTAL MAINTENANCE POST-CARE PLAN TEMPLATE**

**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?

---

**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.

---

**DATE_____ NAME_____**

**PERIODONTAL MAINTENANCE POST-CARE PLAN EVALUATION**

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



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| | | | | | |
|---|---|---|---|---|---|
| **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. |
| **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:**



Approved: Initials/date

**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 stage III or IV.
- An instructor will select 2-3 teeth to be evaluated 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.



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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.

**EVALUATION BY FACULTY**

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

| LIT Dental Hygiene Program<br><br>**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.<br>PC12 Provide specialized treatment that includes preventive and therapeutic services designed to achieve and maintain oral health.<br>a. Perform dental hygiene interventions to eliminate and/or control local etiologic factors to prevent and control caries, periodontal disease, and other oral conditions.<br>b. Control pain and anxiety during treatment through the use of accepted clinical and behavioral techniques.<br>PC13 Evaluate the effectiveness of the implemented clinical, preventive, and educational services and modify as needed.<br>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<br>☐ 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 periodontal 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:** | | | | |



Approved: Initials/date

**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.



Approved: Initials/date

| LIT Dental Hygiene Program<br>**Competency Evaluation**<br>**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.<br>PC10. Use critical decision making skills to reach conclusions about the patient's dental hygiene needs based on all available assessment data.<br>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.<br>e. Obtain the patient's informed consent based on a thorough case presentation.<br>PC12. Provide specialized treatment that includes preventive and therapeutic services designed to achieve and maintain oral health.<br>a. Perform dental hygiene interventions to eliminate and/or control local etiologic factors to prevent and control caries, periodontal disease, and other oral conditions.<br>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<br>☐ 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

**EAGLESOFT SOFTWARE PERIODONTAL CHARTING**

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

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

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

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

**This semester, the pre- and post-periodontal charting from the Fall semester will be used to create a comparison chart. The comparison chart will be used in the patient education session with the periodontal maintenance patient. Instructions and examples of how to create the comparison charts can be found in the Clinic Blackboard.**

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



Approved: Initials/date

LIT Dental Hygiene Program

**EagleSoft Software Periodontal Charting Grade Form**

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<br>☐ 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



Approved: Initials/date

**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.
- Please refer to Assignment & Examination Policies section regarding the use of A.I.

- **Professionalism**
  Edit your paper.
  - Grammar/spelling
  - Completeness—did you turn in all parts of the assignment? Neatness
  - Accuracy—correct values and calculations, information presented, appropriate dental terms
  - Logic of conclusions and appropriateness of recommendations—your conclusions must be consistent with the evidence, and your recommendations must be in line with current nutrition knowledge

**Evaluation**

Place the 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 or to your clinical counselor. 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 50-51 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) | Low | Low | Low | |
| | Mod | Mod | Mod | |
| Relative to individuals without the risk factor | High | High | High | |

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



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.



Approved: Initials/date

**Carbohydrate Intake Analysis Worksheet**

| Carbohydrate (CHO) Intake Analysis Worksheet | | | |
|---|---|---|---|
| **Fermentable CHO** | **Cariogenic?** | **Reason** | **Period of Exposure to Enamel** |
| | | | |
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| | | | |
| | | | |
| **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.<br>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. |



Approved: Initials/date

## SPECIAL NEEDS PATIENT EVALUATION

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

When treating a patient with special needs, dental hygiene students should be thorough in their assessment and consider the patient's overall health. The dental hygiene student also needs to consider various factors to ensure safe and effective care during treatment. Learning what to observe and anticipate, being familiar with signs of potential medical emergencies, or knowing how to avoid a medical emergency are all a part of considering the treatment of a patient with special needs.

Fill out the Special Needs Patient Evaluation Form on the following page and submit it to your clinical counselor after treatment has been completed. Ensure that the chart is ready for audit and include the patients CER.

Be thorough in your explanations and consider the patient's condition, medications and their side effects, potential issues that could arise during treatment, and patient education topics that would personalize the discussion when addressing the patient's oral health care.

The Special Needs Patient Evaluation assesses the student's knowledge, critical thinking, and ability to apply theoretical concepts to practical, patient-centered situations. The goal is to ensure that dental hygiene students are well-prepared to provide safe, effective, and compassionate care to individuals with complex medical needs.



Approved: Initials/date

| LIT Dental Hygiene Program<br>**Special Needs Patient Evaluation** | | | |
|---|---|---|---|
| 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.<br>PC10 Use critical decision-making skills to reach conclusions about the patient's dental hygiene needs based on all available assessment data.<br>b. Identify patient needs and significant findings that impact the delivery of dental hygiene services. | | |
| Student | | Date: | |
| Instructor | | Perio Stage | H G I II III IV |
| Patient | | Prophy Class | 0 1 2 3 4 5 6 7 8 |
| If 'Unacceptable' grade is achieved, the student will need to designate another patient to complete this evaluation. | | Grade | ☐ Acceptable<br>☐ Unacceptable |

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

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

| | |
|---|---|
| 1. | **MEDICAL KNOWLEDGE:** Describe the patient's special need/s. Address the importance of obtaining a thorough medical history before treating the patient. (You may write on the back) |
| | |
| 2. | **ASSESSMENT SKILLS:** Explain and describe any treatment modifications that you had to consider, plan for, or prepare for prior to treatment. Explain and describe any treatment modification that you had to perform during treatment. What were the outcomes of your expectations? Be specific and thorough in your answer. (You may write on the back) |
| | |
| 3. | **MEDICATION MANAGEMENT:** How did you inquire about a patient's medications (if applicable), and why is it crucial for dental hygiene care? |
| | |



Approved: Initials/date

| | |
|---|---|
| 4. | **EMERGENCY PREPAREDNESS:** How would you prepare for and/or respond to a medical emergency during a dental hygiene appointment if this patient presented one? |
| | |
| 5. | **PATIENT COMMUNICATION:** What patient education topics did you address with this patient? What specific items did you need to address due to the patient's special need? (You may write on back) |
| | |
| **Instructor Comments:** | |

## MANIKIN MOCK BOARD EXAMINATION COMPETENCY

A mock board exam simulates the atmosphere and conditions of the actual licensing or board certification exam. It helps students familiarize themselves with the format, time constraints, paperwork, and types of tasks they must complete. This mock exam aims to prepare the student for success on the official board examination.

The purpose of the Manikin Mock Board Examination Competency is to evaluate the student's ability to:

- Detect calculus
- Remove calculus
- Accurately measure periodontal pockets
- Appropriately manage treatment

Grading of the Manikin Mock Board Examination Competency follows the ADEX guidelines set in the 2024 ADEX Dental Hygiene Candidate Manual.
The student must make a 75% to pass this competency. The student will have 2 attempts.

Calculus removal, periodontal probing measurement, final case presentation and tissue management are evaluated by 2 instructors. The student's periodontal probing measurements must be with (+/-) 1mm of the examiners.

Each instructor examines the manikin independently and will record their findings. The instructors are unable to see the evaluation of the other instructor during the checkout process.

Grading of treatment management includes hard or soft tissue damage to the dentition or the gingiva.

- Minor soft tissue damage:
  - A laceration/abrasion that is $\leq$ 3mm
- Major soft tissue damage:
  - A laceration/abrasion that is > 3mm and would require sutures, periodontal packing, or further follow-up treatment.
  - Amputation of papilla
  - An unreported broken instrument tip in the sulcus or soft tissue

- Minor hard tissue damage:
  - Slight hard tissue damage that is inconsistent with the procedure or pre-existing condition
- Major hard tissue damage:
  - Damage to the hard tissue that is inconsistent with the procedure or pre-existing condition

| LIT Dental Hygiene Program<br>**MANIKIN MOCK BOARD COMPETENCY** | | | |
|---|---|---|---|
| DHYG 2262 | | | |
| LIT Competency Statement | P2. Assume responsibility for dental hygiene actions and care based on accepted scientific theories and research as well as the accepted standard of care.<br>PC 12. Provide specialized treatment that includes preventive and therapeutic services designed to achieve and maintain oral health.<br>a. Perform dental hygiene interventions to eliminate and/or control local etiologic factors to prevent and control caries, periodontal disease, and other oral conditions.<br>b. Control pain and anxiety during treatment through the use of accepted clinical and behavioral techniques.<br>PC 13. Evaluate the effectiveness of the implemented clinical, preventive, and educational services and modify as needed.<br>a. Determine the outcomes of dental hygiene interventions using indices, instruments, examination techniques, and patient self-report. | | |
| Student | | Date: | |
| Instructor | | | |
| The following criteria will be used to determine a competency of 75% or higher on this evaluation. Failure to achieve a 75% will result in a retest. | | Grade | ☐ Acceptable<br>☐ Unacceptable |

| Seventy five percent (75%) is needed to be acceptable. | | | |
|---|---|---|---|
| SKILLS ASSESSMENT | CRITERIA | Possible Points | Points Earned |
| CALCULUS DETECTION | • 4 assigned maxillary teeth<br>• 4 surfaces per tooth (M, D, F, L)<br>• 16 surfaces evaluated for presence or absence of subgingival calculus (1 point each) | 16 | |
| CALCULUS REMOVAL | • One mandibular quadrant assigned for scaling<br>• 12 assigned surfaces evaluated for calculus removal (5.5 points each) | 66 | |
| FINAL CASE PRESENTATION | • Evaluation of calculus removal on all remaining surfaces within assigned quadrant. Calculus remaining:<br>○ 1 surface (-3 points)<br>○ 2 or more surfaces (-6 points) | 6 | |
| PERIODONTAL PROBING MEASUREMENT | • 2 assigned teeth (1 anterior; 1 posterior)<br>• 6 measurements per tooth (DF, F, MF, DL, L, ML)<br>• 12 measurements evaluated (1 point each) | 12 | |
| SOFT TISSUE DAMAGE | • One point penalty for each site of minor soft tissue damage; up to 3 sites.<br>• Four or more of minor sites or 1 major site of damage = automatic failure | | |
| HARD TISSUE DAMAGE | • One point deducted for each site of minor hard tissue damage, up to 3 sites<br>• Four or more minor damage sites or 1 major site of damage = automatic failure | | |
| | TOTAL POINTS | 100 | |



Approved: Initials/date