CENTRAL CAROLINA COMMUNITY COLLEGE

DENTAL PROGRAMS

CLINIC MANUAL

2018-2019

SECTION 1: Dental Hygiene Sequence of Clinical Procedures

General Clinic Policies

The even flow of patients through the clinic is dependent upon strict adherence to the rules and regulations governing the clinic. The student must be familiar with the contents of this manual before working in the clinic and learn the policies concerning patient management, care of equipment, and clinical procedures.

Ethics, Conduct, and Clinic Attendance

Ethics

1. Anything less than the highest order of professional conduct and understanding on the part of the student can only result in the loss of the patient's confidence in the student, the school, and the profession. Courtesy and consideration of the patient must prevail at all times. Grades and general standing of the student depend upon his/her total patient care.
2. Criticism of previous dental services is not considered ethical. Students will learn that many circumstances have a bearing upon the present condition of the mouth.
3. Anything involving the student and the patient is strictly confidential. Patient's information should not be discussed with classmates or anyone else except the patient and/or faculty on an as needed basis.

Conduct

1. Proper conduct and ethics encompass all the activities of the student. Students should conduct themselves in a professional manner at all times. Loud and boisterous talking in the corridors and clinic will not be tolerated.
2. The faculty and secretary should be addressed by their last names with the prefix Dr., Mr., Miss, Ms., or Mrs., whichever is correct, and the instructor should at all times be introduced to the patient. All adult patients should be addressed by their last names.

Clinic Attendance

1. The clinic will be open at specified times indicated in the student's class schedule. Students will be expected to follow published schedules for their respective classes.
2. Students will report in proper attire to the clinic as assigned at least thirty minutes prior to the scheduled clinic hours, patient or not, and stay in the clinic until excused. Fifteen to twenty minutes is the allowable time to wait for your patient before attempting to schedule another patient. See CCCC Policies and Procedures Manual for policy on attire.
3. Students should not dismiss a patient until an instructor has given approval.
4. In the event a student does not come to clinic and fails to notify an instructor, a zero will be given for each missed clinical session and all missed sessions will be rescheduled at instructor discretion.

Patient Pool

There are two main sources for dental hygiene clinic patients:

1. Patients who have been to the dental hygiene clinic previously (re-care patients)
2. Those who are new to the clinic (screener patients)

The recruitment of new patients to the clinic largely depends on you, the student. Rather than rely totally on the re-care system, begin to develop your own patient pool. Friends, neighbors, classmates in related classes, faculty, hygiene students, dental assisting students, etc., all make excellent patients. In order to be prepared for patient recruitment, have some Patient Information brochures and business cards with you at home, in your car or purse and give them to prospective patients. Distribute your brochures to your bank teller, hairdresser, husband's coworkers, waitresses, minister, dry cleaner, car salesman, etc. Be a "go getter" and you will never be without a patient! Be sure to also get the prospective patients contact information, so YOU may contact them. Do not just rely on them calling the clinic.

Students should not solicit patients by purchasing advertisements in publications such as the Daily News, or solicit in mass quantities such as Wal-Mart, etc. It is the expectation for students to create a Google account phone number. Students are not to release their personal phone number.

Scheduling Patients

It is the student's responsibility to schedule his/her own appointments. It is not the office manager's responsibility to schedule your patients, cancel your appointments if you are ill, or make calls for you. To properly schedule patients, please follow these guidelines.

1. **Screened patients:** Screened patients will be placed on the "REVISED.2018.NP,Recare Log,&Screened Patient Log"" in Google Docs. Please remember to annotate any action you have taken in regards to scheduling a screening patient or a screened patient in the respective log.
2. **Re-care patients:** Review the re-care patient log to schedule a re-care patient as well as maintain your own log of patients previously treated for re-care appointments. You should also annotate any action you have taken in this log in order to reduce duplicated student efforts.

Once you decide to call a patient, review the Medical History and Record of Treatment. Does the patient have to be pre-medicated or have medical conditions that may alter your treatment plan? Also, does the patient have a history of many broken appointments, uncooperative behaviors, etc.? In other words, know your challenges before you begin; because ***once you start treatment, you must complete it!***

Call the patient to schedule an appointment. Maintain your professional demeanor in all interactions with patients. Always identify yourself first and that you are a student in the CCCC Dental Hygiene program, when calling a patient at home. This is particularly important when speaking to a spouse!

You should record **ALL phone conversations** and messages in the Clinical Chart, Eaglesoft.

It is recommended that you use the REVISED.2018.NP,Recare Log,&Screened Patient Log to document then transfer the note into EagleSoft once you arrive at school. HIPAA rules and guidelines should be followed. Select your patient in EagleSoft. Select "notes" and then create the appropriate entry as a CHART note. You should make an entry each time that you speak with or leave a message for the patient.

- *5-2-13 "Left message on answering machine at patient's home concerning scheduling re-care appointment."*
- *5-5-13 "Left message on patient's cell phone concerning scheduling re-care appointment."*
- *5-9-13 "Left message at home with patient's husband concerning the appointment on 5-11-13. The patient is to call me back and confirm."*

If, after several attempts you are unable to contact the patient for any of the following reasons: the patient has moved, their telephone has been disconnected or they no longer wish to be seen here, indicate all of your attempts on the Record of Treatment in the patient's record, in the Notes section of Eaglesoft. The reason for this is that sometimes patients call and complain that you did not contact them. The office manager or faculty member can soothe an angry patient by saying, "Mr. Jones, I see on your record that the student tried calling you last Friday around noon and then again Saturday night," or "Mrs. Smith, your record indicates that the student left a message on your answering machine on May 9th."

If a patient no longer wishes to be treated in the clinic, or the student and faculty wish to inactivate: 1) make a note in Eaglesoft in Notes section stating the reason for inactivation and on the appropriate call log. It is unprofessional to continue to contact a patient who does not want to return. Unless you note it, other students may call.

If the patient wants to schedule an appointment with you, make sure your patient knows the following:

1. **YOUR NAME AND HOW TO CONTACT YOU TO RESCHEDULE:** Tell them your name and google phone number.
2. **THE LOCATION OF THE DENTAL CLINIC:** Patients are only allowed to park in Visitor's parking (side of Keller Health Sciences-1815 Nash St. entrance).
3. **THE LENGTH OF THEIR APPOINTMENT:** Many hours are wasted in clinic because the patient schedules with you at 9:00 AM but has a class at 10:00 AM, arrives late, or needs to leave early!
4. **WHAT MEDICATIONS OR MEDICAL CONDITIONS ARE PRESENT:** It saves clinic time if you can look information up beforehand rather than utilize your clinic time.
5. **THAT TIMELINESS IS ESSENTIAL:** Make sure your patient realizes that if they are late it may mean they will need additional appointments.
6. Ask if they have ever been seen in the dental hygiene clinic before so a duplicate record will not be made.
7. Students are not to release their personal phone numbers. Students are expected to create a Google account phone number to communicate outside of the dental clinic with their patients.

Eaglesoft Scheduling

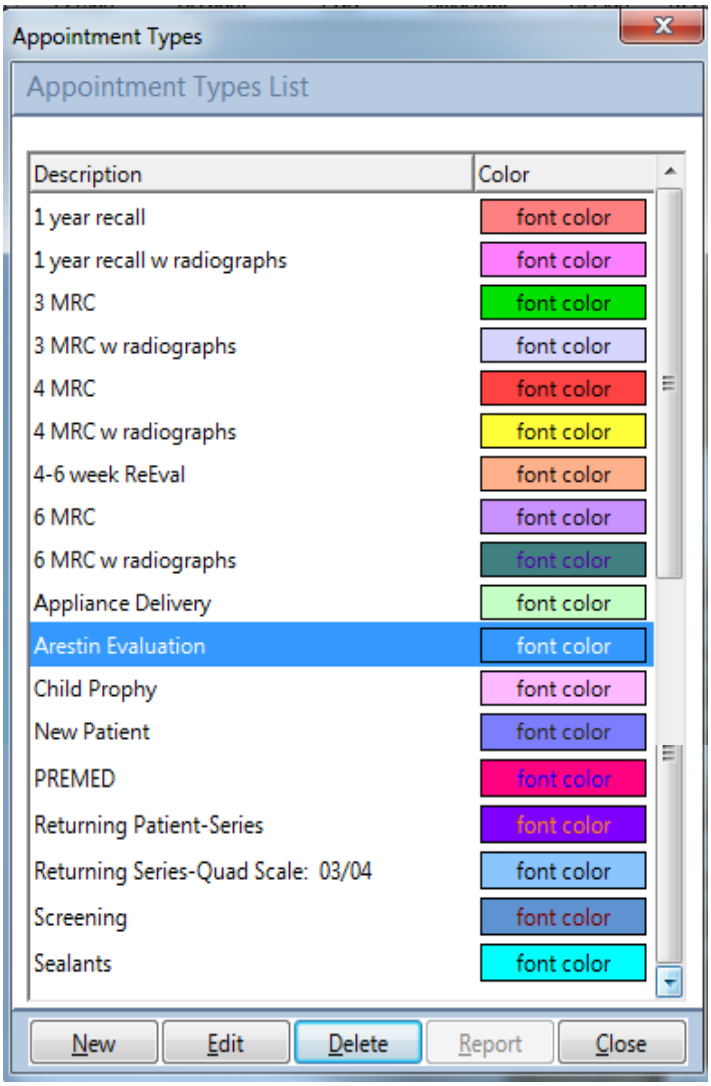
The dental clinic uses Eaglesoft, a dental practice management software system, to keep track of all patients, appointments, treatment notes, and accounts. The system is also used for the intraoral camera and digital radiography – both intraoral and panoramic.

Here are a few basic tips to make your Eaglesoft experience positive. You will be given a detailed Eaglesoft orientation prior to beginning clinic:

1. Your username and password will be assigned to you. Do **not** share your password with another student. **Never** log in as another student – even if the other student asks you to. There is a way to track each user's activities; therefore, you must always use your own login. If you go to a computer and someone else is logged on – log them off and login under your user name before proceeding.
2. If you forget your username and/or password, the course director can provide it for you.
3. **Do not "X"** out of any screen within Eaglesoft. Always look for another way to leave the screen such as Close, Save, Cancel, OK, etc. Remember – red means stop – green means go!
4. When you finish using Eaglesoft, you must logoff to keep others from working under your login. Just click the logoff button in the tool bar. Do NOT close the program – just logoff.
5. When moving from one field to another – use the TAB key. Do NOT press ENTER.
6. When on the main page of Eaglesoft, hold the cursor over any icon and it will label that icon to help you navigate to the appropriate screen

Scheduling Appointments

1. Open Eaglesoft and logon.
2. In order to schedule an appointment for a patient, the patient must be entered into Eaglesoft. Before trying to schedule, check to see if the patient has been entered into Eaglesoft.
    a. In the Front Office Window, click on the computer screen (OnSchedule).
    b. Using the button in the menu bar, go to the date you wish to schedule.
        i. º = today
        ii. << = back 7 days (1 week)
        iii. < = back 1 day
        iv. > = forward 1 day
        v. >> = forward 7 days (1 week)
    c. Find your assigned student provider.
    d. Click on 9:00am to get a blue bar {or the appropriate appointment time}.
    e. Double click on the blue bar and the "Find" box will appear.
    f. In the "Find" box, type your patient's last name. The box below will show all patients with that last name.
    g. If there are several patients with the same last name, you may have to scroll to find your patient. After you find your patient, double click on your patient's name.
3. If the patient has alerts, a yellow box will appear. Check the alerts and click "OK". This box will appear at various stages of the appointment process. Just click "OK" to close the box each time.
4. An appointment block window will appear.
5. At the appointment block window:
    a. Verify that this is the correct patient.
        i. Choose appointment type.



b. Choose primary provider.
    i. Open drop-down menu.
    ii. Click on **your** (Student's) provider number (same as username). This one simple step will assure that this patient appears on your re-care list. You are responsible for printing a re-care list once a semester to assist you in identifying which patients are due to return.

c. Change the number of units needed (a unit is 15 minutes). A two and one-half hour (2 ½ hours) appointment will be 10 units.
d. Click on service (lower left of rectangular white box). ***2nd Year Students only***
    i. Click on the circle by ADA Code.
    ii. Enter ADA code for each service you plan to perform.
    iii. Type in code and click on use.
    iv. As each service appears, click "OK" to use or "CANCEL" if you will not use. You may have several ADA codes typed in box.
e. When finished, click "OK" at top right.
f. If you get the warning that "this provider normally does not…" or you have chosen the wrong chair or tried to schedule a patient when clinic in not in session, click "OK" then click and drag the block to the proper time/chair. When dragging blocks, be sure to look at the screen carefully to insure you are dragging exactly to the proper block location.
g. If the patient requires premedication, a box will appear asking if you want to: "prescribe now, assign a task, or don't prescribe." Consult with CCCC faculty if needed and they will advise you,
h. When you have completed the appointment, click on the red X at the top right to close "OnSchedule."
i. If you do more or less than what was entered in under services for your patient, you must go back and add or delete in the appointment box BEFORE the patient is dismissed from the clinic. **2nd Year Students Only**

Block Scheduling

(This is utilized for patients not yet in Eaglesoft, last minute appointments, CA, Screening days) Failure to schedule in Eaglesoft is a MAJOR error.

1. Select your chair number.
2. Right click on mouse.
3. Select "Schedule Services."
4. Select "Create Block."
5. Enter # of units.
6. Type in description block- Patient name, Screener, Still Looking, etc.
7. If you have not found a patient by 2:00 PM the day before clinic, record "still looking" in your column for the appropriate times. This will allow the clinic manager and faculty to assist you in finding patients. Failure to do this will result in a MAJOR error being assessed.
8. All students must record their patient's information by 2:00 PM the day before their appointment.
9. If your patient cancels the night before clinic and you find a patient who is not in Eaglesoft, you will enter your patient in "Block Scheduling" as soon as you get to clinic in the morning. You will need to communicate any last-minute changes with the office manager.
10. If any of the above information is not properly recorded, a MAJOR error will be assessed.
11. Once a student assigns himself/herself a patient, this patient is the student's responsibility until the patient has been completed in the dental hygiene clinic or until the student has received permission from a clinical instructor to do otherwise. All patients must be completed before a student graduates. If there is a good reason why a patient cannot be completed, a notation must be made on the Clinical Chart Note and signed by an instructor.

Sample Scheduling with Codes-2nd Year Students Only	
EXAMPLES:	
Re-care Pedo patient (under 14)	D0120-(Periodic oral evaluation) D1120-(Prophylaxis-child) D0274-(Bitewings-four films) D1330-(Oral hygiene instructions) D1208-(Topical application of fluoride-varnish)
New to CCCC Class I or II adult patient	DO150-(Comprehensive oral evaluation) DO210-(Intraoral-complete series) D1110-(Prophylaxis-adult) D1330-(Oral hygiene instructions) D1208-(Topical application of fluoride-varnish)
Note: When treating a patient, if you do not perform all the procedures listed or if you perform additional procedures NOT listed in the appointment schedule, it will be necessary to remove them from the system.	

Special guidelines for scheduling patients in DEN 131, Dental Hygiene Clinic I	
Screened patients	Type I and II with 01 or 02 calculus ONLY
Re-Care patients	Type I and II with 01 or 02 calculus ONLY
Quick Screen	• With an instructor's permission, you will be allowed to schedule an unscreened patient. • An instructor will do a quick screen on this patient once a medical history & vital signs have been taken. Once the patient is seated, use an explorer and probe to determine the classification of patient. • When an instructor comes to your cubicle for a quick screen, tell the instructor what classification you think the patient is. If the instructor determines this patient to be too difficult, you will need to reappoint the patient with a second-year dental hygiene student or save the patient until you are more experienced.
*If you schedule a patient who turns out to be more difficult than a Class II-02, that patient will be rescheduled with a second-year student.	

Before You See any Patient

Many good habits that you can develop early in your career will lessen the chance of your being without a patient or incurring MAJOR errors.

Seven days before you see the patient:

1. Check your Eaglesoft schedule to see who you have scheduled.
2. Review the patient's chart to see if they need premedication, anesthesia, etc.
3. Call to confirm the appointment **seven** days in advance of the appointment and again **24 hours** in advance of the appointment. Obtain a list of medications they are on. Get the name, address and phone number of their MD, Pharmacist if needed, and general DDS to research radiographic history. Make sure the patient understands the length of appointment, parking, premedication, knows your full name & phone number etc. If you are scheduled to be "Screener," confirm with the CA that the day's screening appointments have been confirmed.
4. Record your appointments in Eaglesoft "On Scheduler" by 2:00 PM the day before. (If patient's name is not in the appointment book by 8:29 or 12:29 when the schedule is printed from Eaglesoft, your patient will be last to be processed.) Make sure you record the **patient's full legal name and it is spelled correctly**. Failure to do so will result in the assessment of a MAJOR error.
5. Request anesthesia (see Section 2) or premedication (see Section 5) as outlined in the Clinic Manual.
6. Check with an instructor concerning special situations that might alter your plan to treat the patient.

Procedures Before Seating Patient

Before your patient can be seated, many procedures must be followed. Remember that at 9:00 there are many patients waiting to be checked in, phones ringing, etc. If all students help with patient flow, more time can be utilized in actual patient care.

Remember: ALL PATIENTS MUST CHECK IN AT THE FRONT DESK.

1. Set up your operatory. Refer to the Risk Management, Preclinical, Clinical, and Laboratory Infection Control Review your patient's record.
2. Finish setting up your unit or help others while you wait. Students are not permitted to "hang out" in the reception area or by the clinic entrance. If you need to leave the clinic, use the door closest to your assigned operatory.
3. The office manager/CA will check in your patient in the following manner:
   A. At 8:45 or 12:45, the clinic assistant should be at the front desk assisting the office manager if requested.
   B. Once the patient checks in, the office manager places his/her name on the arrival list and the CA (if requested) may hand the patients clipboards to update their information. A patient cannot be seated without checking in first.
   C. If a patient arrives with small children and has made no provisions for their supervision, the office manager will explain why he/she cannot be seen and will ask them to reschedule.
   D. The office manager/CA acknowledges the patient is here and the Health Questionnaire, Patient Rights and Responsibilities, Patient Data Sheet, Scope of Comprehensive Dental Hygiene Care & HIPAA forms are given to patient to complete or update.
   E. Patient Privacy Act (HIPAA) –

i. This form is completed at the patient's initial appointment at the clinic and kept in the chart for the duration of time the patient is seen at Central Carolina Community College. (Once this form is completed and entered in Eaglesoft **you do not need to update it.**)
ii. A copy of the Privacy Practice at CCCC should be made available to your patient during their initial appointment.
iii. In Eaglesoft, a check mark should be placed in the HIPAA block and Privacy Notice block in the patient information page to indicate the form is in the chart. The dates must match.

F. When the Health Questionnaire and HIPAA are completed, the clinic assistant will bring your clipboard to you.
G. Under no circumstances are patients to be in your chair until they have been checked in properly. Even if they are your family or friends they must remain in the patient reception area and are not to be seated in the clinic until after an instructor is in the clinic and proper procedures are completed. Failure to follow proper check-in procedures or to seat a patient before a faculty member is in clinic will result in the assessment of a MAJOR error.
H. Student clinicians may not leave the clinic floor without permission from an instructor.

Seating the Patient – Before Check-In

Once your patient has filled out/updated the Patient Data Sheet, Health Questionnaire, Patient Rights and Responsibilities, Scope of Comprehensive DH Care, and HIPAA, the office manager will set the arrival indicator. (See Appendix D for copies of these forms) **Under no circumstance are you to escort your patient into the clinic until the patient has been checked in.**

Go to the reception area and greet your patient. Escort the patient to your cubicle. Make sure purses and valuables are left in sight of the patient and taken by patient upon leaving the chair.

The College cannot be responsible for personal property of patients. Hang coats on coat racks, not on your cubicle divider. Make sure to have patients turn their cell phones off upon entering the clinic.

Please do not walk patients through patient operatories.

1. Seat patient, adjust chair (including armrests), and headrest for maximum comfort of patient and operator.
2. Have patient rinse for 30 seconds with chlorhexidine mouth rinse, or Listerine Zero and have patient spit into disposable cup. Use saliva ejector if necessary.
3. What the patient sees and hears on his/her first appointment makes a lasting impression on him/her. Create a good impression in appearance, poise, and speech. Be cheerful, kind, and confident no matter how you feel, SMILE! Make your surroundings neat and non-threatening.
4. Words have psychological influence. Do not use such words as "hurt, scrape, dig, needle, cry, afraid," etc., as these words tend to produce the sensation they suggest. Instead, try phrases such as, "this will not bother you" or, "let me know if this is uncomfortable."

Cancelled or Failed Appointments

If a patient calls to cancel an appointment or fails to show up for an appointment:

1. Open “OnSchedule” and go to the appointment block scheduled.
2. Right click on the appointment block and select “DELETE.”
3. Choose:
    a. Failed – if patient did not show or cancelled within 24 hours.
    b. Cancelled – if patient called to cancel at least 24 hours prior to appointment time
4. Unclick “Add this appointment to the quick fill list.”
5. Click “OK.”
6. At “There are services . . .” click “NO.”
7. Record the failed, cancelled, or no-show appointment in the Eaglesoft Record of Treatment. A MAJOR error will be assessed if you fail to do this.

Changing a Scheduled Appointment

1. Open “On Schedule” and go to the appointment block you wish to change.
2. Right click on the appointment block and choose “Move the appointment/block.”
3. Using the arrows in the tool bar, go to the date and time you wish to move the appointment to (the appointment will show in the original location until the move is complete).
4. Click on appoint queue (double arrows on center left of screen).
    a. Left click on patient and drag into preferred appointment slot.
    b. Appointment will now disappear from the initial appointment and appear only in the new block.

Note: When treating a patient, if you do not perform all the procedures listed or if you perform additional procedures NOT listed in the appointment schedule, it will be necessary to remove them from the system.

Significance of Flags

In the clinic, a flag system is used to indicate that you have completed a required task or need the help of an instructor. The flag system is as follows:

1. Black - Student is ready to have their Health Questionnaire and Drug Summary checked. A black flag is also used to request Radiographs.
2. Blue - Student is ready to have their Intraoral/Extraoral Exam checked.
3. Blue/Green - Treatment Plan checked.
4. Yellow - Student is ready to have a scale check.
5. Green - Student is ready to have a polish check.
6. Yellow/Green - Student needs scale and/or polish assistance from faculty.
7. White - Student requests the help of DDS for anesthesia, dental charting, to check for decay, to evaluate radiographs, to evaluate Heath History, to request sealants, and/or to request dental/medical referral.
8. Red - Medical emergency.
9. Blue/Yellow - Indicate student is ready to have a proficiency/competency graded.
10. All - Faculty review of clinical notes.
11. A plastic patient cup placed on top of your cabinet indicates you need help from the CA-screener.

Check-In

1. **General information:**
    a. Students are expected to meet all appointments promptly. **A student is considered tardy if he/she is not in clinic by 8:45 or 12:45.**
    b. Patients under 16 MUST have a parent or guardian in reception area during treatment that can make immediate emergency medical decisions concerning the health of the minor patient.
    c. Students are not permitted to:
        i. Seat patients before they have been processed by the clinic assistant and/or office manager.
        ii. Seat patients before an instructor is in clinic.
        iii. Treat minors (under 18 years old) without a parent or legal guardian signing both the Health Questionnaire, HIPAA and consent form.

2. **Forms and Eaglesoft templates to be completed and checked by an instructor *before you begin scaling***:
    a. Health Questionnaire/Dental Interview
    b. Drug Summary
    c. HIPAA
    d. Extraoral/intraoral inspection/restorative charting (TMJ, OCCLUSION, HEAD)
    e. Periodontal charting and Treatment Plan.
    f. Full mouth probing on adult patient's first visit and each subsequent re-care appointment.
    g. Record of Treatment - patient's full legal name, last name, first name
    h. Name on grade sheet
    i. Calculus charting of the first quadrant to be scaled on all 02 calculus patients in DEN 221 & DEN 231. Staple the calculus chart to your grade sheet.
    j. Bring up most recent radiographs in Eaglesoft.
    k. You MUST have the periodontal chart open to consult during scaling and the most recent set of radiographs pulled up on your computer
    l. Take and process radiographs if the patient needs them and has a dentist to which the radiographs will be sent.

3. **Requesting an instructor:**
    a. All patients must be checked by an instructor before beginning treatment.
    b. When obtaining a Health Questionnaire/Drug Summary, Intraoral/Extraoral Inspection/Restorative charting, Dental Interview/Periodontal Charting/Treatment Plan Worksheet and Care Plan check by an instructor, meet the instructor outside of the operatory to discuss.
    c. Once you have completed the Health/Dental Questionnaire, Drug Summary, and vital signs, put up a **Black** flag and sign faculty sign-up worksheet to have an instructor check and sign.
    d. If you need "permission to proceed = PTP," update your Health Questionnaire and Drug Summary, and put up your **Black** flag.
    e. If you need to "request radiographs" compete your Health Questionnaire, Drug Summary, and necessary forms for radiographs, then put up your **Black** flag.
    f. When you have completed your Intraoral/Extraoral Inspection and Restorative charting, put up your **Blue** flag and sign faculty sign-up sheet to have an instructor check. (TMJ, OCCLUSION, HEAD)
    g. When you have completed your Treatment Plan put up a **Blue/Green** flag and sign faculty sign-up sheet for an instructor to check.

h. To have your scaling checked put up a **Yellow** flag and sign faculty sign-up sheet.
i. If you need help with scaling, root planing, Cavitron, or Prophy Jet, put up your **Yellow/Green** flag and sign faculty sign-up sheet for a **Dental Hygiene instructor only**.
j. If you need to have your patient anesthetized, have questions about decay, radiographs, questions about sealants, or questions about drugs or the Health Questionnaire, put up a **White** flag and sign faculty dentist sign-up sheet for the **clinic dentist only**.

4. **Instructor-Student Interaction:**
   a. After you have briefed the instructor on the Health Questionnaire/Drug Summary or Intraoral Inspection/Restorative Charting or Dental Consent/Periodontal Charting/Treatment Plan, proceed to the operatory.
   b. Always introduce the instructor. In general, the patient's name precedes that of a faculty member. For example, "Mrs. Jones, I'd like you to meet my instructor, Ms. Wesner."
   c. As the instructor checks forms, you will be expected to click on the appropriate tabs being checked so the instructor can read the information or dictate information to the instructor as asked. Be prepared to type in a **red font** to make notations on the computer, on the grade sheet, as the instructor directs. The instructor who checks your periodontal charting will agree or disagree with the classification of the patient that you have circled on the grade form. You may not work ahead. Whatever assignment was given must be checked by an instructor before a student is allowed to move on to another area. MAJOR errors will be assessed in the event a student works beyond their assignment.

Review of the Health Questionnaire (Medical History) - Black

- The Health Questionnaire is completed at the Screening and New Patient appointment. This form is signed by the patient, screener/clinician, and instructor. All entries must be signed for legal purposes.
- Review and update the Health Questionnaire of a screened patient or a patient you have seen before. If the patient is a new patient to you, have the patient complete a new Health Questionnaire. Transfer information into Eaglesoft Medical History.
- You are responsible for all information on the medical history. By following up on information on the Health Questionnaire, you can gain valuable information. Use program drug reference textbooks, such as the *Drug Information Handbook for Dentistry,* to learn about drugs or diseases. Find out why a patient is on penicillin (you could contract strep throat), why they had a chest x-ray (TB?), or why they had the hysterectomy (CA?). It is your responsibility to be able to answer any questions an instructor has concerning your patient's medical history. For patients requiring premedication, refer to your Clinic Manual section on premedication. The medical history must include all prescription medications that the patient is taking.

Sequence of Procedure:

1. Review the patient's Health Questionnaire and Drug Summary prior to any treatment. This must be done at the beginning of every appointment.
2. **New Patients/Screening Patients**
   a. Review dental interview and ask all necessary questions making sure that all information is entered into Eaglesoft accurately and signed by the patient using the signature.

b. Check that only patients of legal age (18 and over) have completed and signed the forms.
c. Health questionnaire forms of patients under age 18 must be completed and signed by parent or legal guardian.
d. If the parent or legal guardian has not completed and signed the health questionnaire and interview form, dismiss and reappoint the patients under 18.

3. **Re-care and Subsequent Appointments**
    a. Review the health questionnaire with the patient/parent.
    b. Ask if there have been any changes in the patient's health since the last visit.
    c. Write any significant changes in the comment section of Eaglesoft; have patient sign using the signature pad.
    d. Have patient sign the electronic health history form at every appointment and when changes are indicated. (ie: medication, illness, etc.)

4. **Evaluation of Health Questionnaire**
    a. Note significant “yes” answers in Medical Alert box and/or comment section in Eaglesoft Health History.
    b. Ask appropriate follow-up questions to "yes" responses.
    c. Record responses in comments section in Eaglesoft.
    d. Any condition that may warrant precaution prior to dental treatment is noted in Eaglesoft alerts. Refer to your pre-clinic notes.
    e. Record that the questionnaire has been reviewed on the Clinic Chart Note. Include any additional information that is deemed necessary.
    Example: Pt. took premed (list name and amount).
    f. Note pertinent information in a concise, scientific, legible manner in Eaglesoft.
    g. Take blood pressure, pulse, respiration, and temperature on every patient during your first appointment with them and **every subsequent re-care appointment, also ask patient to self-report their weight for local anesthetic dosage calculation**.
    h. Make sure your patient has signed and dated the medical history. If the patient is a minor, under 18 years of age, the legal guardian must sign the Health Questionnaire or treatment will not be rendered. If the patient is under 16, the parent must remain in the reception area.
        i. If a minor is not accompanied by his/her parent, all paperwork requiring parental signatures must be signed by the parent or guardian and presented at the time of check in.

ASA Status Classification System

ASA Classification	Definition	Examples, including, but not limited to:
ASA I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use
ASA II	A patient with mild systemic disease	Mild diseases, only without substantive functional limitations. Examples include (but not limited to): current smoker, social alcohol drinker, pregnancy, obesity (30<BMI<40) well-controlled DM/HTN, mild lung disease

ASA III	A patient with severe systemic disease	Substantive functional limitations. One or more moderate to severe diseases. Examples include (but not limited to): poorly controlled DM or HTN, COPD, morbid obesity (BMI>40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, premature infant <60 weeks, history (>3 months) of MI, CVA, TIA, or CAD/stents
ASA IV	A patient with severe systemic disease that is a constant threat to life	Examples include (but not limited to): recent (<3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or ESRD not undergoing regularly scheduled dialysis
ASA V	An moribund patient who is not expected to survive without the operation.	Examples include (but not limited to): ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction
ASA VI	A declared brain-dead patient whose organs are being removed for donor purposes	
*The addition of “E” denotes Emergency surgery. (An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part) Reference: https://www.asahq.org/resources/clinical-information/asa-physical-status-classification-system Last approved by the ASA House of Delegates on October 15, 2014.		

5. **Significant Health Questionnaire Findings**
    a. See medical referral section of this manual for further information.
6. **Procedures for Obtaining Physician's Approval-Healthcare Provider Communication**
    a. The student involved must request the physician’s approval for treatment via fax.
    b. Annotate in Eaglesoft notes that written consent has been received from the physician via a fax bearing MD signature.
    c. Depending on the patient's condition, if the physician cannot be reached the student may need to dismiss the patient and reappoint when medical consultation can be completed.
    d. All correspondence is required to be scanned into Smartdocs in Eaglesoft. Student is responsible for ensuring that this is accomplished. Provide copy to Office Manager to be scanned.

7. **Procedures for Additional Medical Concerns**
    a. **Patient Medications**
        i. Be sure patient has taken medications prescribed for medical conditions.
            1. There will not be any dispensing of pre-medication on-site. Some dental practices will have on-site medications. However, the dental hygiene clinic at CCCC does not maintain medications for patients.
            2. Prescribed inhalers, nitroglycerin, and/or EpiPen are required to be readily accessible during treatment. A critical error will be assessed if not followed.
        ii. Use an appropriate drug reference or call pharmacist for any information about unfamiliar medications. Note all pertinent information and/or precautions.
        iii. Take appropriate precautions for medications, which may affect dental treatment.

            1. **Bisphosphonates:** Bisphosphonates have been mostly used to treat osteoporosis but may also be used to treat cancers. Patients must be asked if they have a history of osteonecrosis while taking this medication due to the increased risk. Jaw osteonecrosis seems to be associated with trauma. Most cases occur after extractions and are located near the mylohyoid ridge. Of those not associated with extractions, they are commonly associated with dentures or exostoses. Chronic periodontitis also increases the risk of osteonecrosis development. Osteonecrosis will appear as exposed yellow-white bone. Sinus tracts and painful ulcers may also be present. Students should be aware of these symptoms and alert the instructor of this medication.

            2. **Warfarin (Coumadin):** Warfarin is an oral anticoagulant used to prevent clotting. It interferes with the blood's clotting by blocking the production of the clotting factors (II, VII, IX, and X), which are vitamin K dependent and are synthesized in the liver. Indications for warfarin include atrial fibrillation, post-MI, or thrombophlebitis. Warfarin's major side effects relate to its action to increase bleeding with symptoms such as petechia, bruising ecchymosis, hematuria (bleeding into the urine), or frank hemorrhage. Whether a patient will exhibit side effects from warfarin is difficult to predict and unrelated to the degree of anticoagulation present.

                Warfarin's anticoagulant effect is monitored using the laboratory test for prothrombin time (PT). Within the last few years, PT has been replaced with the international normalized ratio (INR). The INR uses the prothrombin (PT) but corrects for the variability of the tissue thromboplastin used the laboratory where the test was performed. Therefore, the INR can be compared among laboratories worldwide. Laboratories report their results either at the PT or at the INR.

                Most dental references state that dental procedures can be performed if the PT ratio (ratio of patient's PT to the PT of the control) is ≤ (less than or equal to) 2. A PT ratio of 1.8 would result

in an INR of about 4.5. If the INR is less than 4.5, (or the PT is less than 2) most dental treatment can be safely performed. A recent INR is needed to assess the patient's anticoagulant status.

b. **Guidelines for Management of Patients with Elevated Blood Pressure**
   i. Explain to patient what is to be done.
   ii. Determine and record every ADULT patient's blood pressure on first visit, each re-care visit, and each appointment if the patient reports high blood pressure and/or a history of heart disease.

Identify possible medical emergencies related to the blood pressure and be prepared to handle the emergency should it occur.

SIGNIFICANT HYPERTENSION IN CHILDREN		
AGE	**SYSTOLIC**	**DIASTOLIC**
3-5	>116	>76
6-9	>122	>78
10-12	>126	>82
13-15	>136	>86
16-18	>142	>92

CLASSIFICATION OF BLOOD PRESSURE FOR ADULTS AGE 18 & OLDER**		
Category	**Systolic (mm Hg) (SBP)**	**Diastolic (mm Hg) (DBP)**
Normal	<120 and	<80
Stage 1 Prehypertension	120-139 or	80-89
Stage 2 Mild Hypertension †	140-159 or	90-99
Stage 3 Moderate Hypertension †	160-179 or	100-109
Stage 4 Severe Hypertension †	<180	<110
Source: http://vasculararcures.org/high-blood-pressure-and-vascular-disease/		

** Not taking antihypertensive drugs and not acutely ill. When systolic and diastolic blood pressures fall into different categories, the higher category should be selected to classify the individual's blood pressure status. For example, 160/92 mm Hg should be classified as stage 3 hypertension, and 174/120 mm Hg should be classified as stage 4 hypertension.
† Based on the average of two or more readings taken at each of two or more visits after an initial screening.

DETERMINING RISK/PROVIDING DENTAL TREATMENT	
Normal/Stage 1 Prehypertension	Systolic 139 or lower or Diastolic 89 or lower 1. No contraindications to elective dental treatment.
Stage 2 HTN	Systolic 140-159 or Diastolic 90 – 99 1. Retake and confirm blood pressure. 2. Proceed with elective dental treatment. 3. Monitor blood pressure during appointment. 4. Refer patient to physician for medical evaluation.
Stage 3 HTN	Systolic 160-179 or Diastolic 100-109 1. Retake and confirm blood pressure. 2. If blood pressure is unchanged, consider immediate referral of the patient to a physician or emergency room for evaluation. 3. Emergency or non-invasive elective treatment only if approved by clinic DDS. 4. Medical consult required prior to any dental treatment unless approved by clinic DDS.
Stage 4 HTN	Systolic > 180 or Diastolic > 110 1. Retake and confirm with alternative device, such as mercurymanometer type sphygmamanometer. 2. If blood pressure is unchanged, immediate referral of the patient to a physician or emergency room for evaluation. 3. No treatment of any type should be undertaken. 4. Medical consult required prior to any dental treatment

c. **Transmissible Diseases**

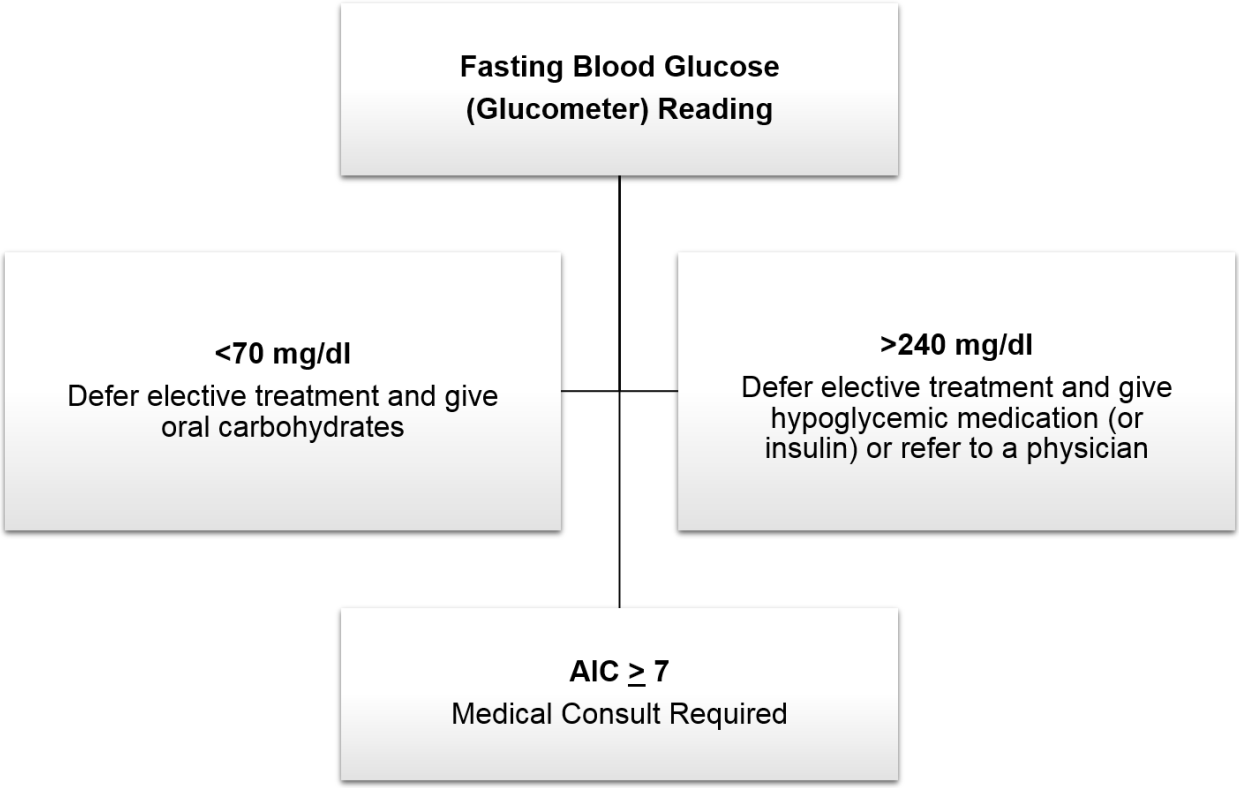
i. Any patient presenting with active infection of a transmissible/communicable disease is to be evaluated for possible dismissal and reappointment upon discussion with the patient and consultation with a faculty member.

ii. Patients presenting with a history of a transmissible disease must be evaluated as to present status of the disease. Consultation with the treating physician is to be made in determining carrier status of the disease, when appropriate. Modifications to dental treatment and possible reappointment will be made based on this evaluation.

iii. Patients who present with clinical signs of Herpes Labialis (fever blisters) will be dismissed and reappointed no sooner than ten days to avoid the spread of Herpes Simplex Type I.

d. **Guidelines for Management of Patients with Diabetes**

BLOOD GLUCOSE LEVELS*



*Decision-Making diagram for dental treatment of patients with diabetes depending on blood glucose levels.

Monitoring Glucose Levels. Blood-glucose levels can be checked chairside using a drop of blood. Glucometers designed for use in a variety of settings, such as nursing homes, health fairs or dental clinics, are available by prescription. Because they are intended for use by multiple individuals, they are designed to facilitate thorough cleaning and disinfection between uses to help prevent the spread of bloodborne pathogens. After each use, the device must be cleaned and disinfected according to the manufacturer's instructions.

Source: https://www.ada.org/en/member-center/oral-health-topics/diabetes

End-Product Evaluation Criteria

Each student is required to complete a PROCESS FOR OBTAINING & ASSESSING A MEDICAL & DENTAL HISTORY SKILL SHEET.

1. Proficiency during DEN 121.
2. End-product evaluation of health questionnaire is done at every appointment.

3. Student should complete the medical history, consent, and HIPAA information on Eaglesoft and be ready for instructor at check in.

Dental Consent/Interview – Black

- The dental interview is done on all patients during the first appointment of the series. The **student** should ask these questions to get to know the patient better, so they can develop a treatment plan accordingly. At this time, the Eaglesoft questions that are found in the HISTORY, GENERAL, and HEALTH tabs are asked. The dental interview will be checked at medical history by faculty. A new dental interview is done at each re-care appointment.
- Faculty will perform a preliminary intra oral and extra oral examination on every patient. Prior to dismissal faculty will also perform an intra oral and extra oral examination on every patient.

Extraoral/Intraoral Inspection - Blue

- Using techniques learned in your preclinic course, perform a thorough extraoral/intraoral inspection. Describe lesions as you would in Oral Pathology. In the CCCC clinic, complete the Eaglesoft tabs on TMJ, OCCLUSION, and HEAD. Use the electronic patient worksheet form and comment on all abnormalities in the space provided. Refer patients as necessary using the guidelines as outlined in Referral Section of this manual.
- A new extraoral/intraoral exam is performed on all patients. **The use/copying of previously gathered data is cheating and will result in dismissal from the program.**

Sequence of Procedure:

Open a new clinical exam tab in Eaglesoft

1. Observe patient during reception and seating to make overall appraisal.
2. Approach exam with a confident attitude, give clear instructions to the patient, and provide adequate explanations.
3. Observe and palpate extraorally, while the clinician stands:
    - Parotid gland region
    - Temporal region (pre- and post-auricular)
    - Temporomandibular joint region
    - Submental, submandibular, and sublingual region
    - Trachea and thyroid gland
    - Occipital region
    - Sternocleidomastoid muscle
    - Cervical nodes (upper and lower)
4. Observe and palpate when appropriate intraorally:
    - Lips
    - Labial and buccal mucosa, vestibules, and frena
    - Floor of the mouth
    - Tongue
    - Hard palate and soft palate
    - Uvula, tonsillar pillars, and oropharynx
    - Alveolar mucosa
    - Edentulous gingival
5. Note occlusal relationship including overjet, overbite, and related habits.

6. Differentiate normal from abnormal and recognize common nonpathologic deviations from normal.
7. Record on the Patient Worksheet form and Eaglesoft Notes a concise, scientific, and legible description of any abnormality including location, size, color, morphology, type, symptoms, and duration. This information is also recorded in the comment section of the Eaglesoft "**Head**" tab.
8. If everything is within normal limits, this should be charted as WNL.
9. Follow up significant findings at subsequent appointments as necessary.
10. Determine need for patient referral and identify the appropriate health professional. Complete a Medical or Dental Referral, sign it and have patient and instructor sign. Annotated in Eaglesoft notes that referral was made and a copy was given to the patient. Place copy in Administrative Assistant's in-box for Eaglesoft Smartdocs scan of document.

Required Evaluations:

A proficiency on the extra and intra oral inspection is completed in DEN 131 - Dental Hygiene Clinic

End-product evaluation will be done after every oral inspection examination procedure.

Periodontal Charting – Blue

- The gingival description and AAP periodontal classification should be completed on the Perio tab of Eaglesoft. Remember to place the CCCC classification in the comment section at the bottom of the Perio Tab. Ex: III 3L. Click on the "circle" in front of the Perio Case Type to indicate Type I, II, III, IV.
- On all screened adults (over the age of 18) the PSR will be completed at the screening appointment. Complete periodontal probing will be done on patients during their first visit and the 1st appointment of the re-care appointment. A new Periodontal Exam must be performed and new chart used.
- For patients under 17 years and under, you must complete PSR in Eaglesoft. Circle all bleeding points as with adults. Also, as with adults, record probing depths over 3mm.
- For all patients 18 years and older, probe all permanent teeth. Record all probing depths, bleeding, suppuration, and recession, mobility, furcations, and fremitus. The mucogingival line will be recorded for your treatment plan patients.

Sequence of Procedure:

A new periodontal chart is completed at each new exam in the appointment series or at the re-care appointment. The use/copying of previously gathered data is cheating and will result in dismissal from the program. In Eaglesoft:

1. Place patient's most recent radiographs on the computer screen.
2. Record the CCCC perio and calculus classification on patient worksheet.
3. Correctly assess within 1 mm of accuracy the periodontal probing depths on all teeth. Record when pockets are above 3 mm or there is recession.
4. Indicate all bleeding points.
5. Correctly assess within 1mm of accuracy the amount of recession (CEJ to the gingival margin).

6. Accurately assess the absence or presence of attached gingiva in all patients. Record your findings.
7. Assess probing depths, recession, bleeding, suppuration, mobility, migration, mucogingival involvement, and furcation involvement as determined by clinical and/or radiographic examination (when radiographs are available.) Record significant findings. Record all findings in Eaglesoft.
8. Review the patient's periodontal condition with the instructor prior to presentation to the patient.
9. Review the patient's periodontal condition with the patient.
10. PSR should be completed for patients 17 and under. Do not probe partially erupted teeth.

Required Evaluations:

1. Each student is required to complete periodontal charting competency at mastery level during DEN 131, DEN 141, 221 and 231 as a part of DH Treatment.
2. End-product evaluation is done after every periodontal charting procedure.
    a. Reading is incorrect if it varies more than 1mm from the clinical instructor's reading.

Errors

1. If a student receives more than 10 errors (to include more than 1mm difference in probing depth; recession and or BOP), they will receive 1 major error and will have to re-chart periodontal errors with instructor assistance.

Classification of Patients

Remember that a patient's periodontal condition is always changing. If your patient was a III-03-H four months ago they may be classified as a III-01-M at the current appointment. Previous periodontal findings should be considered as guidelines when scheduling patients to meet clinical requirements.

In order to satisfy Standard 2-16 of the Commission on Dental Accreditation for Dental Hygiene, each student must complete a variety of patients in the clinical courses. The patients must be completed no later than the last day of clinic in Dental Hygiene Clinic IV (DEN 231). Any student who fails to complete patients in the listed categories will not be allowed to graduate from Central Carolina Community College's Dental Hygiene program. The following categories will be used to classify the patients:

- Child (0-13)
- Adolescent (14-17)
- Adult (18-60)
- Geriatric (61 and over)
- Special Needs/Medically Compromised: Any patient defined as any person with any physical, emotional, social or medical condition where routine treatment needs to be altered.

Patients will be classified as follows:

Periodontal Classification (CCCC)

Type 0	Health	No inflammation or loss of function due to destruction of supporting tissues.
Type I	Gingivitis	Inflammation of the gingiva characterized clinically by changes in color, gingival form, position, surface appearance, and the presence of bleeding, or exudate. No clinical attachment loss or bone loss.
Type II	Slight Chronic Periodontitis	Progression of gingival inflammation into the deeper periodontal structures and slight alveolar crestal bone loss. There is usually a slight loss of connective tissue attachment. Findings may include: three or more areas of probing depths of 4-5mm or CAL of 4-5 mm, recession of 1-2mm, or bone loss up to 20%.
Type III	Moderate Chronic Periodontitis	A more advanced stage of periodontitis, with increased destruction of the periodontal structures and noticeable loss of bone support (20-50%), possible accompanied by increased tooth mobility. There may be furcation involvement in multirooted teeth. Findings may include: three or more areas of probing depths of 6-7mm or CAL of 6-7 mm, recession of 3-4mm, bone loss from 20-50%.
Type IV	Advanced Chronic Periodontitis	Further progress of periodontitis with major loss of alveolar bone support (50% or greater), usually accompanied by increased tooth mobility. Furcation involvement in multirooted teeth is likely. Findings may include: Three or more areas with probing depths of 8 or > or CAL of 8 mm or >, recession of 5mm or >, bone loss of 50% or >.
Type V	Recurrent Chronic or Aggressive Periodontitis	Multiple disease sites that continue to show attachment loss after apparently appropriate therapy. These sites presumably continue to be infected by periodontal pathogens, no matter how thoroughly or frequently therapy is provided. Includes patients with recurrent disease at a few or many sites. Gradual increases in radiographic bone loss due to unfavorable patient response to conventional periodontal treatment.

(AAP) American Academy of Periodontology Periodontal Classification

Gingival Diseases	• Plaque-induced • Non-plaque induced
Chronic Periodontitis	• Localized • Generalized

Aggressive Periodontitis	• Localized • Generalized
Periodontitis as a Manifestation of Systemic Disease	• Hematological disorders • Genetic disorders • NOS
Necrotizing Periodontal Diseases	• NUP • NUG
Abscesses of the Periodontium	• Gingival • Periodontal • Pericoronal
Periodontitis Associated with Endo. Lesions	• Combined periodontic and endodontic lesions
Developmental or Acquired Deformities and Conditions	• Localized tooth-related factors • Mucogingival deformities • Occlusal trauma

Calculus Classifications (0-05)

Type 0	Little or no calculus present; minimal scaling.
Type 01	Slight supragingival calculus in one to two areas, such as the lower lingual anteriors and/or facial surfaces of maxillary molars AND/OR slight subgingival calculus in similar areas not more than 1 mm deep.
Type 02	Slight to moderate supragingival calculus limited to the cervical third, AND slight to moderate subgingival calculus, not more than 3 mm deep, in two or more typical areas of the mouth such as the lingual of the mandibular anteriors, facial surfaces of maxillary molars or interproximally.
Type 03	Moderate to heavy supragingival AND subgingival calculus generalized throughout the mouth, typically involving 2 or 3 surfaces of each tooth. Bands of subgingival may be 2+ mm wide and may be deposited in scattered pockets of 3-5 mm. **There must be a minimum of six (6) teeth per quadrant to receive quadrant credit.**
Type 04	Very heavy, hard, tenacious subgingival calculus generalized throughout the mouth. Accessibility may be difficult due to pockets or tooth alignment. **There must be a minimum of six (6) teeth per quadrant to receive quadrant credit.**
Type 05	(Pre-surgical) Heavy calculus/generalized supra and subgingival with pockets of 6 mm or more. Marked mobility to horizontal and/or vertical forces and tooth migration are present. This classification has been established for cases that are complicated by extreme sensitivity, multiple severely decayed teeth, periapical abscesses, advanced periodontitis, or any other condition, which, in the clinical judgment of the

	instructor, increases the difficulty of the case. Those patients will receive a pre-surgical scaling for a limited number of appointments and the student will receive appropriate credit for a 03/04 requirement. **There must be a minimum of six (6) teeth per quadrant to receive quadrant credit.**

****Calculus ratings of 02 must be determined between two faculty****

Stain Classifications (L, M, H, X)

Class L	Light Stain	Stain may or may not be present. Stain, if present, is slight extrinsic along the cervical line. (May be coffee, tea, tobacco, green, black line, or orange.)
Class M	Moderate Stain	Stain is moderate limited to the cervical third of the teeth and involving not more than half of the teeth.
Class H	Heavy Stain	Stain is heavy and generalized throughout the mouth, covering at least half the exposed tooth surfaces.
Class X	Extra Heavy Stain	Stain is very heavy, tenacious (such as pipe stain, which appears to be "baked-on"). Scaling is generally required to remove stain.

Restorative Charting – White

- Chart all existing restorations for each new patient as instructed in your preclinic class. In the CCCC clinic, use the EagleSoft charting portion of the program.
- On re-care patients, students must **update** existing restorative charts in EagleSoft. Put a white flag up to have your Restorative Charting checked by the dentist during the dental exam. Each clinician will be graded on the data presented. Check carefully to assure that the dental chart is accurate and changes have been updated. Use radiographs.

Sequence of Procedure:

The Eagle Soft dental chart should be updated at each new exam in an appointment series. The student is responsible for accuracy and graded accordingly.

1. Select appropriate examination instruments and armamentarium.
2. Differentiate normal from abnormal and recognize disturbances or changes in the characteristics of teeth, including number, size, form, color, structure, and contact relationship.
3. Identify pathologic changes.
4. Accurately record findings of the examination. Follow the EagleSoft instructions you received in DEN 131.
5. Review recorded findings aloud, when asked, using appropriate dental terminology for verification by the clinical instructor/dentist.
6. Update dental charting after exfoliation and/or dental treatment.

Required Evaluation

1. Each student is required to complete a dental charting tutorial and proficiency during DEN131. All patients new to you must have a new Restorative Charting. Restorative Charting should be updated on re-care patients.
2. End-product evaluation is done after every dental charting procedure.

Dental Exam – White

A dental exam is required for every new patient and at each recare visit. A white flag should be raised when a dental exam is requested.

Sequence of Procedure:

1. Mirror, explorer, and 2x2 gauze should be placed on the bracket tray. (Be sure to clean the mirror.)
2. Be prepared to relay your findings of suspicious areas and patient's chief complaint to DDS.
3. Have radiographs on computer.
4. Be prepared chart dentist's findings in the dental chart of Eaglesoft.
5. Complete referral, if needed, and scan into Smartdocs.

The Treatment Plan Worksheet- Blue/Green

- In all clinical courses, students are required to complete a treatment plan worksheet to aid them in developing a Dental Hygiene Care Plan. The Treatment Plan worksheet is designed to develop critical thinking skills by addressing significant findings, explain what its relevance is to dental hygiene treatment, the procedure or intervention to address that condition, the reason why we are addressing it and how much time the student feels he/she will need (self-assessment with time management). The student attempts to classify the periodontal and calculus classification and formulates a Dental Hygiene Diagnosis statement. When this is complete a blue/green flag signals for an instructor to check the students work and assist with the completion of the treatment plan worksheet, Dental Hygiene Diagnosis and Care Plan. An instructor's signature is required on completion of this document to show it is accurate and then the student will verbally inform the patient of the proposed care plan.

The Dental Hygiene Care Plan and Diagnosis – Blue/Green

- The dental hygiene care plan is an outline of the necessary educational and clinical services and procedures to be performed during the course of the dental hygiene appointment sequence.

Sequence of Procedure:

1. Plan your treatment based on the significant findings from the health questionnaire, dental interview, oral inspection, radiographs, and dental-periodontal charting.
2. Develop and record a planned sequence for completing all educational and clinical dental hygiene services needed by the patient, based on knowledge of oral conditions, patient characteristics, and student abilities. A care plan should be developed for ALL new and re-care patients.
3. List, in sequence, the procedures, and services to be performed at each visit

on the electronic treatment plan form, listing the educational procedures in the right-hand column and the clinical procedures in the left hand column. Be specific and make sure to list any potential medical or dental referrals needed.

4. Write a one statement *Dental Hygiene Diagnosis Statement* identifying the problem "related to" the etiology for that specific patient's periodontal or oral hygiene status.
5. Discuss all aspects of the care plan with the instructor **in front of the patient**.
6. Discuss all aspects of the care plan with the patient **prior** to the treatment. Use terminology that he or she can understand. Include the current condition of the oral cavity and the factors affecting it. **Make sure the patient understands their periodontal and restorative needs!** Inform the patient of the number of appointments you will need to complete their care.
7. Print the care plan. The patient must sign and date the treatment plan form before any treatment is rendered. In the case of a minor, under 18 years of age, the parent, legal guardian, or properly authorized person must sign the treatment plan form.
8. Assess the plan and modify it as necessary at subsequent appointments in light of changes in the oral conditions, patient characteristics, and/or student abilities. Put a **blue** and **green** flag up when you are ready for your Treatment Plan to be checked. The student will begin treatment in the area of 1st priority.

End-Product Evaluation Criteria

1. During DEN 131, faculty shall assist students in developing a care plan.
2. DH care plans are evaluated after PCR is completed (Blue/Green flags).
3. End-product evaluation is done after every DH care plan completed in DEN 141, DEN 221, and DEN 231.

Patient Education

Sequence of Procedure:

1. Identify and record patient health education in the educational plan column on the Dental Hygiene Care Plan.
2. Record your patients' preventive needs and current home care procedures and products used.
3. Select and record on DH Care Plan specific brushing techniques and oral health care products (floss, perio aid, etc.).
4. A plaque control record (PCR) is calculated at each appointment before scaling is started. The student will review essential oral hygiene education with the patient to lower the PCR at subsequent appointments.
5. Discuss what the patient's current OH routine is and what products they are using.
6. Relate to your patient, their home care, restorative work, periodontal condition, radiographs, etc.
7. Explain and demonstrate correct oral hygiene home care to your patient. Record on Clinic Chart Notes the kind of toothbrush, floss, or other dental aids you dispensed.
8. Reevaluate and update home care at every appointment.

Dental Hygiene Treatment - Calculus Removal

Sequence of Procedure:

1. The effectiveness of calculus removal will be evaluated using mirror, explorer, and air by observing the soft tissue condition and response.
2. All tooth surfaces will be free of deposits without injury or damage to the hard or soft tissues.
3. All root surfaces will be free of residual calculus and biofilm by instrumentation, creating a surface that is smooth when explored, and creating an environment that promotes a soft tissue wall that does not bleed upon probing and is normal in color.
4. ***Each tooth must be scaled to completion before moving to the next tooth.***

Calculus Removal Required Evaluation	
DEN 131 and DEN 141	End-product evaluation is completed after every oral prophylaxis procedure. • Subgingival calculus surface errors counted after initial instructor evaluation only. • Plaque, stain and supra calculus surface errors **will be counted twice**, after initial instructor evaluation and after re-evaluation. Example: If the student misses two areas of plaque on check out, the instructor will ask the student to go back and remove the plaque and have the areas checked again. If the plaque areas are still there, the two areas on the grade sheet are circled and instead of two errors, the student has four errors for plaque removal.
DEN 221 and DEN 231	End-product evaluation is completed after every oral prophylaxis procedure. • Surface errors (supra and subcalculus and stain) are counted after initial instructor evaluation and after reevaluation. Example: If upon initial exam the instructor finds three errors, and upon recheck one of those errors remains, that error will count an additional point. Thus, the student will be charged with four errors, not three.
End product self-evaluation is also recorded by the student. Student will record areas missed on the electronic patient assessment form. All 02 calculus rating patients will be determined by two faculty.	

Stain and Soft Deposit Removal

Sequence of Procedure:

1. Procedures used for stain and soft deposit removal include polishing with the slow speed handpiece/prophylaxis angle and/or the air polisher (prophy jet).

2. The objective of polishing is to remove extrinsic stains and plaque not otherwise removed during scaling.
3. Professional judgment based on patient need should be used to determine when a service should be included.
4. Assess the need for polishing. You need only polish areas of plaque and stain - **use selective agent principles.**
5. If polishing is necessary, always use the least abrasive agent.
6. Utilize proper technique for stain/plaque removal to ensure that the tissue is not traumatized and that all plaque and stain are completely removed.
7. Use appropriate aids for interproximal surfaces, orthodontic appliances, bridgework, etc. **Never forget to floss!**
8. If the decision is made not to polish, remove plaque and soft deposits by using appropriate methods (scale, toothbrush). Explain to your patient why you elect not to polish.
9. As a self-evaluation measure, the student should disclose the patient's teeth after polishing and flossing.
10. Call the instructor to evaluate the effectiveness of polishing and flossing procedures only when all plaque and extrinsic stain have been removed.
11. Patient education with respect to polishing.
    a. Plaque and stain form on the natural teeth and their replacements.
    b. Explain why too frequent polishing in the dental office is not advisable.
    c. Explain why it is not necessary to polish all teeth at every appointment.
    d. Explain to the patient the objectives of **selective** agents as they relate to his/her oral condition. Example:
        i. Removes stain that cannot be removed by home care procedures.
        ii. Polishing may have limited positive effects.
        iii. Prevents removal of fluoride rich layer of enamel.
        iv. Reinforces the patient's role in maintaining oral health.
    e. Stains and bacterial plaque removed by polishing can return promptly if plaque is not removed faithfully on a schedule of two to three times each day.
    f. Polishing agents utilized in the dental office or clinic is too abrasive for daily home use.
    g. Explain the need for adapting tooth brushing and flossing techniques to clean abutments.
    h. *If you receive 10 or more plaque errors for polishing on assigned areas in one appointment, you will be required to complete polish with faculty assistance.
    i. Patients must completely plaque and calculus free upon dismissal from their last appointment. You may and should selectively scale and polish quadrants completed in prior appointments.
12. The student will record areas missed on the electronic patient assessment form.

Stain and Soft Deposit Removal Required Evaluation	
DEN 131	The student must complete teaching/ proficiency evaluations on the use of the slow speed handpiece
DEN 131, 141, 221, and 231	Stain and soft deposit removal is evaluated as an end product evaluation. There is no program requirement for these procedures.
DEN 221 and DEN 231	End-product evaluation is completed after every stain, supragingival calculus, and soft deposit removal procedure.

	• Surface errors (supra and subcalculus and stain) are counted after initial instructor evaluation and after reevaluation. Example: If upon initial exam the instructor finds three errors, and upon recheck one of those errors remains, that error will count an additional point. Thus, the student will be charged with four errors, not three.
End product self-evaluation is also recorded by the student. Student will record areas missed on the electronic patient assessment form. All 02 calculus rating patients will be determined by two faculty.	

Documentation-All Flags

- Documentation is a vital part of the comprehensive care dental hygiene process and must be completed at EVERY appointment.

Sequence of Procedure:

1. Fill out your Clinical Chart Note in the appropriate Eaglesoft template.
    a. The written Clinical Chart Note should include the following: All notes must be very neat and legible. Health History, Assessment, Treatment, Exam, Next Visit: **HATEN** format.
    b. Date and patient care for each visit
    c. Review medical history (rev. med. hx.)
    d. Oral inspection –
        i. If all is normal (WNL=within normal limits)
        ii. Describe the location, size, color, borders of each lesion
        iii. Note any abnormality or something that needs to be checked at the next appointment (describe what needs to be re-checked-severe cheek bite L buccal mucosa near #18)
    e. If all readings 3mm or below summarize your findings). For example: All PD are 3mm or less, with no BOP.
    f. If readings are over 3mm, create a summary of your findings. Example: "Generalized moderate gingivitis in posterior areas with 4-5 mm interproximal probing depths and bleeding."
    g. Record findings of biofilm control record. Example: PCR-25%
    h. Be specific on the type of toothbrushing and whether you taught your patient to use any other auxiliary aids. Example: Modified Stillman (Mod. St.) dispensed J & J Reach woven floss and Oral B toothbrush. The patient demonstrated good dexterity with toothbrush but had difficulty flossing.
    i. Exactly what you did (scale, root plane, polish). Recording the quadrants you scaled and polished on the treatment plan from (words will be used in Eaglesoft notes, i.e. UL, LL quads).
    j. If you use the cavitron, piezo, or prophy-jet, make sure you record that information.
    k. If fluoride is given - APF or NaF. (Acidulated Phosphate Fluoride or Sodium Fluoride) or fluoride varnish.
    l. Special patient instructions. Example: Salt water rinse for 7 days

m. If patient was referred to a physician, periodontist, oral surgeon, etc., make sure you note this information and why a referral is being made.
n. If anesthesia was given record type of anesthetic, amount used, and area anesthetized. Ex: 1.8ml 4% Septocaine 1:100,000 epi used in UR quadrant
o. Next visit (N.V. - what you plan to do next visit).
p. Re-care (note only on final visit) - 3 mo., 6 mo., 12 mo. Eaglesoft's default interval is 6 mo.
q. Note anything you want to check on next visit. Example: Ck. lesion on max. rt. buccal mucosa.
r. *Type of radiographs - record under Assessment column. Example: 4-BW, 1-PA, 14- FMX, digital BWX, digital Pan ……. and indicate the number of retakes.
s. *Classification" of patient is under Assessment
t. Review patient education (rev. pt. ed.) - do this at each appointment after initial appointment. Calculate a PCR before you begin patient education so that the patient is aware of their status.
u. If patient was given a prescription, record the drug, dose, and number of tablets. Example: Rx: Amoxicillin 500 mg, 4 tabs.
v. Note that patient took premedication. Example: Pt took 4 tabs of 500 mg Amoxicillin premed at 6:30 AM (time).
w. Date and Dentist's name of where radiographs are being sent (via email or U.S. Postal Service).

IMPORTANT: The Clinical Chart Note must be written and signed by the student **before operatory cleanup is completed**. It is the student's responsibility to make sure the information is complete, and an instructor signs the Clinical Chart Note before leaving the operatory. **Points will be deducted for not having the Clinical Chart Note completed before asking for a checkout**.

Points will be deducted for a clinical chart note without an instructor's signature if discovered after patient's appointment.*

First Year HATEN Example:

H: Patient presents for dental hygiene services. 34/F RB/P:110/70 P:54 R:14 T: 97.2 ASA-III ADL-O LDV: 8 mos. ago. Pt. has not traveled outside of the US within the past 6 mos. Non-smoker. NKA. Patient reports using alcoholic beverages on a daily basis. Patient diagnosed with diabetes (Type II) controlled with diet and hypertension. Patient reports eating a banana and oatmeal for breakfast. Blood glucose at 9:15 am was 125 mg/dl. A1C: 6.0. Pt. takes the following medications: hydrochlorothiazide (HBP), calcium with vitamin D. Dental considerations: HCTZ-orthostatic hypotension and xerostomia (MDDR p.1009), calcium with vitamin D-sensitivity to dental light may indicate toxicity, any signs of weakness, headache, nausea, vomiting, dry mouth may indicate overdose (MDDR p. 1375). No contraindications to dental treatment.

A: Listerine Pre-rinse given. FMX. EOE: No significant findings. Occlusion: R. Molar: Class I. R. Canine: Class I. L. Molar: Class I. L. Canine: Class I. Moderate overbite. 3mm overjet. No midline deviation. #25 torsoverted. #27 torsoverted and labioverted. Teeth: Abfraction on mesial labial #11. Large amount of attrition on incisal surfaces. Porcelain crown on #2,4,5,7,8,9,10, 12,13,14,15,18,22. Porcelain bridge #19-21. MD amalgam #29. MODF amalgam #30,31. Staining on mandibular anteriors. IOE: Lips: Fordyce`s granules left and right labial commissures. Scar on lower left lip. Oral Mucosa: Trauma on left and right maxillary labial mucosa. Mandibular labial mucosa highly vascularized with petechiae. Linea alba on left and right buccal mucosa. Fordyce`s granules inside right labial commissure. Hard Palate: Pronounced palatal rugae. Soft palate: Red patches. Tonsils removed. Floor of mouth: bilateral mandibular tori. Tongue: ventral surface of tongue highly vascularized. Dorsal surface of tongue coated with petechiae on lateral sides. Pt. has good salivary flow. Periodontal assessment: 1 mm recession on # 2,13,15,18,24,25. 2mm recession # 22 & 23. 3mm recession on direct buccal #3. 5mm recession on mesial buccal #3. 1mm mobility #24. I furcation involvement buccal # 31. II furcation buccal #3 (mesial, distal lingual I)#30. III furcation with suppuration buccal #14,19. Gingival description: Generalized pink, scalloped, resilient/firm, with stippling present. Localized blunted papillae on mandibular anteriors. Rolled margins localized to lingual of mandibular anteriors. Abscess on buccal #19. Cleft gingiva on buccal #12. BI: .006%, PCR: 28.4%. AAP: Generalized Chronic Periodontitis and Localized Aggressive Periodontitis Perio: II loc III. Calc: 01. Stain: M

T: OHI: Use of Reach flosser and interdental brush. Hand-scaled and cavitron quadrants I,IV. Hurricane Topical placed. 2.3 ml of 2% lido w/epi administered-UR-PSA, MSA, ASA, LR-IA, lingual, buccal; - aspiration-administered by Dr. _____. Anesthetic consent signed and scanned into SmartDocs. Patient tolerated treatment well.

E: DDS Exam-Dr. _____: Sent referral with patient to have recurrent caries #30,31 and mucocele on right lower lip evaluated.

N: Review med. hx. Reassess, PCR, Update Treatment plan, OHI. Handscale Quads II & III. Student Name/Faculty Name

Upon completion of treatment, denote type of polishing agent and fluoride used.

Second Year HATEN Example:

H: Pt presents for dental hygiene tx. 37/M, RBP:128/92, P:64, R:13, T: 98.0, ASA II, ADL 0, LDV: 1.5 yrs. ago. Non-smoker. NKA. Patient diagnosed with hypertension. Pt. takes the following medications: hydrochlorothiazide (HBP), calcium with vitamin D. Dental considerations: HCTZ-orthostatic hypotension and xerostomia (MDDR p.1009), calcium with vitamin D-sensitivity to dental light may indicate toxicity, any signs of weakness, headache, nausea, vomiting, dry mouth may indicate overdose (MDDR p. 1375). No contraindications to dental treatment.

A: Listerine zero pre-rinse given. 7 VBWX exposed [D0277]. Assessment: [D0180] Popping L TMJ, mucocele R lower lip, incisive papillae cyanotic/erythemic, scalloped tongue, lingual varicosities, bilateral mandibular tori, Occlusion Class I molars and canines, 1mm OB, 1mm OJ, 1mm midline deviation to R, crossbite 13, 19 and 20, attrition 6, 10, 11 and 22-27, gingiva are generalized pink with knife edge margins, pyramidal interdental papillae, stippled texture, BI 2%, See Perio chart for PPD, CAL and furcations. PCR: 32%. AAP: Generalized Moderate Periodontitis and Localized Aggressive Periodontitis. Perio: II loc III. Calc: 01. S: M

T: OHI: [D1330] Use of Reach flosser and interdental brush. [D4341] Quadrants I and IV. Arestin [D4381] placed 2ML, 3DL. Hurricane Topical placed. 2.3 ml of 2% lido w/epi administered-UR-PSA, MSA, ASA, LR-IA, lingual, buccal; - aspiration-adminstered by Dr. _____. Anesthetic consent signed and scanned into SmartDocs. Patient tolerated treatment well.

E: DDS Exam-Dr. _____: [D0150] Sent referral with patient to have mucocele on right lower lip evaluated.

N: 4 week eval for Arestin. Student Name/Faculty Name

Upon completion of treatment, denote type of polishing agent and fluoride used.

HATEN Series of Appointment Examples:

First Appointment: Only the Medical History was completed on this day. An FMX was taken, the Assessment was partially completed. Only complete the Assessment notes when it has been completed. The PCR should be taken at every visit and OHI should be given at every visit no matter how much work is done.
H: Patient presents for dental hygiene services. 34/F RB/P:110/70 P:72 R:14 T: 97.2 ASA-III ADL-O LDV: 8 mos. ago. Pt. has not traveled outside of the US within the past 6 mos. Non-smoker. NKA. Patient reports using alcoholic beverages on a daily basis. Patient diagnosed with diabetes (Type II) controlled with diet and hypertension. Patient reports eating a banana and oatmeal for breakfast. Blood glucose at 9:15 am was 125 mg/dl. A1C: 6.0. Pt. takes the following medications: hydrochlorothiazide (HBP), calcium with vitamin D. Dental considerations: HCTZ-orthostatic hypotension and xerostomia (MDDR p.1009), calcium with vitamin D-sensitivity to dental light may indicate toxicity, any signs of weakness, headache, nausea, vomiting, dry mouth may indicate overdose (MDDR p. 1375). No contraindications to dental treatment. A: Listerine prerinse given. FMX. Assessment in progress. PCR: 28.4%.

T: OHI: Show, tell, do of the Reach flosser

E: N/A

N: Update medical history, complete assessment, DDS Exam, PCR, OHI, Treatment Plan, begin scaling. BMcStudent/AMcTeacher

Second Appointment: At the second appointment, the Medical History was updated and the Assessment, DDS Exam, PCR, OHI, and Treatment Plan were completed. The student was also able to start scaling.

H: Patient presents for dental hygiene services. 34/F RB/P:112/72 P:82 R:14 T: 97.5 ASA-III ADL-O LDV: 8 mos. ago. Pt. has not traveled outside of the US within the past 6 mos. Non-smoker. NKA. Patient reports using alcoholic beverages on a daily basis. Patient diagnosed with diabetes (Type II) controlled with diet and hypertension. Patient reports eating a banana and oatmeal for breakfast. Blood glucose at 9:15 am was 125 mg/dl. A1C: 6.0. Pt. takes the following medications: hydrochlorothiazide (HBP), calcium with vitamin D. Dental considerations: HCTZ-orthostatic hypotension and xerostomia (MDDR p.1009), calcium with vitamin D-sensitivity to dental light may indicate toxicity, any signs of weakness, headache, nausea, vomiting, dry mouth may indicate overdose (MDDR p. 1375). No contraindications to dental treatment.

A: Listerine prerinse given. EOE: No significant findings. Occlusion: R. Molar: Class I. R. Canine: Class I. L. Molar: Class I. L. Canine: Class I. Moderate overbite. 3mm overjet. No midline deviation. #25 torsoverted. #27 torsoverted and labioverted. Teeth: Abfraction on mesial labial #11. Large amount of attrition on incisal surfaces. Porcelain crown on #2,4,5,7,8,9,10, 12,13,14,15,18,22. Porcelain bridge #19-21. MD amalgam #29. MODF amalgam #30,31. Staining on mandibular anteriors. IOE: Lips: Fordyce`s granules left and right labial commissures. Scar on lower left lip. Raised brown lesion on lower right lip area, 6mmx5mm, has been present for two months and irritates patient. Oral Mucosa: Trauma on left and right maxillary labial mucosa. Mandibular labial mucosa highly vascularized with petechiae. Linea alba on left and right buccal mucosa. Fordyce`s granules inside right labial commissure. Hard Palate: Pronounced palatal rugae. Soft palate: Red patches. Tonsils removed. Floor of mouth: bilateral mandibular tori. Tongue: ventral surface of tongue highly vascularized. Dorsal surface of tongue coated with petechiae on lateral sides. Pt. has good salivary flow. Periodontal assessment: 1 mm recession on # 2,13,15,18,24,25. 2mm recession # 22 & 23. 3mm recession on direct buccal #3. 5mm recession on mesial buccal #3. 1mm mobility #24. I furcation involvement buccal # 31. II furcation buccal #3 (mesial, distal lingual I)#30. III furcation with suppuration buccal #14,19. Gingival description: Generalized pink scalloped, resilient/firm, with stippling present. Localized erythemic bands, blunted papillae on mandibular anteriors. Rolled margins localized to lingual of mandibular anteriors. Abscess on buccal #19. Cleft gingiva on buccal #12. BI: .006%, PCR: 28.4%. AAP: Generalized Chronic Moderate Periodontitis, CCCC Perio: III. Calc: 03. Stain: M

T: OHI: Use of interdental brush. Hand-scaled and cavitron quadrants I, IV. Hurricane Topical placed. 2.3 ml of 2% lido w/epi administered-UR-PSA, MSA, ASA, LR-IA, lingual, buccal; -aspiration-adminstered by Dr. _____. Anesthetic consent signed and scanned into SmartDocs. Patient tolerated treatment well.

E: DDS Exam-Dr. _____: Sent referral with patient to have recurrent caries #30,31 and

raised brown lesion on right lower lip evaluated.

N: Review medical history, Reassess, PCR, OHI. Handscale Quads II & III. BMcStudent/RFacultater

Third Appointment: At the third appointment the student updated the Medical History, Reassessed, PCR, OHI, and continued scaling of the patient.

H: Patient presents for dental hygiene services. 35/F RB/P:112/70 P:85 R:14 T: 97.5 ASA-III ADL-O LDV: 8 mos. ago. Pt. has not traveled outside of the US within the past 6 mos. Non-smoker. NKA. Patient reports using alcoholic beverages on a daily basis. Patient diagnosed with diabetes (Type II) controlled with diet and hypertension. Patient reports eating a banana and oatmeal for breakfast. Blood glucose at 9:15 am was 125 mg/dl. A1C: 6.0. Pt. takes the following medications: hydrochlorothiazide (HBP), calcium with vitamin D. Dental considerations: HCTZ-orthostatic hypotension and xerostomia (MDDR p.1009), calcium with vitamin D-sensitivity to dental light may indicate toxicity, any signs of weakness, headache, nausea, vomiting, dry mouth may indicate overdose (MDDR p. 1375). No contraindications to dental treatment.

A: Listerine prerinse given. Reassess: trauma on the incisive papilla due to hot food burn, ulceration 3mmx2mm, PCR: 13%. AAP: Generalized Chronic Moderate Periodontitis, CCCC Perio: II loc III. Calc: 03. Stain: M

T: OHI: Show, tell, do Modified Bass brushing technique. Hand-scaled and cavitron quadrants II,III. Hurricane Topical placed. 2.5 ml of 2% lido w/epi administered-UL-PSA, MSA, ASA, LL-IA, lingual, buccal; - aspiration-administered by Dr. _____. Patient tolerated treatment well.

E: Dr. _____ was informed that a report was submitted by the patient from the pathologist noting that the lesion on the lower lip is benign. The report was scanned into SmartDocs.

N: 4-6 Week Re-eval, Review medical history, Reassess, PCR, OHI, re-probe, scale/polish/floss/fluoride. BMcStudent/RFacultater

Fourth Appointment: At the fourth appointment (4-6 week re-eval) the student updated the Medical History, Reassessed, PCR, OHI, probed, scale/polish/floss/fluoride.

H: Patient presents for 4-6 week re-eval. 35/F RB/P:112/74 P:78 R:15 T: 97.5 ASA-III ADL-O LDV: 8 mos. ago. Pt. has not traveled outside of the US within the past 6 mos. Non-smoker. NKA. Patient reports using alcoholic beverages on a daily basis. Patient diagnosed with diabetes (Type II) controlled with diet and hypertension. Patient reports eating a banana and oatmeal for breakfast. Blood glucose at 9:15 am was 125 mg/dl. A1C: 6.0. Pt. takes the following medications: hydrochlorothiazide (HBP), calcium with vitamin D. Dental considerations: HCTZ-orthostatic hypotension and xerostomia (MDDR p.1009), calcium with vitamin D-sensitivity to dental light may indicate toxicity, any signs of weakness, headache, nausea, vomiting, dry mouth may indicate overdose (MDDR p. 1375). No contraindications to dental treatment.

A: Listerine prerinse given. Reassess: trauma on the incisive papilla has healed completely, PCR: 9%. AAP: Generalized Chronic Moderate Periodontitis, CCCC Perio: III. Calc: 01. Stain: M

T: OHI: Show, tell, do of Superfloss for bridge. Hand-scaled all quadrants, fine selective polish, floss, Fl varnish. Patient tolerated treatment well.

E: N/A

N: 3-4-Month Recall. BMcStudent/BTeachery

Remember: Once you complete the medical history, open up your instrument kit, place the indicator strip on the keyboard, sign in on your faculty's sign-in sheet, throw your flag, and wait for the faculty.

Once the faculty checks the medical history, the faculty will complete a quick intraoral exam to make sure it is OK to treat the patient that day.

At the end of the appointment, faculty should check the oral cavity one more time before the patient leaves to ensure that there have been no injuries or concerns with the oral cavity at that point.

Request for Anesthesia -White

Sequence of Procedure:

If your feel that your patient requires anesthesia, please follow this procedure:

Prior to appointment:

1. Show dentist the patient's chart and if possible, let the dentist meet your patient and discuss anesthesia with them.
2. Give the reasons that you feel your patient needs to be anesthetized.
3. Be prepared to discuss the nerves that you feel will need to be anesthetized.

At appointment time:

1. **Review the medical history and take blood pressure and annotate patients self-reported weight at the beginning of each appointment anesthesia is needed.**
2. Once DDS agrees that the patient will be anesthetized, **assemble the syringe** out of the patient's view. Make sure the anesthetic is not out of date. Place the syringe and the anesthetic (normally 3 cartridges) on the assistant bracket tray. ***Complete the anesthetic consent form.***
3. Once DDS gives you permission, dry the tissue and isolate the area to be anesthetized. Follow all manufactures' instructions for dosage and application guidelines.
4. Assist DDS and rinse the patient's mouth after the injection.
5. Document in the Clinical Chart Note:
    a. Type of topical anesthesia placed (Hurricane, benzocaine, Cetacaine, Oraqix, ect.)
    b. Type of anesthesia used - including % (4% Septocaine, 2% Lidocaine)
    c. Amount of epinephrine (1:100,000)
    d. How much anesthetic was used (ml)
    e. Which area was anesthetized (UR, or specific teeth #)
    f. Injections given (PSA, MSA, ASA, NP, GP, IA, LB, L, mental, infiltration Teeth #).

g. Document how patient tolerated procedure (PTP: good, fair, nervous, jumpy etc.).
h. For example: Profound topical placed, 4% Septocaine 1:100,000 x 1.7ml LR quadrant IA, LB, L. PTP very well.
i. Document whether a negative or positive aspiration occurred.

6. Never tell your patient that the injections will not hurt. Instead, if asked by the patient, let them know to expect the sensation of a "pinch" and the discomfort is "minimal."

Required Evaluations

Local anesthesia proficiency is part of DEN 131 and must be completed.

Periodontal Evaluation: Sequence of Procedure		
Patients receiving clinical care in the CCCC Dental Clinic: • Verify need with your clinical instructor at the time your dental hygiene care plan is graded • List the re-evaluation appointment on the care plan		
Patients demonstrating health, no inflammation, or loss of function due to destruction of supporting tissues	Perio Case Type 0	Clinical care: 1. Medical history update 2. Medication update 3. Vital signs 4. PTP from instructor {permission to proceed} 5. Cursory IO/EO 6. Gingival Exam 7. Periodontal exam 8. Self-care evaluation 9. Develop dental hygiene diagnosis statement, care plan worksheet, and care plan for the day. 10. Discuss status with instructor and patient. 11. Receive assignment from faculty {whole mouth}. 12. Oral hygiene instructions 13. Ultrasonic to: a. remove any stain b. disrupt subgingival biofilm 14. Selective polish any plaque-stain 15. Set re-care interval 16. Receive credit for stain-biofilm removal 17. Dismiss patient
Patients demonstrating gingivitis *Severe gingivitis modified by a. Endocrine system b. Medications c. Viral – fungal infections	Perio Case Type I	Clinical care: 1. Medical history update 2. Medication update 3. Vital signs 4. PTP from instructor {permission to proceed} 5. Cursory IO/EO 6. Gingival Exam 7. Periodontal exam 8. Self-care evaluation

d. Systemic conditions		9. Develop dental hygiene diagnosis statement, care plan worksheet, and care plan for the day. 10. Discuss status with instructor and patient. 11. Receive assignment from faculty {whole mouth}. 12. Oral hygiene instructions 13. Ultrasonic to: a. remove any residual/new deposits-stain b. disrupt subgingival biofilm 14. Selective polish any plaque-stain 15. Set re-care interval or refer 16. Receive credit for calculus-stain-biofilm removal 17. Dismiss patient
Patients demonstrating early periodontitis	Perio Case Type II	Clinical care: 1. Medical history update 2. Medication update 3. Vital signs 4. PTP from instructor {permission to proceed} 5. Cursory IO/EO 6. Gingival Exam 7. Periodontal exam 8. Self-care evaluation 9. Develop dental hygiene diagnosis statement, care plan worksheet, and care plan for the day. 10. Discuss status with instructor and patient. 11. Receive assignment from faculty {whole mouth}. 12. Oral hygiene instructions 13. Ultrasonic to: a. remove any residual/new deposits-stain b. disrupt subgingival biofilm 14. Selective polish any plaque-stain 15. Set re-care interval or refer 16. Receive credit for calculus-stain-biofilm removal 17. Dismiss patient
Patients demonstrating moderate to severe periodontitis 1. Four to six weeks after completion of initial therapy/scaling appointment	New to CCCC-Perio Case Type III or IV	Clinical care: 1. Medical history update 2. Medication update 3. Vital signs 4. PTP from instructor {permission to proceed} 5. Cursory IO/EO 6. Gingival Exam 7. Periodontal exam 8. Self-care evaluation

2. Schedule a re-evaluation appointment for approximately 1-1.5 hours. ***Do NOT schedule Perio Case Type III or IV patients who are in the perio maintenance phase of care to meet this program requirement		9. Develop dental hygiene diagnosis statement, care plan worksheet, and care plan for the day. 10. Discuss status with instructor and patient. 11. Receive assignment from faculty {whole mouth}. 12. Oral hygiene instructions 13. Ultrasonic to: a. remove any residual/new deposits-stain b. disrupt subgingival biofilm 14. Selective polish any plaque-stain 15. Set re-care interval or refer 16. Receive credit for calculus-stain-biofilm removal 17. Dismiss patient

<table>
<tr>
<td rowspan="2">Continued care Perio Case Type III or IV patients

***These patients will remain on 3-4 month perio maintenance re-care and will not meet quad scaling/DH TX Comp</td>
<td>Unstable perio status

-Increasing probing depths

-BOP or suppuration present</td>
<td rowspan="2">Next full series of appointments for this patient-type of credit that you will receive
• The patient's perio status should improve
• You will receive credit for this patient as the re-classification at the re- evaluation appointment
Example: A II-03-M may be reclassified as a II-01-L

Document the following:
1. Medical history update
2. Vital signs
3. Cursory EO/IO – Head tab of Eaglesoft
a. Note any significant changes
b. Note any significant findings
c. Do NOT note deviations from normal at this appointment (as you have already noted these)
d. Gingival exam – Perio tab of Eaglesoft
e. Describe soft tissue status
4. Periodontal exam-Perio chart-New perio exam
a. Probing depths
b. Recession-CAL
c. BOP
d. Suppuration
e. Furcations
f. Mobility
g. Measure mucogingival line ONLY if area has inadequate attached gingiva
5. RECLASSIFY this patient.
a. Self-care evaluation:
i. PCR
b. All clinical care delivered.
c. What next:
i. Continue perio maintenance re-care
ii. Refer to dentist of record for perio referral</td>
</tr>
<tr>
<td>Stable perio status

Example:
1. Receiving hygiene care every 3-4 months
2. Probing depths unchanged for 24+ months
a. Excellent self-care
b. Little or no BOP

In compliance with 3 or 4-month perio re-care appointments</td>
</tr>
</table>

Incomplete Patients

Follow the directions you will receive in each clinical course for incomplete patients.

Check Out

- Ask instructors for assistance as soon as you need it. DO NOT wait until the end of the appointment. Remember to put a **Yellow** flag out to get a scale checked. **Whatever scaling procedures were started during a clinic will be evaluated for a grade that same day.** It is important not to begin scaling areas that cannot be completed.

- The student is responsible for documenting all authorizations, prescriptions, recommendations, dental referrals, etc. It is also the student's responsibility to annotate patient information on the record repair form to give to supervising faculty to check the documentation for all prescriptions, procedure authorizations, and forms in Eaglesoft. It is the student's responsibility to make notes in Eaglesoft of all of the above.
- Check out time varies per semester. See course syllabi for specific times.

*****Time management points will be deducted on the grade sheet for failure to put a Yellow flag up by designated checkout time.*****

Before requesting a checkout, make sure you are ready!

1. Clean your mirror so that it is immaculate. Bracket tray should be neat and blood wiped off instruments. A clean 2 x 2 should be on the tray. The patient should be in supine position. If necessary, change the patient napkin. All soiled sponges should be placed in a cup on your bracket tray. Tidy up! Aseptic points will be deducted when an instructor comes to your cubicle for assistance or checkout if the above is not followed. Pass essential instruments to the instructor for each evaluation.
2. Make sure to have the correct # of teeth scaled and polished as well as the correct total # of teeth on the grade sheet.
3. Put up yellow or green flag. Complete check-out procedure - your instructor will come to your operatory and check the following:
    a. Scaling (what was completed that day).
    b. Polishing (what was completed that day).
    c. Patient education - be specific as to what instructions you gave your patient – type of aids dispensed.
    d. Whether a medical or dental referral is being done.
4. Be ready to record any areas you have missed in scaling or polishing on the assessment form electronically.
5. If areas are missed, you will be asked to remove them and be rechecked. An instructor will recheck the areas missed.
6. Apply fluoride if indicated.
7. An instructor will complete your grade sheet. They will also review your Clinical Chart Note and sign. The Clinical Chart Note will be checked after patient dismissal but before operatory clean up.

Incomplete Check-out Procedure

The instructor will come to your operatory and check the following:

1. Check teeth that were scaled and polished to completion and record areas missed on your grade sheet. You must complete areas missed and have them rechecked before dismissing the patient.
2. Schedule the patient's next visit.

3. Clinical Chart Note- make sure the instructor signs this. It is your responsibility to make sure your Clinical Chart Note is signed by an instructor before operatory clean up.

Dismissal of Patient

- Escort the patient to their personal belongings and help them to get oriented. Do not rush them out of the clinic. Escort them to the clinic waiting area. Every patient should be escorted out of clinic.
- The student is responsible for his/her assigned area at the end of each clinic session. There should be no trash, extra forms, personal belongings, dust, dirt, etc. left in any assigned area.

Paper records that need to be scanned into Eaglesoft Smartdocs as follows:

1. Recent Health Questionnaire and Drug Summary (if not able to complete and sign in Eaglesoft)
2. DH Care Plan
3. Dental/Medical Referral

DENTAL EMERGENCY AFTER HOURS
If patients have a dental emergency after 5:00 p.m., please advise them to contact their local dentist.

Patient Survey

Upon completion of each adult patient, the student must have **each patient complete a Patient Survey**. This form should be completed by the patient in the reception area and given to the office manager. Surveys are anonymous.

Completion of Dental Appointment

Clinical Patient Summary Evaluation forms must be completed within 48 hours of the patient's appointment time. Failure to do so will result in a deduction of points. Radiology Interpretation and grade sheets must completed within one week of the patient's appointment.

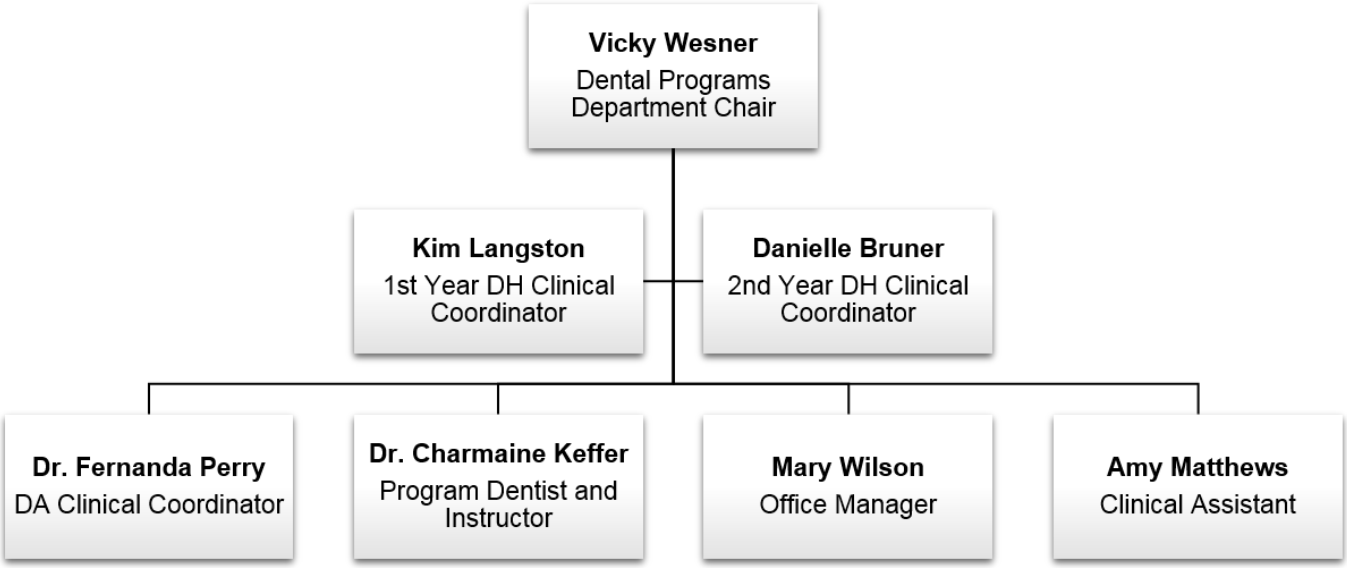
1. Follow steps outlined in the Infection Control Section for disinfection of unit and sterilization of instruments.
2. Students are expected to leave clinic area clean with unit turned off. Request supplies as needed from the *Faculty Clinical Assistant*. Make sure the area around the sink is dry. The floor around chair and unit must be clean at all times. The dental light, arms of unit, base of chairs, cavitron platform, view boxes, and the computer should be free of dust and debris. Adjust chair, light, and bracket tray. Raise chair, place light over chair in line with other lights, and adjust bracket tray over the chair seat. Dry sink and counter top.
3. Turn off the monitor. Swing the monitor out of the way of the dental chair.
4. If there are any problems with your unit, record what is wrong on the *dental maintenance work order form* located on the outside of each operatory. After completing this form, give to the instructor to sign and then to the office manager. You must acquire a full-time faculty's signature on this form before turning it in to the administrative assistant.

5. Students are not to leave the clinic until ten minutes before the hour. If you have finished all your work, help fellow classmates. Check with the CA/RA and screening student to help them complete their duties. Straighten the reception room, stock your cubicle, and ask the faculty if you can help them in any way! Be known as a team player and a helper - not as the "first one out the door!" Students who leave early without permission will have professional responsibility points deducted.

Cancellations and Failed Appointments

1. Students should call to confirm all patients seven days before their appointment and again 24 hours before. If the patient states they cannot come, note this in their record of treatment with the reason given, annotate on your record repair form for instructor review and initial.
2. Recurrent cancellations and failed appointments must be brought to the attention of the student's clinic instructor. All phone calls, failed appointments and cancellations, late arrivals or broken appointments must be properly recorded on the patient's record of treatment and in Eaglesoft.
3. If your patient fails to come by fifteen minutes after the scheduled appointment, call them. They may have overslept! If the patient cannot be reached or plans not to come, write “no show” in the notes section of Eagle Soft (give a brief statement as to why the patient failed the appointment) and let the front desk know immediately. You should find another patient.
4. If you cannot find another patient, ask your instructor what he/she would like you to do to help. This is not a time to study for an exam. There is always something to clean or a student who can use an assistant.
5. This is a good time to practice your team player skills.

Clinic Organizational Chart



SECTION 2: Clinical Requirements and Disciplinary Policy

Pre-Clinic/Clinic Evaluation Definitions:

Process Evaluation

- A Process Evaluation is an evaluation that tests a particular skill, independent of other skills being learned and demonstrated.
- When evaluating a procedure by process, each defined step of the procedure is personally observed by the assigned faculty member, ensuring that the student has properly executed each step.
- Examples of process evaluation include the Teaching, Proficiency and the Competency evaluations.
- Plan for these evaluations in advance and place the process evaluation sheets and magnet in/on the bin outside of the operatory.

Teaching

- "Practice" process evaluation (PE). Students perform a process evaluation/ proficiency without being formally evaluated. No grade is recorded for a teaching PE. During the teaching PE the instructor can offer appropriate coaching at each step, if necessary and desirable.
- Teaching PEs provide both students and faculty with additional opportunities for one-on-one instruction.
- The use of teaching PEs is encouraged prior to proficiencies and competency evaluations as a means of solidifying the student's confidence in his/her ability to perform at a desired level of competence.
- Put the blue and yellow flags up to request an instructor to evaluate your teaching PE.

Proficiency

- "Graded" process evaluation; an evaluation that tests the student on the performance of a newly learned skill.
- The student performs independently without faculty assistance, while the faculty observes.
- Proficiencies are used to determine the student's achievement of competence. Minimum performance levels and criteria are stated for each task.
- Students who do not achieve determined mastery levels during the proficiency evaluation may receive remedial instruction from the faculty and must be reevaluated until the stated mastery level is attained.
- If proficiency is completed at mastery level, it counts toward program requirements.
- Put the blue and yellow flags up to request an instructor evaluation.

Competency

- After the proficiency evaluation, competencies are completed at the stated mastery level.

- The student performs a competency evaluation as listed in each clinical syllabus until program requirements are met.
- The competency evaluation is intended to ensure that the student maintains the competence originally achieved with the proficiency evaluation and consistently performs at mastery level.
- The student must identify the patient as a competency patient and the instructor must give permission prior to the competency.
- The faculty member is not required to observe each detailed step of the criteria but must attempt to be present during some of the procedure.
- Once program requirements are met, the student is not observed, and the procedure is evaluated within the end product evaluation.
- All competencies must be met by the end of the program. The student will not graduate unless these are completed.
- Competencies will be tested as clinical skills develop: therefore, the level or difficulty of required competencies will increase with each successive semester.
- For example, patient assessment will be tested earlier in the curriculum and comprehensive care will be evaluated later in the curriculum.
- Students also will be evaluated on more difficult patient classifications as they progress through the curriculum.
- For the semester-by-semester PEs and competencies refer to chart provided in Section 2.
- If the student is unsuccessful at completing the competency exam successfully on first attempt, the student must meet with their supervising faculty before attempting the competency exam a second time. If the student is unsuccessful at completing the competency exam a second time, their course grade will result in an F. All students must meet 85% on a competency exam to pass. (If a student attempts the competency exam two times and passes it the highest possible earned grade is 85%)

Dental Hygiene Clinic Requirements

Requirements	Clinic I	Clinic II	Clinic III	Clinic IV
Patient Focus	Gingivitis (I) Calculus 0 & 01	Slight Periodontitis (II) Calculus 1 & 2	Moderate Periodontitis (III) Calculus 2 & 3 Recare Patients	Moderate to Advanced Periodontitis (IV) Calculus 3 & 4 Recare Patients - Total Care
Adult Patient Completion (min.=grade of 3)	5 complete treatment (max. of 2 Calculus 0)	5 complete treatment (max. of 2 Calculus 01)	8 complete treatment (max. of 2 calculus 01, 3 calculus 02) 8 quads need to be calculus 03/04	9 complete treatment (max. 1 Calculus 01, 3 Calculus 02) 8 quads need to be calculus 03 or 04 3 recare patients (will count as 2 of 9 complete)

			2 recare patient	
Child & Adolescent Patients	1 (primary or mixed dentition)	2 (primary or mixed dentition)	3 (at least 1 mixed dentition)	3 (at least 1 mixed dentition)
4-6 week re-eval	0	0	1	2
Geriatric	0	1	1	1
Medically Compromised Patients (Special Population)	0	1	1	1
Radiographs (Min=85%)	FMX-2 Panoramic-1 Adult BWX-3	FMX-2 Panoramic-1 Adult BWX-2 Pedo BWX-1 (1 HBWX)	FMX-2 Panoramic-1 Adult BWX-4 Pedo BWX-1 (2 HBWX, 2VBWX)	FMX-2 Panoramic-1 Adult BWX-4 Pedo BWX-1 (2 HBWX, 2 VBWX)
Intraoral Camera	0	0	1	1
Study Models	0	1	1	0
Pit & Fissure Sealants	0	1	8 teeth by end of Clinic IV	
Nutritional Counseling	0	1	1	1
Appliance Cleaning	4 appliances by end of Clinic IV			
Local Drug Delivery	1 patient by end of Clinic IV			
Healthcare Provider Communication	3 patients by end of Clinic IV			

Clinical Competencies and Process Evaluations per Clinical Course

Clinical Course	Process Evaluations	Practicals/Competencies
DEN 121	Refer to Course Syllabus	• UNC 15 Probe • ODU 11/12 Explorer • Area-Specific Curettes

		• Scalers • Universal Curettes • Polishing
DEN 131	• PSR • Gingival & Periodontal Exam (4 Process Evals) • Instrumentation (all instrument PE) • Oxygen Use • Patient Education • Dental Charting • Coronal Polishing • Fluoride Application (gel and varnish) • Syringe Set Up	• 3 Assessments • 2 Dental Hygiene Treatment *-healthy patient with simple calculus 0/1*
DEN 141 If a case patient is found, assess only. Schedule in the fall for treatment.	• Instrument Sharpening • Periodontal Instrumentation (1 quad – Type II or higher and 02 or higher) • Treatment Planning • OHI • Radiographic Interpretation • Oraqix Delivery • Emergency Procedures • Nutritional Counseling • Study Model • Tray Fabrication	• 2 Assessments *-one must be slight periodontal disease with calculus 02 or higher* • 1 DH Treatment *-must be slight periodontal disease with calculus 02 or higher* **Clinical Competency Process Evaluations:** • PSR • Gingival & Periodontal Exam (4 Process Evals) • Instrumentation (all instrument PE) • Oxygen Use • Patient Education • Dental Charting • Coronal Polishing • Fluoride Application (gel and varnish) • Syringe Set Up
DEN 221 Find perio maintenance patient. Find case patient. Intraoral photos	• 2 quads perio instrumentation (moderate deposit) • Local Drug Delivery • Re-evaluation • Intraoral Photography Series • Intraoral Camera • Preventive Counseling • Ultrasonic Instrumentation	• 3 Assessments *-must be one moderate periodontal disease* *-must be one 03/04* • 1 DH Treatment *-must be moderate periodontal disease* • 3 DH Treatment *-two calculus 01/02*

required.	• Air Abrasive Polish • Desensitization • 2 Extramural site rotations (2)	*-one calculus 03/04* • 2 Sealants **Clinical Competency Process Evaluations:** • Instrument Sharpening • Treatment Planning • OHI • Radiographic Interpretation • Oraqix Delivery • Emergency Procedures • Nutritional Counseling • Study Model • Tray Fabrication
DEN 231 Complete case patient.		• 3 Comprehensive DH care (includes assess, plan, DH treatment, supportive treatment and evaluation, and documentation) • 2 comp DH care must be moderate to advanced periodontal disease (at least one 03/04 with a 4-6 week re-eval) • 1 periodontal maintenance **Clinical Competency Process Evaluations:** • Perio Instrumentation (moderate to heavy deposit, Perio Type III or IV) • Local Drug Delivery • Re-Evaluation • Intraoral Photography Series • Intraoral Camera • Preventive Counseling • Ultrasonic Instrumentation • Air Abrasive Polish • Desensitization • Extramural site rotations (2)
Appliance Care – 4 appliance care completed by the end of Clinic IV		
Healthcare Provider Communication – 3 completed by the end of Clinic IV		
Sealants – 8 teeth completed by the end of Clinic IV		
After clinical competency is achieved for each process evaluation, the skill will only be graded as a portion of the end product evaluations.		

DISCIPLINARY PROCEDURES/POLICIES OF THE DENTAL HYGIENE PROGRAM (For additional information see the CCCC DH Policies and Procedures Manual)

ESCALATING PENALTY POLICY: NON-COMPLIANCE IN CLINICS/LABS

CRITICAL ERROR POLICY FOR CLINICS AND LABS*

Critical errors include those violations that are of grave consequence to the professional and ethical training of the student and/or the safety of all persons present in the clinical and/or lab area. The intent of this policy is to encourage students to:

- Maintain ethics and care in the treatment of patients.
- Maintain safety of all persons working in the clinic as it pertains to asepsis, the use of sterilization equipment, monitoring of sterilization, and dissemination of sterile instruments.

Critical Errors applying to all DEN courses and clinic - These critical errors include but are not limited to:	
CUMULATIVE CRITICAL ERRORS; PENALTIES CARRY OVER FROM 1ST YEAR TO 2ND YEAR **A critical mass asepsis error places groups of people at a health risk; it is not an isolated incident where a student breaks the chain of asepsis and exposes themselves to pathogens from their scheduled patient or vice versa. ****Examples are not all inclusive****	Mass Asepsis Critical Error: any breach in asepsis protocol that places the students, faculty, staff, and/or patient population at risk. A critical violation of asepsis involves failure to maintain and follow established clinic protocol such as: • Failing to operate and/or monitor sterilization equipment according to training procedures/established protocol; • Disseminating instruments that have not been adequately sterilized; • Using or preparing to use instruments that have not been sterilized; Other violations based on failure to follow established protocol in clinic that predisposes patients (and others) to infection or harm

NON-CUMULATIVE CRITICAL ERRORS; PENALTIES DO NOT CARRY OVER FROM 1ST YEAR TO 2ND YEAR
 	
****Examples are not all inclusive****
	• All infection control errors; however, mass asepsis errors are cumulative errors
	• Chronic non-compliance with established policies and protocols
	• Medical History:
	  ○ Failure to communicate medical history with faculty
	  ○ Failure to obtain a medical consult
	  ○ Failure to obtain appropriate signatures
	  ○ Failure to take a new medical history
	• EOE/IOE:
	  ○ Does not perform EOE/IOE
	• Management:
	  ○ Fails to obtain appropriate signatures
	• Communication

	○ Fails to provide consulting faculty with appropriate information regarding patient treatment
**ALL INFRACTIONS ARE CONSIDERED ON A CASE-BY-CASE BASIS AND FACULTY DISCRETION MAY BE USED.*	

Critical Error Penalties: Cumulative and Non-Cumulative	
CUMULATIVE and NON-CUMULATIVE CRITICAL ERRORS: The student will be required to comply with the following penalties/reprimands:	
1st Offense	• A grade of ZERO (0) for that patient will be given. • Remediation with clinical coordinator. • Student not allowed in clinic until remediation is successfully completed. Any missed clinical sessions will result in a ZERO (0). • Meet and discuss lessons learned/prevention techniques with the Dental Hygiene faculty prior to re-admittance to clinic. • Complete up to three (3) proficiency/competency evaluations on applicable clinical skills; student must score a minimum of 80% to be considered competent. Less than 80% will necessitate remediation in accordance to the instructions outlined in the course syllabus. • Student must sign an Admission of Critical Error Code of Conduct Form and state his/her knowledge of the repercussions of a 2nd offense: (signature denotes acknowledgement not always agreement)
2nd Offense	• A grade of ZERO (0) for that patient will be given. • Remediation with clinical coordinator. • Student not allowed in clinic until remediation is successfully completed. Any missed clinical sessions will result in a ZERO (0). • Complete up to three (3) proficiency/competency evaluations on applicable clinical skills; student must score a minimum of 80% to be considered competent. Less than 80% will necessitate remediation in accordance to the instructions outlined in the course syllabus. • Student must meet with the Dental Hygiene faculty and sign an Admission of Critical Error Code of Conduct Form that states his/her knowledge of the repercussions of a 3rd offense: (signature denotes acknowledgement not always agreement)
3rd Offense	• Dismissal from program. • Student will receive a dismissal letter. • Possibilities of re-admittance will be discussed with the student. • NOTE: Re-Admission or Advanced Placement Standing Policy will be followed if students desire to re-enter program.
**Students are allowed 2 cumulative and/or non-cumulative critical errors over the course of the entire program prior to dismissal. The only difference between cumulative and non-cumulative critical errors is that non-cumulative critical errors do not carry over from 1st year (DEN 121, DEN 131, DEN 141) to 2nd year (DEN 221, DEN 231) whereas cumulative critical errors are cumulative across all clinical courses. All critical errors will be cumulative within a given semester and/or academic year.	

Example 1	1 cumulative critical error plus 1 non-cumulative critical error equals 2 critical errors unless the non-cumulative critical error has been removed after DEN 141. Upon the 3rd critical error (cumulative or non-cumulative), the student will be dismissed and not eligible for re-entry.
Example 2	1 cumulative critical error in DEN 131, 1 non-cumulative critical error in DEN 141, 1 non-cumulative or cumulative critical error in DEN 221= 2 critical errors (the DEN 141 non-cumulative critical error did not carry over from the first year of training to the second year of training. Upon the 3rd critical error (cumulative or non-cumulative), the student will be dismissed and not eligible for re-entry.
Example 3	1 cumulative critical error in DEN 131, 1 cumulative critical error in DEN 141, 1 cumulative or non-cumulative critical error in DEN 221= 3 critical errors and program dismissal. Upon the 3rd critical error (cumulative or non-cumulative), the student will be dismissed and not eligible for re-entry.
**Disclaimer: These lists are not all inclusive. Additional areas may be incorporated/assigned if necessary to increase compliance to clinical policies. Students will be informed via class announcements, clinical discussions, and/or notations made on clinical grade sheets or progress notes prior to imposing additional penalties.	

GROUNDS FOR DISMISSAL*

Upon proof of any of the following student code of conduct violations, the student will be referred to the appropriate person(s) for discussion and evaluation of the violation. In accordance with the policies noted in the Dental Hygiene Handbook/Orientation Manual and/or CCCC Student Handbook/Catalog, positive findings of the following ***may result in the student being administratively dismissed from the program:***

- Plagiarism
- Neurological, sensory, physical, and/or emotional problems that inhibit training or jeopardize the safety of the patient
- Significant problems with eye/hand coordination that jeopardizes the safety of the patient and does not respond positively to training in a timely fashion
- Drug and/or alcohol abuse
- Insubordination
- Disregard for Program policies
- 3rd Critical Error Offense
- Insufficient grades
- Excessive absences
- Stealing
- Cheating on quizzes, tests, or exams
- Falsifying Information: Recording, or allowing to be recorded, any information that is not the truth. Falsifying of information may occur in many ways: on medical histories, periodontal charts, treatment records, appointment plans, clinical assignments/reports, etc. Falsifying information may result in health concerns for the patient and thus legal action against the school: this cannot be allowed.
- Refusal to Treat a Patient: Refusal to treat a patient who has been approved for treatment by the Program Director and/or Dental Hygiene faculty is discriminatory and constitutes a critical error.

Disclaimer: These lists are not all inclusive. Additional areas may be incorporated/assigned if necessary to increase compliance to clinical policies. Students will be informed via class announcements, clinical discussions, and/or notations made on clinical grade sheets or progress notes prior to imposing additional penalties.

SECTION 3: Clinical Evaluation of Student Performance

How to Complete a Grade Sheet in Clinic

Students: PLEASE USE BLACK INK PEN, Print Legibly

1. Print **Student Name**, last name, first name.
2. Print **Patient Last Name** (no nicknames) last name/chart ID #.
3. Complete the **Date**.
4. Is this a **New** patient (first time for re-care or screened), **Series** (continued care) or **Recall** (completed previously by you), you will circle New or Recall and or Series.
5. **Age** of patient.
6. **Number of Teeth** in the patient's mouth that you will clean. This number must equal the # teeth evaluated further down on the grade sheet.
7. **Patient Type:** Circle Pedo, Pedo-MD, Adolescent or Geriatric and/or special needs (list specific special need).
8. **PTP** (Permission to Proceed) is initialed by an instructor after the medical history is checked. **ASA Type, Medical Consultation, Medically Compromised** and **Conditions** should be completed after medical history approved by faculty.
9. Right after an instructor checks your periodontal charting circle the classification of **Perio, Deposits**, and **Stain**.
10. Fill in the case and competency points.
11. **Case Type & Status**: Circle G, CP, AP, SD or I, II, III, IV, V
    a. **G**=Gingivitis
    b. **CP**=Chronic Periodontitis
    c. **AP**=Aggressive Periodontitis
    d. **SD**=Systemic Disease
12. By check out the student must have put the # **teeth Evaluated** for Calculus and **Stain/Soft Deposit**.
13. When an instructor grades calculus and stain/soft deposit the student will enter the areas on the electronic assessment form.
14. An instructor will record the # **Surface Errors** for both calculus and stain/soft deposit and will initial. No grade sheet can be verified by an instructor without all the proper instructor initials.
15. **Adjunctive Services/Process Evaluations/Competencies**- an instructor must indicate the number of utilizations/# of teeth that met mastery level and initial.
16. **Total Penalty Pts**.- number of minor, major, and critical errors (see Major and minor grading criteria)
17. Complete **Treatment Completed Today** and **Next Visit**.
18. Student initials and dates this line after grade review.
19. Faculty will sign grade sheet once grade sheet is complete. Grades and requirements will not be entered without proper faculty and student signatures and grade sheets being completely/accurately filled out.

CLINICAL EVALUATION CRITERIA

Goal Setting

One characteristic of a professional is the ability to self-evaluate and plan for personal growth. Setting personal goals is an important part of life-long learning. Since not everyone has had

experience with setting goals, learning to set and use goals is as much a part of the curriculum as learning to use hand instruments or to examine a patient. In each semester's clinical course, students will be asked to identify personal goals beyond course expectations. Goals can focus on any area of clinical development that fits your needs and interests. Students will also be expected to write a reflective paper about goal achievement. See specific clinic syllabi for assignment due dates.

Written Assignments

A critical aspect of clinical development requires the **integration of didactic (classroom) knowledge with clinical decision-making**. Problem-solving and the ***critical thinking processes*** are less observable behaviors than demonstrated clinical tasks. In order to evaluate the ability to independently solve clinical problems, students will have written assignments. Specific assignments will vary by semester but may include case-based assignments, journal writing, and literature-based papers. Patient Summary Evaluations are a great tool to evaluate the integration of didactic knowledge with clinical decision-making.

Clinical Requirements

Basic patient requirements will be assigned each semester in order to give clinician adequate clinical experiences. These requirements are subject to change based upon need.

Mastery Level

The percentage grade that students must achieve on proficiencies and competencies in order to receive credit is the mastery level. The mastery level is 75% for DEN 131, 80% for DEN 141, 85% for DEN 221, and 90% for DEN 231. See clinic grade scale section to determine clinical mastery level per semester.

End Product Evaluation

End Product Evaluation is an evaluation that tests the student's performance of a combination of skills toward a desired overall result. The student is evaluated on the end product or final result of the total patient care at each clinic session. This evaluation does not require that the faculty member observe each step of the student's performance. During the end product evaluation, the student is evaluated on his/her overall performance of a variety of combined skills.

Example:

- Specific instrumentation techniques are not observed step by step. Instead, the student is evaluated on effective instrumentation by the amount of deposit remaining.

End product evaluations always imply and include process evaluations. **Penalty points are used during the end product evaluations for errors in the process performance of the skill or procedure.**

Example:

- A student is observed using the incorrect end of an instrument; a minor error is given for "instrumentation" on the grade sheet and figures into the total end product grade at the end of the semester.

Major Errors

Flagrant errors in any area will constitute a MAJOR error. Faculty may use their discretion when determining major/minor errors and clinical session grades.

Critical Errors

Critical Errors are given on proficiencies and end product evaluation. Critical Errors are errors that may affect the patient/operator welfare and thus warrant special attention.

A zero will be assessed for any critical errors.

Final Grades

The final grade in each semester of clinic is based on the students' performance in five areas: Process evaluations, competencies, clinic end product, radiology and problem-solving skills (self-evaluation/goals). Refer to course syllabus for further details. All course requirements must be met for any passing grade to be rendered. Refer to course syllabi for additional details.

Clinical Promotion Policies

A student must successfully pass all process evaluations, competencies, clinic end product, radiology and problem-solving skills (self-evaluation/goals) in each clinical course in the dental hygiene curriculum to progress to the next clinical course and graduate from the program.

Each of the following are evaluated each clinic session, per patient.

1. **Aseptic technique**
    a. Comply with all infection control standards.
2. **Area/Post Appointment**
    a. Cleanliness of unit and surrounding area.
3. **Instrumentation: Adaptation**
    a. Differentiate between the different instruments and select the appropriate instrument for the task.
    b. Select the correct working end of the instrument.
    c. Keep tip in contact with tooth surface by rolling handle.
    d. Direct tip apically toward the junctional epithelium.
    e. Establish angulation appropriate for type of stroke.
    f. Maintain parallelism by pivoting on the fulcrum.
4. **Instrumentation: Condition**
    a. Instruments should be maintained and used in proper condition so that the clinician can apply the proper amount of pressure to remove the deposits without damaging the tooth surfaces.
    b. A clean, SHARP cutting edge will leave the tooth surfaces free of deposits and the root surfaces ready to accept cell growth and allow the healing of periodontal tissues.
    c. Instruments have a finite useful life because reduction in the size of the blade from repeated sharpening results in decreased strength. Once instruments have been thinned significantly, they must be replaced to minimize the risk of breaking off instrument tips inside the patient's mouth. Hu-Friedy allows you to trade in your used instruments for a nominal fee.

d. The following criteria must be used in determining proper instrument condition:
    i. Use only those instruments that have been properly sterilized and stored. Check each instrument visually for any caked debris remaining on the blade or handle. If debris is present, consider the instrument contaminated, scrub instrument and re-sterilize.
    ii. Assess the quality of the cutting edge of the instruments selected for use at each clinic session. This assessment is done by visual inspection and tactile discrimination using your sharpening stick.
e. Evaluate the quality of the working ends of each instrument before use to identify overly thin blades. Any working end that has been reduced by 50 percent should be used only for light calculus removal. Any end that has been reduced by more than 50 per cent should be returned to Hu-Friedy for replacement.

    If you need to send an instrument back to Hu-Friedy because it has been sharpened wrong or is broken, fill out an "Instrument Return Form" and attach the sterilized bagged instrument to be replaced. This will have to be mailed to Hu-Friedy. Returns, repairs, replacement information for dental hygiene schools can be found in the link below:
    https://www.hu-friedy.com/sites/default/files/352_HF-138P_Returns_Repair_Form_2016-10_MC.pdf

    The following is the mailing address to Hu-Friedy:
    Hu-Friedy Mtg. Co, LLC.
    Attn: Technical Services
    3232 N. Rockwell
    Chicago, IL 60618-5982

5. **Instrumentation: Fulcrum**
    a. Use tip of ring finger.
    b. Ring finger is straight and supports weight of hand.
    c. Placement is close to working area.
    d. Appropriate palm direction.
    e. Appropriate pressure for stabilization.
    f. Placement on an incisal or occlusal surface or embrasure or use of an extraoral fulcrum in the posterior segments.

6. **Instrumentation: Grasp**
    a. Modified pen grasp
    b. Use pads of fingers to contact instrument.
    c. Index finger and thumb near handle/shank junction.
    d. Middle finger on shank.
    e. Handle rests between second and third knuckle of index finger.
    f. Fingers curved and relaxed, using appropriate pressure for the instrument and task.
    g. All fingers contact instrument as a unit.

7. **Instrumentation: Selection**
    a. Each instrument is designed for a specific purpose and is intended to be used for the purpose for which it was designed.
    b. The student will be able to differentiate between the different instruments and select the appropriate instrument for the task.
    c. The following characteristics should be considered when selecting instruments:

i. The anatomy of the tooth
ii. Root curvatures and furcations
iii. Location and extent of calculus deposits
iv. Anatomy of the sulcus or pocket

8. **Instrumentation: Stroke**
    a. Activate instrument with a unified wrist-forearm motion; use a rocking or rotating motion.
    b. Pivot from the fulcrum.
    c. Direct stroke to protect soft tissue from trauma and to preserve tooth structure and margins of restorations.
    d. Use an exploratory stroke to insert to junctional epithelium or to most apical extent of deposit.
    e. Use short, controlled strokes.
    f. Cover circumference of teeth.
    g. Overlap line angles and proximal mid-lines.
    h. Execute controlled stroke with appropriate length, pressure and speed for the task.
    i. Use a systematic approach to instrumentation, completing each tooth, surface by surface, before proceeding to the next.

9. **Instrumentation: Sharpening**
    a. Produce and maintain a sharp cutting edge.
    b. Sharpen instruments according to technique taught in DEN 130.
        i. **Evaluation**
            1. During DEN 141, each student must complete an instrument sharpening proficiency for a universal curette, sickle scaler and Gracey at mastery level.
            2. During DEN 221, each student must complete a competency at mastery level. The student must also demonstrate mastery on all instruments as verified by end product.

10. **Patient Data Integration**
    a. Current radiographs, periodontal charting and care plan should be accessible during patient treatment.
    b. Radiographs should be integrated at appropriate interval into care plan.
    c. All assessment data becomes part of the patient's treatment plan.

11. **Patient Education**
    a. Oral Hygiene instruction performed.
    b. Appropriate aids taught and demonstrated.
    c. Biofilm Control Record performed, calculated, and recorded before the clinician begins to deliver clinical services.

12. **Patient/Operator Position**
    a. Appropriate chair positions for operator obtained for appropriate instrumentation.
    b. Appropriate chair positions for patient obtained for appropriate instrumentation.

13. **Professional Demeanor/Appearance**
    a. Follows guidelines in Policy and Procedures Manual such as:
        i. Hair pulled back and away from face/eyes.

ii. Clean, pressed scrubs and lab coat.
iii. Professional attitude towards other students, faculty, and patients.

14. **Clinical Judgment**
    a. Utilize critical thinking skills and demonstrate ethical behavior in delivering clinical/educational services to the patient.
        i. Ex: if a patient needs four sealants you should complete **all four sealants** and not just the one sealant you may need to meet graduation requirements.
    b. ***The patient's dental needs are to be your priority; not your graduation requirements*.**
15. **Record Management**
    a. Accurate documentation in all Eaglesoft.
    b. Accurate recording on all clinic evaluation forms.
    c. All faculty signatures obtained.
    d. All appropriate documents scanned into Smartdocs.

Clinical Evaluation Criteria

ASSESSMENT AND DENTAL HYGIENE DIAGNOSIS		
ASSESSMENT	**MAJOR ERROR**	**MINOR ERROR**
Medical History **Critical Errors:** • Fails to communicate med. hx. with faculty • Fails to obtain patient (or guardian) and/or faculty signature prior to beginning procedure • Fails to obtain medical consultation • Fails to take new med. hx. when indicated	• Not familiar with medical status of patient • Fails to look up unfamiliar medications in PDR or compute. • Fails to follow-up to yes response • Fails to determine patient compliance of medication	• Does not record amount, type, etc. of medication taken • Does not update demographic section • Does not determine if prescriptions are expired/outdated (i.e. pre-med, nitroglycerin
Vital Signs **Critical Errors:** • Begins treatment without taking vital signs • Fails to follow clinical protocol when vitals are too high to treat patient	• Does not take vitals before seeking instructor check	• Fails to record vital on medical history/update/record • Does not use correct technique • Is unaware of patient's past history of vital signs
EOE/IOE **Critical Errors:** • Does not perform	• Fails to follow-up on previously reported pathology • Does not determine the need for a consult	• Fails to document findings correctly (i.e. size, shape, proper terminology)

	• Discloses oral cavity prior to faculty evaluation • Fails to detect obvious findings	• Does not utilize correct technique • Does not explain technique to patient prior to beginning procedure • Fails to detect minor abnormalities
Teeth/Occlusion	• Fails to perform an occlusal assessment • Does not detect apparent caries or faulty restorations • Fails to integrate current radiographs during caries assessment • Fails to chart existing restorations, missing teeth, etc.	• Does not correctly identify occlusion • Does not document findings correctly • Does not use proper technique for caries assessment (i.e. air, transillumination, instrument selection) • Fails to detect conditions of teeth (i.e. attrition, fluorosis)
Gingival Description	• Does not perform • Fails to determine disease state • Does not determine the need for consult	• Does not document findings correctly • Gingival assessment incorrect • Does not use correct technique
Periodontal Status	• Does not probe • Causes tissue trauma during periodontal probing • Incorrectly measures four (4) or more probing depths by greater than 1mm • Fails to identify an area of obvious deep periodontal pocketing • Fails to perform and/or calculate a bleeding index	• Incorrectly manages patient (i.e. determining use of topical anesthetic) • Does not use correct technique • Makes inappropriate decision (ie. PSR vs. standard probing) • Incorrectly measures up to three (3) probing depths by greater than 1 mm
Diagnosis/Calculus Classification	• Causes tissue trauma during exploring • Fails to detect gross supragingival and/or subgingival deposits • Does not explore to determine type and amount of deposits • Fails to utilize radiographs	• Utilizes incorrect instrument and/or technique to determine calculus type • Does not document type and amount of deposit correctly

		• Fails to detect fine deposits
Re-Evaluation	• Does not perform	• Brought patient in before 4 weeks
Restorative Charting	• Does not dental chart • Fails to identify an area of obvious decay • Fails to differentiate normal from abnormal and recognize disturbances or changes in the characteristics of teeth, including number, size, form, color, structure, and contact relationship	• Incorrectly records findings • Does not use correct terminology • Does not clean mirror for faculty/dentist use

DH CARE PLAN AND PRESENTATION

	MAJOR ERROR	MINOR ERROR
Care Plan and Presentation	• Does not generate a care plan. • Does not include oral hygiene instructions in care plan • Does not integrate patient's needs into care plan • Does not discuss care plan with patient or does not obtain patient's consent to treatment • Does not follow through on need for consultations or referrals during treatment	• Oral hygiene instructions do not fully meet special needs of patient • Treatment plan requires slight revision (i.e. nutritional counseling, fluoride therapy, anesthesia needed, instrument or equipment selection appropriate) • Number of appointments inappropriate or not identified. • Recall interval not appropriate or not identified • Treatment sequencing may be inappropriate • Necessary revisions not made to treatment plan at subsequent appointments in a multiple appointment treatment plan

DH TREATMENT

	MAJOR ERROR	MINOR ERROR
DH Treatment	• Fails to do preventive counseling • Generalized soft tissue trauma evident as a result of removal of hard and soft deposits	• Inappropriate use of detection skills (i.e. air syringe, explorer, disclosing, indirect vision) • Inappropriate deposit removal technique (i.e. instrument technique, instrument selection,

	• Localized or generalized severe tissue trauma evident as a result of deposit removal • Four (4) or more hard deposits remaining after instrumentation (1 major error for each set of 4) • Four (4) or more soft deposits remaining after instrumentation (1 major error for each set of 4) • Does not re-assess following instrumentation	instrument sharpness, handpiece technique) • Slight tissue trauma evident in localized areas following instrumentation • Up to three (3) hard deposits remaining after instrumentation (1 minor/deposit) • Up to three (3) soft deposits remaining after instrumentation (1 minor/deposit) • Fails to get 2 faculty to confirm diagnosis of calculus classification of 02

MANAGEMENT

	CRITICAL ERROR	MAJOR ERROR	MINOR ERROR
Clinical Judgment	Fails to obtain appropriate signatures	• Fails to correctly reflect treatment rendered in progress notes • Fails to review protocol for clinical procedures and anticipate treatment (i.e. cleaning dentures) • Incorrectly administers fluoride treatment	• Frequently leaves patient or interrupts appointment • Fails to alter existing treatment plan in a timely manner according to patient needs or in response to treatment (i.e. need for increased use of topical or local anesthesia). • Fails to maintain professional atmosphere with peers (i.e. inappropriate conversation) • Fails to adhere to clinic dress code (i.e. hair, nails, clothing, personal hygiene)
Infection Control	All infection control errors are critical if not identified by the student. (Examples not all inclusive)		

	• Fails to follow Universal Health Precaution Procedures • Fails to properly prepare clinical unit • Fails to follow clinical protocol for handling “sharps” • Fails to follow clinical protocol for post-exposure evaluation and treatment when an exposure incident occurs • Fails to place internal indicator on keyboard at medical history		
Time Management		• Use of inordinate amount of time during any phase of treatment	• Fails to utilize non-productive time effectively and efficiently (waiting for anesthesia, waiting for faculty evaluation, etc.) • Fails to apply management techniques to non-cooperative patient
Preparation/ Organization		• Prepares for clinic at time patient should be seated • Fails to determine and assess most recent/appropriate radiographs and have them up on viewbox or computer • Fails to review patient chart prior to appointment	• Fails to review previous treatment • Fails to review active treatment plan • Fails to follow proper check-in procedures or to seat a patient before a faculty member is in clinic will result in the assessment of a MAJOR error
Communication	• Fails to provide consulting faculty with appropriate information regarding patient	• Fails to provide patient with treatment planned, individualized oral hygiene instructions	• Fails to solicit assistance for non-cooperative patient if own efforts are unsuccessful in

	treatment (i.e. perio consultation, referral)	• Fails to demonstrate respectful attitude to faculty, patients, peers, health professionals, supportive staff (i.e. confrontational, displays negative personal feelings or behaviors) • Inappropriately discloses confidential information	obtaining control (i.e. sexual harassment, talkative patient, "jumpy" patient, non-responsive patient, failure to apply topical anesthesia when appropriate) • Fails to keep patient/faculty informed of aspects or changes in treatment or appointments (i.e. need for anesthesia, need for biopsy, need for radiographs, multiple appointments and/or changes) • Fails to communicate effectively with faculty, patient, peers, health professionals, supportive staff • Fails to solicit faculty assistance or communicate problems to faculty • Fails to be discrete in making comments relating to patients, peers, faculty, health care professionals or supportive staff

*****The above lists are intended as examples only. Flagrant errors in any area will constitute a MAJOR error. Faculty may use their discretion when determining critical/major/minor errors and clinical session grades. Safety and/or infection control errors and extreme lack of judgment will constitute a CRITICAL error and a grade of zero will be assigned.***

Clinic Grading System

Each student will earn one grade for the completed patient on the Dental Hygiene Clinical Evaluation form (i.e. Assessment & DH Diagnosis, DH Care Plan & Presentation, DH Treatment, Management, and Re-Evaluation). 5 being the highest and 0 being the lowest point score earned. Each point is equal to a number grade (i.e. 5 = 100 =A). The points earned are by level of training are listed below.

Clinic Grading System		
1st year*	2nd year Fall**	2nd year Spring***
5 = 100	5 = 100	5 = 100
4 = 89	4 = 86	4 = 83
3 = 79	3 = 76	3 = 73
2 = 69	2 = 66	2 = 63
1 = 59	1 = 56	1 = 53
0 = 0	0 = 0	0 = 0

Points	Grade		Clinical Evaluation Criteria & Grading System
5	**100**	**A**	• Accurately assesses patient by recognizing existing conditions and the implications for further use of information • Thoroughly reviews patient's chart and identifies all pertinent information • Correctly identifies patient's needs and discusses treatment plan with patient • Treatment plan includes appropriate therapeutic services, appropriate referrals and consultations, patient education and prevention • Effectively debrides all surfaces • Utilizes patient's oral condition to motivate and educate patient in daily care • Is sensitive to the patient and alters appointment if indicated • Communicates effectively with patient and others involved in treatment • Utilizes proper infection control techniques throughout the appointment. • Is organized and efficient • Demonstrates respect and concern for patient, faculty, staff, and other students through conversation, behavior, appearance, and attitude • Evaluates finished product • Sets appropriate re-evaluation appointment or recall interval. Performs all procedures within a time frame typical of a proficient practitioner • Obtains appropriate signatures and approvals during appointment • Ease in decision making and time appropriate for level of experience
4	***89 **86 ***83**	**B**	• Accomplishes most of the tasks described in 5 • May have up to 3 minor errors in patient assessment & DH diagnosis, care plan & presentation, DH treatment, and management • No major errors are allowed
3	***79 **76 ***73**	**C**	• Accomplishes most of the tasks described in 5 • May have 4 or 5 minor errors ***OR*** 1 major error in patient assessment and DH diagnosis, care plan and presentation, DH treatment, and management • Remediation is indicated but the overall well-being of patient or clinician is not endangered
2	***69 **66 ***63**	**D**	• Lack of skill or judgment in patient care. May have 6 to 7 minor errors OR 1 major error plus 1 to 5 minor errors ***OR*** 2 major errors in patient assessment & DH diagnosis, care plan & presentation, DH treatment, and management • Remediation is indicated but the overall well-being of patient or clinician is not endangered
1	***59 **56 ***53**	**F**	• Errors exceed numbers listed in criterion 2 • Remediation is indicated but the overall well-being of patient or clinician is not endangered • Remediation is indicated but the overall well-being of patient or clinician is not endangered
0	**0**	**F**	• Extreme lack of skill or judgment causing potential harm to patient or clinician. **Any critical error.**

*, **, *** See Grading System Chart on previous page.

Case Points

These points are assigned to each patient according to their level of difficulty or involvement.

Example: A patient assigned as a Periodontal Case Type IV will be assigned 4 case points. The student has 5 minor errors in the Assessment portion of the appointment but makes no major critical errors. The student will be assessed only 1 minor error instead of 5 minor errors.

CCCC Case Type	Case Points DEN 131/141	Case Points DEN 221/231	# Minor Errors	Errors Assessed
I	1	0	0-1 no major/critical errors	0/1
II	2	0	0-2 no major/critical errors	0/2
III	3	1	0-3 no major/critical errors	0/2
IV	4	2	0-4 no major/critical errors	0/2

Competency Points

These are the points a student receives based on the assigned calculus rating.

Example: The calculus 04 patient is assigned 8 competency points. The students has 12 minor errors in managing the DH Treatment portion of the appointment but makes no major or critical errors. The student will be assessed 4 minor errors instead of 12.

CCCC Calculus Rating	Case Points DEN 131/141	Case Points DEN 221/231	# Minor Errors	Errors Assessed
01	2	0	0-2 no major/critical errors	0/2
02	4	2	0-4 no major/critical errors	0/2
03	6	4	0-6 no major/critical errors	0/2
04	8	6	0-8 no major/critical errors	0/2

Critical Errors

Critical errors are given on proficiencies and end product evaluation. Critical errors are errors that may affect the patient/operator/faculty welfare and thus warrant special attention. All case/competency points will be deducted for any major/critical errors.

SECTION 4: Preclinical, Clinical, and Laboratory Infection Control and Risk Management Protocol

Goals

1. Provide safe environment for our students, faculty, staff, and patients that is in accordance with OSHA standards and supported by sound biological principles.
2. Provide a reasonable, but effective infection control model that will aid in the education and understanding of infection control issues that are in accord with the recommendations of the American Dental Association (ADA), the American Dental Education Association (ADEA), the Centers for Disease Control (CDC) and the Environmental Protection Agency (EPA).
3. Comply with the recent standards published by the Occupational Safety and Health Administration (OSHA). (*See generally, "Occupational Exposure to Bloodborne Pathogens; Final Rule," Federal Register, Friday, Dec. 6, 1991 or 29 CFR 1910.1030; and "Guidelines for Infection Control in Dental Health-Care Settings-2003." MMWR Vol 52, No RR 17.1, 12/19/2003.)*

Introduction

Scientific information as well as public and professional concerns over the risks of blood borne disease transmission has brought the topic of infection control in the dental environment to the forefront. An effective infection control policy requires the cooperation of students, faculty, and staff. This can best be achieved through education, demonstration, monitoring, and evaluation. Faculty bares the primary responsibility for infection control in the clinic. Since students are the primary providers of care, their actions will determine whether or not infection control is effective. All personal must monitor, practice, and enforce established infection control procedures in order to assure students are conforming to these guidelines.

Purpose

The purpose of infection control policies and procedures is to minimize the risk of transmission of blood borne and airborne pathogens to patients and dental health care personnel (DHCP) in the dental clinic setting.

This will be achieved by:

1. Hepatitis B immunization as well as vaccination for other appropriate diseases.
2. Tuberculosis screenings.
3. Education and training in infection control procedures.
4. Use of current and appropriate barrier techniques.
5. Preventing exposure of patients and DHCP to blood and other potentially infectious material (OPIM), including saliva.
6. Engineering controls and work practice controls.
7. OSHA regulations.
8. CDC and ADA recommendations.

Infection Control Protocol

Standard Precautions:

1. Blood and other body fluids, including saliva, of ALL patients is to be regarded as potentially infectious for HBV, HIV, and other blood borne pathogens.
2. Standard precautions will be used for all patients.

Upon review of health history

1. Patients presenting to the dental clinic with **ACTIVE** infectious diseases will not be treated **UNTIL** the active infectious state has cleared or until a physician has approved the proposed treatment for that patient. A physician's note or notice from the health department is required prior to treatment in our facility.
2. Students presenting to the dental clinic with **ACTIVE** infectious diseases will not be allowed to treat patients **UNTIL** the active infectious state has cleared.
3. Patients presenting to the dental clinic with an **ACTIVE** positive history of hepatitis B, hepatitis C, or HIV must present a written clearance for treatment from their physician. Patients will be treated upon compliance.
4. Patients presenting to the dental clinic with a positive history of hepatitis A within the past six weeks must present clearance from their physician.
5. Infectious diseases may include, but are not limited to: conjunctivitis, herpes simplex, TB, varicella zoster, and viral respiratory diseases.

Engineering & Work Practice Controls

Engineering controls reduce the exposure by removing the hazard or isolating the worker from the hazard. Work practice controls reduce the chance of exposure by altering the way a task is performed. The following are engineering and work practice controls utilized by the CCCC Dental Department:

1. Personal Hygiene

The following applies to all clinic personnel (student, faculty, and staff) who may come into contact with blood and OPIM:

- Hair must be neat, pulled back, and away from the face (no loose ends).
- Facial hair will be covered with a face mask or shield.
- Wearing of jewelry during treatment procedures: follow guidelines as specified in current course syllabus and/or Dental Hygiene/Assisting Orientation Handbook and Manual.
- Fingernails will be kept short and well-manicured (no colored polish or artificial nails, tips or gels)
- Hair nets worn at all times when in a clinical setting.

2. Hand Washing

Hand washing is mandatory:

- Before glove placement prior to treatment
- During treatment if infection control asepsis is violated or the glove integrity is compromised,
- After glove removal
- Between patients

- Before leaving the treatment area.

Hand Washing Protocol: To be implemented at the beginning of the appointment, upon visible contamination of hands, and at any time that the integrity of the gloves becomes compromised.

Antiseptic Hand-Rub Protocol: May be used during patient care if hands are not visibly contaminated.

Using a "dime size" amount of a commercial hand antiseptic rub agent that contains 60-95% ethanol, vigorously rub the hands together with emphasis on the finger tips, nail beds, and ventral side of the hand until dry. This should take approximately 15 seconds. Example of products: Purell.

Follow the hand washing procedures as demonstrated in Pre-Clinic Labs.

Personal Protection

Routine use of appropriate personnel protective equipment will be used since blood, saliva, and gingival fluids from ALL dental patients must be considered infectious.

a. Non-Sterile, Non-Latex Exam Gloves
All individuals having patient contact will wear disposable gloves whenever there is contact with blood, saliva, or mucous membranes. Gloves must not be washed or otherwise reused. Gloves must be changed between patients. Gloves must be removed and hands washed before leaving the clinical area. Skin breaks should be covered with Band-Aids before donning gloves. Utility gloves shall be worn for housekeeping procedures.

b. Masks and Eyewear (with solid side shields, and/or Face Shields)
Disposable masks and protective eyewear will be worn. Change masks between patients or during treatment if the mask becomes wet. When not in use, the mask should not be placed on the forehead or around the neck. Protective eyewear is mandatory for the clinician and patient's use. Both sets of eyewear should be cleaned between uses, being certain not to handle them with unprotected hands until they have been decontaminated.

c. Clinic Attire: Gowns and Clinic Jackets
All students will routinely wear appropriate attire to prevent skin exposure and soiling of street clothes or uniform when contact with blood or saliva is anticipated. Clinical patient-care jackets must be clean and wrinkle-free when in clinical settings. Clinical patient-care jackets must not be worn outside the clinic. Attire must be changed at least daily or when visibly soiled. When leaving the clinic for the day, clinic jackets must be placed in a clear garbage bag labeled with a biohazard sticker. It is recommended to wash soiled jackets independently of other clothes.

d. Needle Recapping and Sharps Disposal
To prevent needle-stick injuries, needles are ***NOT to be recapped by moving the needle towards a body part, especially a hand,*** but can be recapped using an appropriate one-handed technique or an appropriate recapping device. Used needles are to be disposed of in an appropriate puncture-resistant container and should not be

purposefully bent or broken after use. Containers should be located as close as possible to an area of operation. Empty anesthetic cartridges, broken instruments, completed spore vials, microscope slides or other sharps must be disposed of in these same containers.

e. Utility Gloves
Sturdy, unlined utility gloves should be worn for all cleaning and disinfection of instruments, dental units, and environmental surfaces. Utility gloves have an increased resistance to instrument punctures. Utility gloves should be autoclaved regularly; weekly is recommended. Utility gloves must be replaced if the integrity of the gloves is compromised.

Environmental Surface/Equipment Cleaning and Disinfecting

Many blood-and saliva-borne, disease-causing microorganisms such as Hepatitis B virus, HIV virus, Herpes virus and Mycobacterium tuberculosis can remain viable for many hours –even days-when transferred from an infected person to environmental surfaces within dental operatories and other clinical areas. Since subsequent contact with these contaminated surfaces can expose others to many microbes and may result in disease transmission, adequate measures must be used in each clinical area to control possible transmission from contaminated surfaces.

Identification of dental environmental surfaces:

a. "**touch surfaces**" – surfaces that require contact and become potential cross-contamination points during dental procedures (emphasis on required). Many surfaces could be touched during dental procedures, but only a few actually require being touched.
b. "**transfer surfaces**" – surfaces contaminated by contact with instruments or other inanimate objects. Handpiece holders and instrument trays are two transfer surfaces. Thought-out set-up and disciplined chair-side procedures will help reduce the number of transfer surfaces in the operatory.
c. "**splash and splatter surfaces**" – operatory surfaces which are not "touch surfaces" or "transfer surfaces" or parts of items that enter the oral cavity (also referred to as: aerosol surfaces). Examples: parts of the patient chair not covered by the chair bag, including the base, arm rest, seat, etc., light cover or plastic shield, counter top and sinks.

A practical and effective method for routinely managing operatory surface contamination between patients is to use disposable blood/saliva impermeable barriers, such as plastic film and aluminum foil, to shield surfaces from direct and indirect exposure in combination with chemical disinfection. Removal of blood, saliva, and microbes is accomplished by routinely changing surface covers between patients. Time-consuming cleaning and disinfection procedures between patients can be minimized.

Only those chemical disinfectants that are EPA-registered hospital-level mycobacteria tuberculosis (tuberculocidal claim) agents capable of killing both lipophilic and hydrophilic virus at use dilution, are considered acceptable agents for environmental surface disinfection. Use of any chemical killing agent not so approved is unacceptable.

When deemed necessary, the surface disinfectant solution is to be applied with a "wipe, discard, wipe" technique. Although it is required to pre-clean surfaces with a disinfectant,

it is recommended that all touch surfaces be disinfected at the beginning of the day prior to use of the first barriers, or at the end of the day after the last set of barriers are removed.

Use the following procedures:

a. Using the multi-purpose disinfectant/decontaminate wipe, wipe the surface to be cleaned.
b. Discard the wipe.
c. Re-wipe the surface and allow the disinfectant solution to remain on the surfaces for the recommended contact time before placing barriers. (read and follow the manufacturer's directions).

SURFACE	PROTOCOL & FREQUENCY
Touch & Transfer Surfaces Light handles/switch, main body of unit and cradles, hoses/nozzles, bracket tray handles, stool adjustment levers, patient head rest adjustment	• Use barriers (covers) for all, unless the surface in an item that enters the oral cavity, which must be heat sterilized or disposable. • Use the surface disinfectants ONLY AT THE BEGINNING OF THE CLINIC DAY prior to placement of first set of barriers AND when it is evident that the barrier has been compromised. • Replace barriers between patients. Remove without causing cross-contamination. NO disinfection of a barriered surface is necessary. Just re-barrier.
Spatter Surfaces Painted surfaces of unit, ie. Tray arms, patient chair back and seat, seat and back of operator stool, counter top, sinks	• Use surface disinfectant. • Some splatter surfaces may be barriered, such as patient chair, back of operator stool, and bracket tray, if desired.

Daily Protocol

1. Unit Preparation and Pre-Treatment Set-Up
   - Wash hands, don mask, nitrile gloves and safety glasses.
   - Clean, including dusting, the operatory and all equipment using an intermediate level disinfectant.
   - Disinfect all "touch and transfer surfaces", allow them to dry.
   - Place barriers over all "touch and transfer surfaces" that may be contaminated during treatment.
   - Make sure there is a biohazardous waste disposal bag in the designated can per operatory.
   - Fill water bottle daily with fresh treatment water, install and wait for pressurization, then clear any air from line.

Patient Treatment

During **ALL** patient treatment, wear gloves, masks, and protective eyewear. Only touch surfaces related to patient treatment such as instruments, control buttons, plastic covered

items such as computer mouse or keyboard.

NEVER touch personal body, mask, goggles, or any other unprotected surfaces during the treatment phase. Infractions of infection control may require student dismissal from the dental hygiene program. Mass asepsis errors concern safety for the patient, students, and staff and will not be tolerated.

Charting:

When an entry has to be made in the record during treatment, an appropriate barrier must be used over the computer keyboard and mouse.

Radiographic Procedures:

Infection control measures during radiographic procedures and related darkroom procedures should be consistent with other infection control policies.

High-Speed Evacuation:

High-speed evacuation should be used at all possible times when using the high-speed handpiece, water spray, ultrasonic scaler or air polishers or during a procedure that could cause spatter. Rationale: Appropriate use of high-speed evacuation systems has been shown to reduce spatter and droplets.

Three-way Syringe:

The three-way syringe is hazardous because it produces spatter. Therefore, caution must be used when spraying teeth and the oral cavity. When used, a potential for spatter must always be considered and appropriate precautions taken (for example, use of barrier protection.)

Dropped Instruments:

An instrument that is dropped ***will not be picked up and reused***. If the instrument is essential for the procedure, as sterilized replacement instrument must be obtained.

Disposable Items:

Used disposable items must be discarded immediately to avoid contamination of other items. Medical waste (soaked with blood/OPIM) must be discarded in BIOHAZARD red bags located in designated can (biohazard sticker affixed to outside of can) in each operatory. Follow protocol for appropriate disposal.

Clean-Up After Patient Treatment

1. The following protocol may be used:
   - Remove gloves and wash hands immediately.
   - Complete entries on all forms and records relating to the treatment and dismiss the patient. Return to clinic.

- Apply utility gloves, mask and glasses, remove all disposables and discard in appropriate containers.
- Place all contaminated instruments, syringes, needles and other sharps as well as any other reusable in a sealed plastic container and transfer to the sterilization area.
- Discard of any sharps into sharps containers located in central sterilization.
- Place contaminated instruments or cassette into a holding solution or ultrasonic cleaner immediately then return to operatory.
- Remove all barriers and place into inverted chair bag and discard of entire bag into one of the black trash bag-lined waste receptacles located throughout the clinic, secure lid.
- Following operatory surface management procedures, clean, disinfect, and/or prepare the unit for the next patient (including flushing of water lines for 20-30 seconds). Any area covered by a barrier may be re-covered without cleaning and disinfecting if the barrier was not compromised.

Continuous Infection/Hazard Control Monitoring Policy

Evaluation of Students: At the beginning of each preclinical, lab, and clinical course, adjunct faculty are to evaluate the clinical dress, physical hygiene, and restraint of hair of each student assigned to the adjunct faculty that day.

Infection Control Violations Forms: Infractions found with faculty or program students will be recorded on individual Infection Control Violation Forms. The Infection Control Violation Form is utilized for all preclinical, lab, and clinical courses during the program in order to evaluate infection control violations committed by each individual of all courses for students, and during the employment of all faculty.

Report to Program Director: The course director will inform the program director of infection/hazard control violations immediately. The program director will log the incident on the Infection Control Violations Master List.

Consequences of Infection/Hazard Control Violations: Depending on the severity of the violation and repeated violations, students will be referred to the Policies and Procedures Manual concerning consequences of infection control infractions. Faculty will be counseled on infection/hazard control policies as infractions occur in order to realign faculty infection control practices.

Instrument Recirculation

1. Transporting

All contaminated instruments and instrument cassettes should be transported from the operatory to the sterilization area in a sealed plastic container provided between each operatory. Students should use heavy nitrile utility gloves when working with contaminated instruments.

2. Containment

All contaminated instruments and instrument cassettes that are not immediately placed in the ultrasonic cleaner must be submerged in an appropriate holding solution or otherwise

confined to a limited area until such time as it may be cleaned.

3. Decontamination

Ultrasonic and other mechanical means of cleaning instruments have proven to be more effective and efficient and safer than hand-scrubbing and will be implemented if at all possible. Always use the ultrasonic cleaner with the lid in place. Rinse, dry and visually inspect items for bioburden/debris.

Renewal

1. Heat Sterilization

All contaminated re-usable instruments, including handpieces, must be sterilized in verifiable heat-sterilizing devices, must be thoroughly cleaned and heat sterilized before use in the treatment of another patient. All items must be packaged for sterilization in quality wrapping materials or pouches that will maintain sterility. The use of chemicals as a substitute for heat sterilization of these items is unacceptable. Biological monitoring is performed weekly on each sterilization device.

2. Chemical Sterilization/Disinfection

All re-usable items that cannot be heat sterilized must be thoroughly cleaned and appropriately treated with EPA-registered sterilant according to manufacturer's instructions specified for sporicidal activity. Any use of a chemical disinfectant agent for infection control purposes that is not EPA-registered as a dental instrument sterilant/disinfectant is unacceptable.

3. Maintenance

All packages that have been exposed to sterilization procedures must be stored in a manner that will prevent contamination. Sterile packages shall be placed on clean shelves or in clean drawers. All packages shall remain wrapped until needed and opened at chair-side at time of use.

Biohazard or Medical Waste Disposal

All medical waste collected from each operatory is to be disposed of in a red biohazard bag located in designated receptacle per clinic operatory. At the end of the clinic day, the red bags from the biohazard receptacles will be collected; squeezed to remove excess air and inserted into the medical waste cardboard box, provided by the waste collection company, then sealed with packaging tape.

Body Fluid Spills

All body fluid spills, such as vomit and blood, are to be cleaned and removed by designated personal with the clinic spill kit located in the clinic. Call for assistance immediately. Protect the spill from contact with others until appropriate action has been taken.

Exposure Incident/Accidents

Non-threatening, non-invasive accidents occurring in the classroom, laboratories, and/or clinic will be cared for according to the following procedures:

1. Students should report the accident to the supervising instructor immediately.
2. The instructor will direct the care of the wound and send the student to their personal physician or emergency room for care.
3. CCCC Accident (Incident) and OSHA forms must be filled out and delivered to the President, the three Vice Presidents, and Public Information Officer within 12 hours.

If you incur an exposure incident, do not make a scene in front of your patient. Quietly excuse yourself from the operatory and complete the following:

Blood-Borne Incidents/Sharps Exposure

Accidents resulting in blood borne pathogen exposures to the operator and/or patient will be cared for according to the following procedures: Immediately remove gloves.

- Immediately go to the sink and flush the wound under very warm water.
- Thoroughly clean the wound(s) and surrounding tissue with running water and soap to ensure cleanliness.
- Hold the site in a downward position; **DO NOT SQUEEZE** the flesh to extract/promote bleeding.
- Have a classmate contact the instructor immediately.
- The instructor will direct the care of the wound and send the student and/or patient to their physician or hospital emergency room for care.
- CCCC Accident (Incident) and OSHA forms must be filled out and delivered to the President, the three Vice Presidents, and Public Information Officer within 12 hours.
- If blood cannot be expressed or does not pool under the skin, it may be an exposure incident has NOT OCCURRED and no further action is required.
- In regards to the patient: the patient will be asked for consent to be sent for baseline status if sero status is unknown.

Students are reminded that occupational exposure incidents occur; **students are not punished in cases of instrument sticks.** It is a flagrant error of judgment, however, to hide the incident and not report it to the instructors. All students who knowingly allow an incident/accident to go unreported are equally guilty of dishonesty and will be reprimanded in accordance to the Disciplinary Procedures of the Dental Hygiene/Assisting Program.

for blood borne pathogen exposures, consult instructor immediately

Splash On to Oral, Nasal, or Eye Mucosa

- Immediately seek assistance from nearest clinical instructor.
- In the event of eye and/or nasal splash, remove yourself immediately to the nearest eyewash station and cleanse your eye with copious amounts of water.
- In the event of oral mucosa splash, do the same. Rinse with an antimicrobial mouthwash.
- If at CCCC, the instructor will complete a CCCC Accident and Incident Report form & other documents, as necessary.

- Report to the doctor's office or hospital to have injury and necessary preventive measures/tests taken. The student accident report form to obtain insurance claim form to place where services were rendered. (See attached forms).
- If on an off-site clinical rotation when an accident/exposure occurs, follow the policy for Accidents Occurring Off Campus.

Eyewash Station: What Every Employee/Student Should Know

1. Where the station is located in the clinic and laboratory
    a. How to use the station
    b. Lift the dust covers off the spray heads.
    c. Push against foot pedal to start the flow. If no water comes out, be sure the water flow is turned on from the wall.
    d. Lift the hand lever to turn the unit off.
2. When to use the station – when any potentially hazardous material contacts the eye(s)
3. Eye Irrigation – First Aid Information
    a. Chemical exposure to the eye may cause damage from chemical conjunctivitis to severe burns. Therefore, remove all chemicals from the eye(s) quickly.
    b. Signs & Symptoms of Exposure – local pain, visual disturbances, lacrimation, edema, and redness

Basic Treatment for the Eye

1. Flush with water using a mild flow from the eyewash station and continue for **at least 15 minutes.**
2. Ask the victim to look up, down, and side to side as they rinse in order to better reach all parts of the eye(s).
3. DO NOT let the victim rub his/her eye(s).
4. DO NOT let the victim keep his/her eye(s) tightly shut.
5. DO NOT introduce oil or ointment into the eye(s).
6. DO NOT use hot water.
7. Notify medical authorities when someone is injured.
8. Use the incident report form to record details of the injury

Dental Programs Hazard Control Policy

The Dental Program maintains a Hazard Control Program. The students, faculty, and staff are made aware of the various chemical and other hazards through the presentation of the program. It is the responsibility of each instructor to cover occupationally related hazards as they pertain to the courses they teach.

A copy of the Program's Hazard Control Policy is located in the Dental Department Office. This program contains all Material Safety Data Sheets for each chemical, and when necessary, ensures the labeling of secondary containers.

CCCC also maintains a campus-wide Hazard Communication Program due to the large number of hazardous chemicals and other substances maintained on the campus. **A copy of procedures is maintained by Frank Bedoe, Director of Campus Security and Safety (919-718-7211).**

Accidents/Cross-Contamination Incidents Occurring Off Campus

Accidents/cross-contamination incidents that occur off campus to CCCC students while on school-sponsored activities should be handled according to school guidelines as follows:

1. **Wounds/Injuries:** Cleanse the wound appropriately and cover with appropriate material, i.e., Band Aid, 4 x4, etc. Prepare an Incident Report and send it to the Student Development Services. If the wound/injury requires a physician's intervention/assessment, take the student to the hospital or medical doctor.
    - Tell them this is a CCCC student, not an employee.
    - Student is to obtain an insurance claim form from SDS to give to the hospital or medical doctor that rendered services.
    - Life Threatening Injuries: Call 911

2. **Cross-Contamination:** Immediately stop the procedure.
    - Remove contaminated gloves
    - Wash hands thoroughly using antimicrobial soap and warm water. Dry hands
    - Complete applicable cross-contamination follow-up steps (verify with rotation site).
    - Notify the instructor and extra-mural site of the cross-contamination and follow-up steps taken immediately following the incident.

Clinical Rotations

Dental Hygiene/Assisting students need to alert the dentist and/or office manager when an injury or cross-contamination incident has occurred. Follow the guidelines of the office and contact supervising faculty at CCCC to fill out an Accident/Incident report that will be sent to Student Development Services after all signatures have been obtained. Student is responsible for obtaining an Insurance Claim form to turn into place where services were rendered.

Medical Emergency Procedures

The primary focus of action during a serious medical emergency is the immediate care of the injured person. Medical emergencies, which require immediate medical attention, should be handled by following these procedures:

Serious Injuries/Medical Emergencies (General Locations)

- Stay with the injured person at all times; maintain an attitude of calm and reassurance.
- Control the environment (including bystanders) to prevent further injury or loss of privacy for the victim.
- Designate someone to call **911**-describe the type of illness/injury and location.
- Designate someone to call the CCCC Switchboard Operator at (919) 775-5401. Advise the operator of the situation and steps taken already ("**911** has been alerted"). The Switchboard Operator will notify the administration (Vice President and Dean).
- If a doctor, dentist, or a more "trained" person should be present, the more responsible/trained person should take charge until EMS personnel take control.
- If the injured person refuses EMS transportation, proper notation should be documented in the chart

DO NOT:

- Allow movement of the victim if head, neck, or spinal injury is suspected.
- Attempt to place anything into the victim's mouth.
- **Transport the victim to the emergency care center in your personal vehicle or allow patients to transport victims in their personal vehicle.** EMS personnel should make transportation decisions, victims can accept or deny the next level of care.
- Once the victim has been transported to an emergency care center, caretakers, should stay and write a descriptive, detailed report of the accident or illness for CCCC and/or OSHA forms (full name, social security number, telephone number, address, time, date, place, etc.).
- Submit report to the VP of Student Learning, VP of Student Services, VP of Administrative Services, Dean of Health Sciences and Human Services, Administrative Assistant to the VP of Student Services, Controller, and Safety Coordinator.

Serious Injuries to Patients/Medical Emergencies in the Clinical Setting

During the treatment of patients, if a serious emergency occurs, the student should:

- Stay with patient at all times; instruct someone to immediately alert the supervising dentist and an instructor.
- Maintain an attitude of calm and reassurance.
- Control the environment (including bystanders) to prevent further injury or loss of privacy for the patient.
- Maintain an open airway; loosen restrictive clothing.
- Monitor and record the patient's vital signs. (Include a time chronology with all entries).
- Be prepared to administer cardiopulmonary resuscitation.
- Be prepared to succinctly relay health data, the events leading to the medical emergency, and the symptoms to the dentist or instructor.

A. Upon arrival of the supervising dentist:

- The dentist will be in charge of directing emergency medical care of the patient.
- An instructor will be responsible for obtaining emergency equipment and supplies.
- The student operator and/or instructor should monitor and record the patient's vital signs and provide assistance as directed by the dentist.

B. If an ambulance is needed:

- The dentist will direct a student or instructor to call 911, then the Switchboard Operator at (919) 775-5401.
- Advise the 911 operator that an ambulance is needed immediately at Oscar A. Keller Jr. and Elderlene R. Keller Health Sciences CCCC Dental Clinic, room 222. (Give address, etc.) 1815 Nash St. Sanford, NC 27330. 2nd Floor, Give the nature of the emergency.
- Return to the dentist to relay any messages or acknowledgments that an ambulance is on its way.
- The dentist will direct two or more students to monitor all building entrances and direct ambulance personnel to the emergency site.

C. Upon arrival of EMS personnel:

- The dentist, instructor, and necessary students will maintain care of the patient until EMS personnel are ready to take charge.

- The dentist, instructor(s) and involved students will relay information to the CCCC Administration with a written descriptive, detailed report of the accident or illness for CCCC and/or OSHA forms (full name, social security number, telephone number, address, time, date, place, etc.).
- Submit report to the VP of Student Learning, VP of Student Services, VP of Administrative Services, Dean of Health Sciences and Human Services, Administrative Assistant to the VP of Student Services, Controller, and Safety Coordinator.
- The dentist will be responsible for documenting all information in the patient's record (with input from the student and instructor).

D. Miscellaneous:

- All injuries (serious or minor) must be reported to the Department Chair and Dean. The Dean will then inform the President, all Vice Presidents and the Public Information Officer. CCCC Accident (Incident) Forms must be filled out and submitted within 12 hours of the incident.

Emergency Equipment Location

A. First Aid Kits are Located:
    - Dental Clinic, Sterilization Area on emergency cart
    - Dental Materials/Simulation Laboratory Classroom: On wall near door
    - Dental Radiology Clinic
B. Oxygen Tanks and Masks are located:
    - Dental Clinic, Sterilization Area on emergency cart
C. Emergency Drug Kit is located:
    - Dental Clinic, Sterilization Area on emergency cart
D. Eyewash Station is located:
    - Dental Clinic, attached to sink between Operatory 1 and 2
    - Dental Materials/Simulation Laboratory Classroom, attached to sink
E. AED: Sterilization Area on emergency cart

Evaluation of Emergency Inventory

- Medical supplies should be updated routinely, at least once every three (3) months.
- The Program Director will appoint the faculty clinical assistants to be in charge of evaluating the currency of the medical supplies and ordering of replacement as needed.
- Students and staff should be informed/reminded of this policy on an annual basis.
- The Program Director/Lead Instructor will be responsible for informing staff members; instructors will be responsible for informing their respective classes.

Emergency Cart Contents

Emergency kits/first aid kits will vary per clinic rotational site. This list only pertains to the CCCC Dental Hygiene/Assisting Programs. CCCC medical emergency cart is located within the dental clinic.

Medical Emergency		
Sterilization Area on emergency cart	2	Oxygen Tank Portable on a Cart
Sterilization Area on emergency cart	1	First Aid Kits
	2	CPR masks w/ 1 way valve, filter, O2
	1 Box	Thermometer
	2	BP cuff – adult
	2	BP cuff – child
	1	BP cuff- obese
	1	BP monitor
	5	Stethoscopes
	1	Digital BP cuff- wrist
	1	Glucometer
	1 box	Glucose lancets
	1 box	Glucose strips
	3 boxes	Ammonia inhalants
	2	Cold compresses
Sterilization Area	1	Master spill kit
Office Manager	1	OSHA Compliance System (MSDS)
Sterilization Area	2	Eyewash stations
	1	AED 10 with accessories
Every Operatory	1 box	Alcohol prep pads
Supply Closet/Dental Custodial Room	2	Pillow-waterproof/reusable item #B2183

Emergency Kit Contents:	2 - EpiPen 3 - Ammonia inhalants 2 - packs aspirin (on shelf) 1 - diphenhydramine (on shelf) 1 - nitrolinual pump spray 1 - tube glucose 15 2 - albuterol inhaler 1 - CPR pocket mask 1 - airway 1 - 16” latex-free tourniquet
First Aid Kit Contents	40 - 3/4” x 3” plastic strips 20 - assorted flexible strips 10 - 2” x 3” plastic strips 1 - ½” x 5 yd. waterproof adhesive tape 5 - 2” x 3” nonadherent pads 2 - 21/8” x 25/8” oval eye pads 1 - 37” triangular bandage 1 - ½ oz absorbent sterile cotton 1 - 2” x 5 yd (stretched) elastic bandage 1 - ½ oz first aid cream 2 - ammonia inhalants 1 - 5” x 9” combination pad 1 - pair non-latex gloves 4 - antiseptic wipes 1 - cold pack 1 - scissors 1 - tweezers 1 - first aid information
Master Spill Kit (Sterilization above Sink, Simulation Lab)	1 - Biological spill powder 1 - scooper and pan 1 - pair safety glasses 1 - pair nitrile gloves Disposable bags and biohazard labels Dispatch hospital cleaner Antiseptic handwipes

Foreign Object Policy

Protocol for incidents involving patients swallowing various foreign objects associated with dental treatment provision-rubber dam clamps, bur, implant parts and pieces of scaling instruments:

- The provider should alert supervising faculty or the dentist.
- The provider will stay with patient, monitor vital signs, observe for acute respiratory distress, and make a preliminary diagnosis from the clinical signs and symptoms and the patient’s response to careful questioning.

IN EVENT OF A FOREIGN OBJECT EMERGENCY CALL 911

- Patient will need to be transported to the hospital for x-rays.

- Complete and Incident Report and forward it to the Student Development Services.
- Make an entry in the patient's record completely describing the occurrence, but do NOT refer to the Incident Report in your entry.
- If the patient refuses the radiograph, proper notation should be documented in the chart

(See Appendix D for Incident Report Forms)

Avoiding Litigation

Treatment Area

The Central Carolina Dental Center is a dental treatment area. Specifically, the dental treatment area is focused on our treatment cubicles and the immediate surrounding clinical area. This dental treatment area is restricted to dental treatment personnel and the patient being treated ONLY. No other person should be in the dental hygiene clinical services area. If for some reason an exception is required (e.g. a legal guardian is required), you should be granted permission from the dental hygiene faculty.

Emergency

"Something has gone wrong" and the reasonable expected outcome is not attained. The "DUTY" of the doctor "owed to the patient" in case of an emergency is:

- Primary prevention from further injury or debilitation.
- Secondary relief from discomfort.

Abandonment

The termination must be in writing to the patient and a copy must be included in the record. All procedures on a given treatment plan should be completed before termination of the school/patient relationship. The school has the legal obligation to continue treatment to a logical stopping point.

1. Do it in Writing
2. Give Sufficient Notice
3. Offer to Refer

Before Dismissal

1. The patient must not be dismissed until he/she is signed out by a faculty member.
2. Faculty will make sure students have made proper entries in the treatment and progress notes before signing the students out.
3. Information should include type and amount of anesthetic used, including vasoconstrictors, information relating to patient relations and reactions, and any other information pertinent to treatment of the patient.

Adequacy of Records

1. It is important that the tendency toward abbreviated and cryptic references be avoided. Many years may elapse between the creation of the record and the need to defend it.

2. Dentist's personal observations as to patient's disposition and attitude are appropriate. Such observations must be factual and not malicious. Such observations should not make judgmental or diagnostic statements that are outside the author's area of specialization.
3. A record of how well patients follow recommendations and treatment plan goals should be made. A record of all drugs prescribed, dosage, expected results and number of refills should be included.

Consent

1. **Implied Consent:** grants permission to examine the patient.
2. **Informed Consent:** by court judgment, must inform the patients of all:
   - Risks
   - Consequences
   - Benefits
   - The Proposed Procedure
   - Alternate Procedures
   - Possible Consequences of No Treatment

3. The explanations must be done in "lay terms".

Late Entry or Addendum Protocol

1. The late entry or addendum should be made in the Progress and Treatment Notes of the patient record using the date the entry is made.
2. The treatment date that the late entry or addendum references should also be listed.
3. The entry must be signed by a faculty member.

Correcting an Error in Charting

1. The error should be corrected in the appropriate area of the patient chart and approved by a faculty member.
2. A statement of correction should be made in the Progress and Treatment Notes and signed by a faculty member.

Audit of Records for Adequacy of Documentation

1. The administrative section for quality assurance will have responsibility for audit of patient records for adequacy of documentation.
2. Inadequacy will be brought to the attention of the student and the Program Director.
3. Students are required to present the Record Repair form that indicates if mistakes were made during the appointment timeframe.
4. Mistakes are indicated on the Record Repair form at the end of every appointment.
5. Chart audits are performed daily on every patient treated in the clinic. Students complete record repair forms for faculty to use in the auditing process. Students are informed of any errors found during the audit process via the record repair form.

Guidelines for Managing Patients Seeking Legal Condemnation of Previous Dental Treatment

Purpose:

These guidelines are set forth to establish uniform procedures to manage patients who may express concern, or who may be seeking professional and/or legal advice regarding previous dental treatment.

Applicability:

These guidelines apply to assigned clinical patients only. Unassigned patients seeking consultation will be handled under other established guidelines.

Philosophy:

It is the position of Central Carolina Dental Center that we have the obligation to, with our best professional judgment; present a true and accurate assessment of the dental needs to every assigned patient. This assessment of dental needs should be based on a thorough diagnosis and approved treatment plan.

The dental treatment should restore optimal oral health and function, considering the current status of the patient. The development and presentation of the treatment plan is to obtain the goal of optimal oral health and function for the patient and is not intended as criticism of previous dental treatment. However, we should not avoid recommending the replacement of existing restorations, prosthesis or any other treatment when necessary to obtain the treatment goals.

Precaution:
The student and faculty are cautioned to refrain from making judgmental remarks concerning past or proposed future treatment. This is particularly important during the early phases of diagnosis. If the patient inquires about past or proposed future treatment, the patient should be told their condition and proposed treatment will be carefully reviewed at the time of treatment plan is presented.

A. PROCEDURE

1. Treatment Plan:
   - Regardless of quality of previous treatment, the patient should be presented with an **APPROVED** treatment plan.
   - It is unnecessary to dwell on previous treatment except as it relates to the patient's ability to maintain the future treatment.
   - After the approved treatment plan is presented, if the patient expresses concern for the quality of previous treatment, the following procedures should be followed:
   - The faculty member responsible for the treatment plan should be asked to explain the situation to the patient and carefully document the patient's concern in the progress and treatment notes.
   - If, in the opinion of the faculty member, a problem may still exist, the Program Director of the involved discipline should be consulted and noted in the patient's record.

- The Program Director will make a final evaluation of the patient and make appropriate documentation in the progress and treatment notes in the consultation section of the patient's record.
- If the patient requests advice concerning steps to be taken to recover for previous dental treatment, he/she should be directed to contact the dentist who provided the treatment in question.
- If, after contacting the dentist who provided treatment in question, the patient still seeks advice concerning steps to be taken to recover for previous dental treatment, he/she should be directed to contact the NC State Board of Dental Examiners at 919-678-8223, Ext. 1783 or info@ncdentalboard.org who can assist him/her.

Additional Policies

****Non-compliance with any stated policy will result in disciplinary procedures or grade penalty assessment.****

Cell phones:

- Cell phones, tablets, laptops must be turned off during preclinic, clinic and lab sessions unless faculty approves use.

No Food in Any Clinic or Lab Area:

- No food, drink or gum chewing in teaching laboratories or clinic areas.
- Everyone should clean his/her own lunch or snack debris by depositing it in the appropriate waste receptacles.
- Exercise care when transporting food and drink through the halls.

SECTION 5: Referrals

Dental Referrals

In reviewing a patient's restorative charting, periodontal charting, or radiographs, many conditions will present themselves that need to be referred back to the patient's dentist. If this is the case, fill out a Dental Referral Form and have it ready for your instructor at check-out or attached to your x-rays when you turn them in to be graded. If your instructor agrees that the patient should be referred:

1. Explain to the patient why they are being referred.
2. Have patient sign the form.
3. You sign the form.
4. Have the referring faculty member/DDS sign the form.
5. Record on patient's Clinical Chart Note that a dental referral was made and **WHY**.
6. Give the patient a copy
7. Place a copy in the Administrative Assistant's Scan File to be scanned into SmartDocs
8. Annotate referral in patient's notes

Medical Referrals

In reviewing the patient's health questionnaires, many conditions will present themselves which will require you to decide whether treatment should be rendered or a medical consultation is indicated. To help you make this decision, the following is recommended:

1. Find out as much information as possible regarding the condition of the patient.
2. Refer to your Drug Information Handbook for Dentistry or call the patient's pharmacist to ask if the drugs the patient is taking may alter your treatment of the patient. Document your call in the record!
3. Take all the information you have gathered to your instructor. The instructor will decide if a medical referral is required.
4. If a medical referral is required, fill out Medical Referral form in SmartDocs and have an instructor sign, you sign and have the patient sign. Give the original to the patient and place a copy in the Scan Box to be scanned into the patient's record as a SmartDoc. Document on the record of treatment that referral was given and why. It is now up to your patient to see his/her physician and return the white copy of the form back to you before treatment is rendered. You may also choose to fax the document to the physician's office if the decision can be made without the patient scheduling an appointment. Place the completed medical referral with physician recommendation and signature in the Scan Folder to be scanned into the patient's record via SmartDocs. In the Clinical Chart Note, make an entry stating that the Medical Referral form has been returned and the patient is released by the physician for treatment or any recommendation the physician documented.

Introduction:

These protocols reflect sound medical/dental practice. They are not intended to be a rigid and comprehensive set of rules nor are they intended to replace the need for a medical consultation. They should, however, be helpful to all practitioners interested in a conscientious approach to medical and dental care.

Unacceptable Cases **Consultation with physician may be required in some cases. You should use the health history questionnaire and patient interview to identify cases that are not acceptable in the dental hygiene clinic. This would include patients who indicate a history of the following:**	1. Active herpetic lesion (labials, facialis, or oral) 2. Contagious skin conditions (impetigo, ringworm, scabies) 3. Head lice 4. Conjunctivitis 5. Elevated oral temperature (in excess of 100 degrees F) 6. Respiratory infections involving inflamed throat and/or elevated temperature 7. Active tuberculosis 8. Viral hepatitis (active cases only) 9. Cardiovascular accidents, cardiac bypass surgery or stroke within the last six months 10. Unstable angina 11. Other contagious conditions or diseases
Medical Consultation **Patients with the following conditions will require a medical consultation record from his/her physician:**	1. Stage III Hypertension >160/100 see pg. 74/75 2. Patients with a pacemaker, ascertain whether shielded or unshielded 3. Current anticoagulant therapy 4. Heart surgery other than bypass 5. Other systemic diseases, including cardiac arrhythmias, angina, congestive heart failure, renal and hepatic disease 6. Congenital cardiac defects 7. Surgically constructed systemic-pulmonary shunts 8. Congestive heart failure 9. Diabetes if the patient has not had the condition checked by a physician within the last year 10. Uncontrolled, unstable diabetes mellitus and uncontrolled Addison's Disease 11. Tuberculosis if the condition has been active during the last five years 12. Currently under cancer treatment (including long-term chemotherapeutic drug therapy) 13. Current or history of anticancer chemotherapy including use of chemotherapy drugs for noncancerous conditions i.e. Methotrexate for rheumatoid arthritis 14. Patients who report history of chemotherapy to determine possible use of bisphosphonates 15. Post-irradiation of the mandible or maxilla with greater than 5,000 rads total dose 16. Renal transplant and hemodialysis 17. Glomerulonephritis or other active renal disorder 18. Patient receiving interferon treatment 19. Patients having had a splenectomy 20. Chronic steroid therapy (over 10 days) within the last two years (20 mg./day)

	21. Blood diseases, especially acute leukemia, agranulocytosis, granulocytopenia aplastic anemia and agamma globulinemia 22. Systemic lupus erthyematosus 23. Any immuonsuppressed patient such as those with acquired immune deficiency syndrome (AIDS) 24. Pregnant patient requiring anesthesia or any other medication 25. Organ transplant 26. Prosthetic Joint Replacement Faculty discretion based on 2015 ADA Guidelines http://www.ada.org/en/member-center/oral-health-topics/antibiotic-prophylaxis

Consultation Letters

Indications for Physician:

The following is a list of common medical conditions that may be identified while reviewing a medical history. It is the student's responsibility to indicate to faculty that the condition exists and seek guidance for whether or not a physician consultation will be required. This list is not all inclusive and there are certainly other medical conditions that may be identified and may or may not require a medical consultation. The guidance of the dental hygiene faculty and the consulting dentist will determine if a medical consultation will be required prior to patient treatment.

Myocardial Infarcts	Myocardial infarcts that have occurred within the last six months or patients who have had multiple myocardial infarcts. Information needed from the physician should include his/her evaluation of the cardiovascular condition and medications the patient is taking. Generally, no treatment until reply received.
Tuberculosis	A recent history of tuberculosis or a history of tuberculosis in which there is a question as to the effectiveness of the treatment. Information needed from physician: What type of treatment did the patient receive; has there been adequate follow-up?
Malignant Disease	Any malignant disease currently under treatment or discovered within the last two years. Information to be requested from the physician should include the exact nature of the malignancy, the treatment rendered, and the prognosis. Example: Cancer.
Bleeding or Clotting	A history of bleeding or clotting abnormalities in which a diagnosis has been made. The physician should include the exact nature of the malignancy, the treatment rendered, and the prognosis.
Congenital Heart Defects	Physicians should be asked what type of defect is present.
Uncontrolled Diabetes Mellitus	Uncontrolled Diabetes Mellitus or a patient who is suspected of having diabetes mellitus and is not being treated for it. Patient

	receiving daily insulin needs a consultation prior to surgery (oral or periodontal) to adjust the amount of their daily insulin dosage to compensate for the decreased food intake. The physician needs to be asked his opinion of the control of diabetes in the patient and the most recent A1C.	
Jaundice	Physicians need to be asked the cause of the jaundice: Was it the result of hepatitis, and what type hepatitis? Antigen-antibody levels, if available, need to be determined.	
Multiple Medications	Multiple medications, four or more, especially if they involve corticosteroids, psychotropics, and anticoagulants or sedatives. The physician needs to be asked to verify that the medications are prescribed. Tactfully ask for what condition they are prescribed.	
Pregnancy	**Radiographs:**	Elective radiographs will not be taken on the pregnant patient, but emergency radiographs are permitted with proper leaded apron protection.
	Anesthesia:	Consult with attending dentist. A consultation letter is sent primarily to inform the obstetrician that dental treatment is being rendered.
AIDS, HIV	Determine the stage of the patient's disease, the opportunistic infections the patient has and what other associated conditions are present. Request consultation to determine platelet count (<60,000 cells/mL) and WBC-neutrophil (<500 cells/mL) and patient's ability to heal after dental treatment. Source: www.ada.org/en/member-center/oral-health-topics/hiv)	
Splenectomy	Determine if the patient has had a splenectomy and the reason for the procedure, specifically if the patient has sickle cell anemia.	
Vascular Surgery	Indwelling catheters and shunts. Determine if these are present. If a vascular graft, determine if artificial material was used. AHA endocarditis prophylaxis regimen to be used on all patients with artificial grafts, catheters, and shunts.	
Joint replacements	Orthopedic prostheses including total hip, knees, and elbows those with joint replacements and rheumatoid arthritis, systemic lupus erythematosus, disease, drug induced or radiation-induced immunosuppression.	
Faculty discretion to be used for additional medical conditions not listed above		

Antibiotic Prophylaxis

Premedication Procedures

In your Preclinic and Pharmacology courses, you are given information on when to pre-medicate patients before dental treatment.

1. If your patient has a documented need for premedication, you will need to discuss the need for them to obtain a prescription before their appointment. As you were taught in Pharmacology, the first drug of choice for premedication is amoxicillin, the 2nd drug is clindamycin, the 3rd drug is azithromycin, the 4th drug is clarithromycin, and the 5th drug of choice is cephalexin.
    a. The standard regimen for prescribing amoxicillin is: 4 tabs of amoxicillin 500mg one hour prior to the dental appointment.
    b. The standard regimen for prescribing clindamycin is: 4 tabs of clindamycin 150mg one hour prior to the dental appointment.
    c. Above prescriptions are for one appointment. If your treatment plan calls for more than one appointment, dispense the proper number of tablets.
2. Always ask new patients on the phone when you are scheduling their appointment if they need to be pre-medicated. This will help you avoid wasting clinic time.

Premedication with Antibiotics to Prevent Infective Endocarditis

Infective endocarditis (IE) also called bacterial endocarditis (BE) is an infection caused by bacteria that enter the bloodstream and settle in the heart lining, a heart valve, or a blood vessel. Although IE is uncommon, people with some types of congenital heart disease have a greater risk of developing it. The American Heart Association updated their guidelines in 2007 for preventing endocarditis. In the past, children or adults with nearly every type of congenital heart defect needed to receive antibiotics one hour before dental procedures or operations on the mouth, throat, or gastrointestinal, genital or urinary tracts.

Patients with the following conditions will require premedication with antibiotics unless a consultation record from the patient's physicians has been received:

1. Previous history of infectious endocarditis
2. Prosthetic cardiac valve
3. Certain specific, serious congenital (present from birth) heart conditions, including:
    a. Unrepaired or incompletely repaired cyanotic congenital heart disease, including those with palliative shunts and conduits
    b. A completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention, during the first six months after the procedure
    c. Any repaired congenital heart defect with residual defect at the site or adjacent to the site of a prosthetic patch or a prosthetic device
4. A cardiac transplant that develops a problem in a heart valve.

Surgical procedures or instrumentation involving mucosal surfaces or contaminated tissue commonly cause transient bacteremia that rarely persists for more than 15 minutes. Bloodborne bacteria may lodge on damaged or abnormal heart valves or on endocardium or endothelium near congenital anatomic defects, resulting in bacterial endocarditis or endarteritis ("endocarditis" is used here for both endocarditis or endarteritis). Although bacteremia is common following many invasive procedures, only a limited number of bacterial species commonly cause endocarditis. It

is impossible to predict which individual patient will develop this infection or which particular procedure will be responsible.

Bacteremia

Certain cardiac conditions are more often associated with endocarditis than others. Patients at risk are those who have congenital or acquired endocardial, endothelial, or valvular defects. Furthermore, certain dental and surgical procedures are much more likely to initiate the bacteremia that results in endocarditis than are other procedures. Prophylactic antibiotics are recommended for patients at risk for endocarditis whenever they undergo procedures likely to cause bacteremia with organisms that commonly cause endocarditis.

Time Parameters
Antibiotic prophylaxis is most effective when administered pre-operatively in doses that are sufficient to assure adequate serum antibiotic concentrations during and after the procedure. To reduce the likelihood of microbial resistance, it is important that prophylactic antibiotics be used only during the preoperative period. They should be initiated shortly before a procedure (one-hour prior) and should not be continued for an extended period. In unusual circumstances or in the case of delayed healing, it may be necessary to provide additional doses of antibiotic even though bacteremia rarely persists longer than 15 minutes after the procedure.

Clinical Judgment:

This statement represents the recommended guidelines to supplement the practitioner in his/her clinical judgment and is not intended as a standard of care for all cases. It is impossible to make recommendations for all clinical situations in which endocarditis may develop.

Bacterial Endocarditis Risk Reduction:

Poor dental hygiene and periodontal or periapical infections may induce bacteremia even in the absence of dental procedures. Individuals who are at risk for bacterial endocarditis should establish and maintain the best possible oral health to reduce potential sources of bacterial seeding.

Antibiotic prophylaxis is recommended with all dental procedures likely to cause gingival bleeding, including routine professional scaling. If a series of dental procedures is required, it may be prudent to observe an interval of seven days between procedures to reduce the potential for emergence of resistant strains of organisms. If possible, a combination of procedures should be planned in the same period of prophylaxis.

On-Site Pre-Medication: None

There will not be any dispensing of pre-medication on-site. Some dental practices will have on-site medications.

Prescription Medication Contraindications	
Appetite Suppressants: (Fen-Phen, Dexfluramine, Fenfluramine, Phentermine, Adipex, Pondimin, Redux)	ADA statement on HHS Warning to Former Phen-Fen Users: The U. S. Department of health and Human Services is now recommending that the estimated 4.6 million people who were taking the appetite suppressant drugs fen-phen (fenfluramine and phentermine) or dexfenfluramine of fenfluramine alone receive a complete physical examination and echocardiogram to determine if they have any adverse heart conditions.
Warfarin (Coumadin)	Warfarin is an oral anticoagulant used to prevent clotting. It interferes with the blood's clotting by blocking the production of the clotting factors (II, VII, IX, and X) which are vitamin K dependent and are synthesized in the liver. Indications for warfarin include atrial fibrillation, post-MI, or thrombophlebitis. Warfarin's major side effects relate to its action to increase bleeding with symptoms such as petechia, bruising ecchymoses, hematuria (bleeding into the urine), or hemorrhage.
Bisphosphonates: (Actonel, Actonel+Ca, Aredia, Boniva, Didronel, Fosamax, Fosamax+D, Reclast, Skelid, and Zometa)	Antiresorptive agents often are used to treat osteoporosis, lowering the risk of related fractures. In rare cases, use of antiresorptive agents has been associated with osteonecrosis of the jaw. However, the risk of developing antiresorptive agent-induced osteonecrosis of the jaw (ARONJ) is low, with the highest prevalence estimated at 0.10% in a large sample of patients (n=952) who had taken oral bisphosphonates. Although osteonecrosis can occur spontaneously, more commonly ARONJ has been reported after dental treatments—most often invasive procedures like tooth extractions—in patients treated with antiresorptive agents.
Tagamet (and other acid reducers)	Anesthetic with epinephrine.
*****This list is not all inclusive, always review every medical condition, medication and consult with faculty*****	

Section 6: Screener, Clinical Assistant, Radiology and Infection Control Duties

Some of these responsibilities are duly shared between the Clinical Assistant (CA) and Radiology/Screener as a team effort

Screening Appointments

All adult patients (18 years or older) must be screened before they can be appointed for a cleaning. It is the CA's responsibility to remind the patient of his/her appointment 24 hours.

The dental office manager or student making a screening appointment for a patient should first find out if the person has been a patient in our clinic before.

***If the person says no or that it was over 2 years, then he/she will need to schedule a screening appointment. Ask the patient the following questions:**

1. Is this screening appointment for an adult (18 years or older)? **Anyone under 17 years old does not need to be screened.**
2. Have you ever been told to take premedication before dental treatment? If the patient responds "yes" to this question, the patient should be advised of the new premedication guidelines. See medical consult form.
3. Do you have any heart problems? If the patient responds "yes" to this question, ask the patient when the heart problem occurred and if he/she is under the care of a physician. Consult with an instructor to see if the patient's heart problem would contraindicate treatment in our clinic.
4. Do you have a cold sore? If a cold sore is present and not fully healed they cannot be seen. Reappoint the patient once the cold sore is **TOTALLY HEALED- No scab can be present.**
    a. Give patient the following information about the screening appointment:
        i. A student will examine their teeth and determine whether a 1st or 2nd year student will see them. Their teeth will not be cleaned at this appointment.
        ii. There will be no charge for the screening appointment.
        iii. The appointment will last about 45 minutes.
        iv. Arrive 15 minutes early to complete a health questionnaire and a HIPAA form.
        v. Patients will receive a Patient Responsibilities Form, Scope of Comprehensive DH Care Form, and a Patient Information Form. (See Appendix D for these forms)
5. See Appendix D for a sample Patient Screening Appointment Information Form

Complete a grade sheet during clinic, have an instructor initial it.

For each clinic period, one student will be assigned to be the Radiology/Screener This student will be screening patients and performing the following duties:

1. Gather necessary paperwork: medical history, patient's rights and responsibilities, patient data sheet, scope of comprehensive dental hygiene consent and HIPAA.
2. Seat the patient, verify that the HIPAA and consent forms have been signed and review the health questionnaire.

3. Have patient read and sign welcome letter, answer any questions the patient may have about the clinic policies.
4. If a patient needs to be pre- medicated before the screening appointment, verify that the patient has taken their prescribed medication prior to doing any probing. If required, fill out any appropriate medical referral forms. Example: blood pressure greater than 159/95.
5. Take and record the vital signs of the patient. This includes his/her blood pressure, and pulse. Blood pressure and pulse should be recorded on the back of the health questionnaire.
    a. See Section 1: Review of Health History Questionnaire: Guidelines for Management of Patients with Elevated Blood Pressure
6. ***Review the medical history with an instructor before proceeding.**
7. Perform a cursory intraoral examination to make sure there are no lesions.
8. Use the appropriate probe to perform the PSR. (PSR probe)
9. Record sextant score and date on stamped area or sticker on patient Record of Treatment.
10. Inspect for hard and soft deposits.
11. Explain to the patient that his/her name will be placed in the screening log and one of the students will call him/her if the student needs the classification the patient is assigned. Do not promise the patients that they will be seen in the clinic. Inform the patients that multiple appointments will be necessary when they return for their cleaning and that CCCC will not be able to see them every 6 months.
12. In DEN 131, 141, 221 & 231 the appointments are at 9:00 & 10:00. **One patient should not be scheduled for an entire morning clinic.**
13. Give the patient the Patient Information Brochure which describes procedures and policies of our program and the Oral Health Notification.
14. Complete Eaglesoft Notes indicating services rendered at the screening appointment. Remember to include the classification of the patient in the Notes and that a pamphlet was given.
15. Fill out the screening log indicating the date, service rendered, and the patient's classification. Note the student who is to contact that patient. If you are the screener, you have the first option to see that person. This is our “patient pool.”
16. Have instructor sign Notes in the presence of the patient being screened before patient is dismissed.
17. Example of Screener Documentation:

Central Carolina Community College
Dental Clinic Record of Treatment

Date	Clinical Chart Note
5/17/15	Screening Appt. H: Rev. med. Hx. – 34/F, RBP 141/82, P: 77bpm, R: 16, T: 98.0, ASA-II, ADL 0, non-smoker. Pt has not traveled outside of US within 6 mos. NKA. Patient diabetic (Type II) controlled with diet. Pt. ate breakfast, blood sugar level was 130. No contraindications to treatment. A: FMX and Pano. Cursory oral inspection, PSR, informed patient that their perio class is II, calculus class is 02, and stain is moderate. Patient informed that she will need 2-3 appts including FMS and cleaning. Patient placed on screening log. N: Reve Med Hx, EOE/IOE with 2nd Year DH Student.

	Student Name/Faculty Name				
	PSR Date 5/17 (In Eaglesoft)				
		3	1	3	
		2	3	2	

Clinical Assistant Responsibilities

Complete a clinical assistant grade sheet during clinic, have an instructor initial it.

For each clinic period, a student will be assigned to be Clinic Assistant. This person will report no later than 8:15 for clinic, in the proper clinic uniform, and will be responsible for the following:

Evaluation of Clinic Asstistant Duties

Key: Evaluate each step as: S = satisfactory or N = needs improvement
****SA=Student Self-Assessment FE=Faculty Evaluation**

	SA	FE	Tasks
1			Maintains asepsis throughout clinical session(s).

Beginning of Clinical Session

	SA	FE	Tasks
1			CA has arrived a minimum of 45 minutes prior to clinic
2			Compressors and Air units are turned on
3			Ultrasonic cleaner filled with water and sani-soak solution
4			Autoclaves and Statim: water reservoirs are filled with distilled water

During Clinical Session

	SA	FE	Tasks
1			Maintain a list of items needed from supply room that are low in stock in clinic and the clinical lab. Stock sterilization supplies-Distribute supplies (student request form).
2			Run contaminated instruments through ultrasonic for 10 minutes. • Rinse cassettes/instruments thoroughly with water • Dry cassettes/instruments • Bag/wrap cassettes/instruments: initial, date and identify sterilizer & load numbers on bags (LIDS) • Ensure that internal indicators are in sterilizers/cassettes/bags • Clean/oil handpieces prior to sterilization (DO NOT place handpieces in the ultrasonic). • Load instruments into the Midmark

3			Run a fully loaded Midmark-verify that all contaminated instruments are processed fully.
4			Document in appropriate log books of # of loads, results by placing heat indicator strips into log book and listing Load # as related to tracking system on the log located in sterilization near sterilizers.
5			After drying cycle is completed for Midmark, place sterilized instruments in above cabinets to complete drying.
6			Once instruments are fully dried, place instruments in proper cabinets.
8			Run Statim as needed following above steps.
9			Assist students with perio charting, sealants, etc. as requested by faculty.
10			Work with RA to confirm patients for the next clinic session. Example: Tuesday CA will confirm for Thursday. **All messages annotated will be recorded within Eaglesoft and the shared google drive** Memos for each student to review**
11			See front office to acquire all clinical forms to be stocked and make copies as needed.
12			Maintain a clean and organized lab and sterilization areas.
13			Work on any projects that faculty assigns.

Completion of Clinical Session

	SA	FE	Tasks
1			Set out containers of Or-Evac (clean suction lines) for use in every operatory.
2			Disinfect all countertops (including sterilizer countertops), cabinets, sinks, and drawers.
3			Prepare mop water for daily clinical session. • Sweep/Mop the common areas • Verify that peer students sweep/mop individual operatories. • Empty mop container in sink
4			Verify units are shut off & equip. replaced to original position.
5			Turn off and drain ultrasonic.
6			Verify sinks are clean and wiped with baby oil or orange solvent.
7			Verify dust, debris cleaned from dental chair base, arms & crevices.
8			Verify all clinic trash has been taken out.
9			Turn off suction/vacuum pumps system.
10			Clinical Lab: • Assess for cleanliness/orderly appearance, countertops are streak and debris free. • Refill paper lab slips as needed.

			• Ensure that individual Sim Manikins and stations are clean, free of debris and fully operational. Annotate any problems with Sim Manikins.
11			Complete any and all duties assigned by faculty.

Weekly

	SA	FE	Tasks	Fall	Spring	Summer
1			**First Clinic of the week:** Test eye water station in clinic and sim lab. Record results in Cabinet 1 and in sim lab	Tuesday	Monday	Monday
2			Run Spore Test	Tuesday		
3			Check and document Spore Test in log	Thursday		
4			**Last Clinic of the week:** Empty water bottle and reinstall it. Purge lines. Clean and lubricate O-rings in suction and water bottle connection.	Thursday	Friday	Thursday

Monthly

	SA	FE	Tasks	Fall	Spring	Summer
1			Change and clean traps (verify each room changed)	First Tuesday	First Monday	First Monday
2			Clean autoclaves, annotate in log	As indicated on the autoclave unit		

Quarterly

	SA	FE	Tasks
1			**Last Thursday of Semester:** Change gauze in dental unit exhaust collector

****Review CA duties with assigned faculty member prior to signing of evaluation of CA duties worksheet and dismissal for the clinic day.****

Radiology Assistant Responsibilities

Complete a radiology assistant grade sheet during clinic, have an instructor initial it.

For each clinic period, a student will be assigned to be Radiology Assistant. This person will report no later than 45 minutes prior to the assigned clinic start time, in the proper clinic uniform, and will be responsible for the following (See Evaluation of Radiology Assistant Duties):

1. The RA will also be responsible for organizing student use of radiology for each clinic session.
2. Assign students requesting radiographs to a clean room
3. Ensure cleanliness of each radiology room after use by assigned student
4. Processing Scan-X
5. Students should leave the appropriate radiology grade sheet with all appropriate information with exposed Scan-X phosphor plates
6. After processing, bring phosphor plates, grade sheet, and copy of radiographs to faculty for retake approval and sign in of phosphor plates.
7. Faculty will place in student boxes after approval.

Evaluation of Radiology Asstistant Duties

Key: Evaluate each step as: S = satisfactory or N = needs improvement
****SA=Student Self-Assessment FE=Faculty Evaluation**

	SA	FE	Tasks
1			Maintains asepsis throughout clinical session(s).

Beginning of Clinical Session

	SA	FE	Tasks
1			RA has arrived a minimum of 45 minutes prior to clinic
2			Turn all units on and setup rooms and processors for initial use.
3			Ensure that dust, debris, and cuff marks are cleaned from dental chair bases, arms, and crevices.
4			Stock all items necessary for radiology, i.e. masks, gloves, paper towels, cotton rolls, sterile XCP cassettes, screening instrument kits, cups, disinfectant wipes, etc.
5			NOMAD carts: See that the NOMAD batteries are charged. The carts are stocked with XCP cassettes and the black light safe transfer boxes.
6			15 minutes prior to official clinic start time (morning and afternoon): Assist the dental office manager in the front office with patient check in, answering phone calls, and taking patient messages in preparation for the clinic day. **All messages annotated will be recorded within Eaglesoft and the shared google drive DH 20** Memos for each student to review**

During Clinical Session (After team morning huddle)

	SA	FE	Tasks
1			Maintain a list of items needed from supply room that are low in stock. • Ensure that Radiology forms are restocked, inform faculty when supplies are low.
2			Process radiographs, return radiograph grade sheet and phosphor plates to instructor for signature for sign in and retakes.

3			Transport contaminated XCP's and screening instrument kits to clinic-work with CA to run through ultrasonic for 10 minutes
4			Work with CA to confirm patients for the following week out. Example: Tuesday RA will confirm for the following Tuesday. **All messages annotated will be recorded within Eaglesoft and the shared google drive DH 20** Memos for each student to review**
5			All other duties as assigned by faculty.

Completion of Clinical Session

	SA	FE	Tasks
1			Put away all sterile XCP`s and sterile screening kits in their proper location.
2			Clean all countertops (including processor countertops), cabinets, and drawers.
3			Clean sinks out properly to ensure they are free of debris. • Include baby oil or orange solvent as a last step to protect sinks
4			Ensure that all units/processors are turned off and equipment replaced to the original position.
5			Place ALL tubeheads against the wall with arm closed.
6			Prepare mop water for radiology area (complete toward end) • Sweep/Mop the common areas • Sweep/mop individual radiology operatories
7			Ensure that dust, debris, and cuff marks are cleaned from dental chair bases, arms, and crevices.
8			Ensure that all trash has been taken out of radiology.
9			REMOVE battery from NOMAD and charge if necessary. If a NOMAD battery has been charging during clinic session and is complete removed and place battery back in the NOMAD cart.
10			Empty mop water
11			Turn off all radiology lights. Shut down all computers and ScanX machines.

Weekly

	SA	FE	Tasks	Fall	Spring	Summer
1			**First Clinic of the week:** Refill water bottles in Radiology Room 4 and empty ops.	Tuesday	Monday	Monday
2			**Last Clinic of the week:** Empty water bottle and reinstall it. Purge lines. Clean & lubricate O-rings in suction and water bottle connection in	Thursday	Friday	Thursday

			Radiology Room 4 and empty ops.			
3			**Last Clinic of the week: Clinical Lab:** • Assess for cleanliness/orderly appearance, countertops are streak and debris free • Refill paper lab slips as needed • Ensure that individual Sim Manikins and stations are clean, free of debris and fully operational. Annotate any problems with Sim Manikins	Thursday	Friday	Thursday

Monthly

	SA	FE	Tasks	Fall	Spring	Summer
1			Change and clean traps in Radiology Room 4 (screening room) and empty ops	First Tuesday	First Monday	First Monday
2			Clean all three Scan X machines by running a cleaning sheet through the inlet. Cleaning sheets can be reused if clean. Discard cleaning sheet if it has visible debris.	First Tuesday	First Monday	First Monday

Quarterly

	SA	FE	Tasks
1			Last Thursday of semester- Change gauze in dental unit exhaust collector in Radiology Room 4 (screening room) and empty ops

****Review RA duties with assigned faculty member prior to signing of evaluation of RA duties worksheet and dismissal for the clinic day.****

SECTION 7: Supplies

Cubicle Organization

1. Cubicles in the dental clinic are used by three different groups of students and are no one group's personal "home".
2. All personal items must be kept in the student cabinets.
3. Do not tape anything to walls or place personal items in drawers! Anything you buy should be put in your student cabinet at the end of clinic.
4. See location of items as listed below in order to properly organize your cubicle. All units should be identical.
5. NO ITEMS WITH EXPIRATION DATES ARE ALLOWED TO BE STORED IN CUBICLES. ***Exception: Topical Anesthetic***

Front Cabinet (Top Left)	• Water Bottles • Alcohol Prep Pads • ICX Tablets
Front Cabinet (Top Middle)	• OHI Aids, pamphlets, coupons • Vaseline • Floss holder • Disclosing solution • Dappen dishes (disposable) • OHI Material • Tooth Model/Toothbrush
Front Cabinet (Top Right)	• English/Spanish Translation Guide • UltraLume LED 5
Front Cabinet (Recessed Countertop)	• Mirror • Kleenex
Front Cabinet (Bottom Left Side)	• Prophy paste (coarse, medium, fine) • Prophy angles • Saliva ejectors • Suction tips • Hazardous waste bags
Front Cabinet (Bottom Middle)	• Ultrasonic (Cavitron)
Front Cabinet (Bottom Right)	• Topical anesthetic • Needles • Protectors • Fluoride Trays
Side Cabinet (Top Glass Cabinets-OHI Items)	• Glide Floss • Toothpaste • Sensodyne • Adult toothbrushes • Kids toothbrushes • Floss threaders

	• Floss • Reach flosser
Side Cabinet (Countertop)	• Tongue Depressors • Cotton rolls • Cotton tipped applicators • 2x2 gauze • 4x4 gauze
Top Drawer	• Patient napkins • Paper tray covers
Bottom Drawer	• Bouffant caps • Pink Sterilex card
Large Side Cabinet	• Chair covers/Barriers • Prophy angles
Top Cabinet (in between cubicles)	• Large gloves (top shelf) • Small gloves (top) • Medium gloves (bottom) • Cups (bottom left) • Paper towels (middle back) • Masks (middle front) • Sink stopper (bottom right)
Top Cabinet (countertop in between cubicles)	• Listerine Zero (left) • Hand Sanitizer (right)
Bottom Cabinet (in between cubicles)	• Plastic Instrument Carrier • Soap spray bottle • PD Care spray bottle • Large soap dispenser • Dental vacuum line cleaner • PD Care wipe container • Small sharps container • Purple nitrile utility gloves
No personal items in drawers ***No extra barriers are to be kept in the drawers***	

Please use metal file holders to store patient paperwork and process evaluations for each appointment. A neat, clean work environment is both important and productive.

Storage Room and Inventory

To request Inventory from Storage Room, fill out “Inventory Request Form” on clipboard in the right-hand corner of the secretary’s desk with information as follows:

- Name of Student Requesting Inventory
- Date
- Specific Inventory items needed
- Specific Quantity of each item needed

Hand “Inventory Supplies Request Form” to Faculty Clinical Assistant and notify the CA that you are requesting items to be pulled by 8:45. The Faculty Clinical Assistant will then pull the items indicated from the Storage Room and turn them over to the student requesting the supplies.

If an item is needed right away and an instructor sends you to get it from the storage room, please fill out the request form for the item (s) you removed out of the storage room and turn it in to the administrative assistant.

Example Form:

Daily Product Inventory Sheet

Name: _____

Date of Request: _____

Product	Amount Pulled	Date	Initials

Laundry Services

Policy

All students/faculty/staff/instructors will ensure that clean and sanitized towels are adequately laundered to promote clinical work flow of Dental Department.

Procedure for Laundry Services

1. Clean and soiled towels are to be kept separate in the laundry. Clean storage environment is designed primarily to prevent contamination of clean towels.
2. All soiled towels used within the Dental Department shall be placed in the "Dirty Towels" cabinet in Central Sterilization (CS) **INSIDE THE LINED CONTAINER**.
3. Once each liner is full of soiled DRY towels, the bag should be tied off and placed inside the laundry basket in CS.
4. Once the Dental Department has a full bag of soiled towels, the Dental Programs Office Manager is to be notified so that arrangements can be made for the soiled laundry to be picked up and cleaned.
5. Notify Dental Programs Office Manager to contact MacDuff's Cleaners for pick up. 217 S Gulf St., Sanford, NC 27330 (919) 775-7012

Washer and Dryer

The CCCC Dental Programs washer and dryer will only be utilized to launder clinic towels and faculty jackets. Clinic towels must be washed with no other items. Faculty jackets must be thoroughly searched for pens to ensure no ink staining during the washing process. Jackets will be placed on hangers on the hanger rack.

Section 8: Guidelines and Policies Regarding the Use of Ionizing Radiation

Refer to the Radiology Manual issued during the DEN 112 Dental Radiology Course for complete information.

Endorsements: The policy of Central Carolina Dental Center CCCC Dental Programs regarding the use of ionizing radiation will be endorsed by the American Dental Association, American Association of Dental Schools, American Academy of Oral & Maxillofacial Radiology, the National Center for Devices and Radiological Health (NCDRH), and North Carolina Department of Energy and Natural Radiation (NCDENR).

Purpose: Radiographic examination(s) must be ordered only after a complete review of the medical, oral, and dental histories and following a thorough clinical examination. Diagnostic radiographic examinations provide essential information for diagnosis, treatment and prevention of oral and dental diseases. Diagnostic radiographs are thus an indispensable and integral component of dental practice authorized at the discretion of the dentist to benefit the patient based on specific selection criteria.

Selection Criteria

A. Films and Frequency:

The following selection criteria will be utilized by CCCC Dental Programs to determine radiographs to be taken on patients, and their frequency.

B. Required Examination

1. All patients will be clinically examined and their medical and dental histories obtained prior to diagnostic radiation exposure.
2. A dental faculty member will review recommendations by dental hygiene students and determine which and how many radiographs are to be ordered and exposed.

C. New Patients

1. New patients will be asked if recent radiographs are available during their screening visit.
2. If recent radiographs are not available, then an appropriate radiographic examination will be completed.

D. Faculty Approval

1. Radiology film/sensors or XCP kits will not be dispensed to students unless ordered by faculty/DDS.
2. Retakes will not be permitted until after the radiographs have been reviewed by the faculty/DDS.

E. Retakes

Non-diagnostic radiographs should be retaken by faculty or trained staff unless it is their

opinion that the student can successfully retake the film; then, they must be retaken under direct supervision.

F. Pregnant Patients

Elective radiographs will not be taken on the pregnant patient, but emergency radiographs are permitted with proper leaded apron protection.

G. Academic Purposes:

1. For academic reasons radiographs should not be repeatedly taken to obtain radiographs that are perfect if other radiographs contain similar diagnostic information.
2. Routine examination will not be used on new patients to determine their acceptability as patients for students.
3. Radiographic examinations must not be used routinely for checking progress of treatment.

Radiation Protection

A. **Record Keeping:**

1. All patient exposures will be recorded in the patient's electronic record.
2. The date, type and number of radiographs will be recorded.

B. **Procedures:**

1. All exposures of patients will be performed using lead aprons and leaded cervical thyroid shields.
2. All exposures will be performed using the posted appropriate kVP, mA and time settings.
3. Users of X-ray generated equipment will follow good radiation hygiene practices.
4. During exposures, radiology personnel will stand behind shielded walls or doors (exception Nomad use), will not hold films for patients, and will observe patients through the glass shields so that no unnecessary retakes occur as the result of tube, film, or patient movement.
5. NOMADs are stored in rolling carts in the locked main dental clinic supply closet. At all times when not in use the NOMADs are to be transferred in the rolling carts.
6. NOMADs must be disinfected with the OPTIM disinfectant after usage. The NOMAD cart must also be wiped down after usage.
7. The Radiology Assistant is responsible for overseeing the care and storage of the NOMAD.

NOMADS are to be placed on charge if light indicates charging necessary. NOMAD must NOT remain on charger for more than 12 hours in efforts to save battery life. NOMADS to return to black rolling carts at the end of every clinic day. NOMADS and carts are to be disinfected following manufacturer's instructions with Optim 3D wipes ONLY. Cavi wipes are not to be used to disinfect NOMADS. The black carts are to house NOMADS when NOMADS are not in use during radiation exposure. This prevent breaking or dropping of NOMAD.

C. **Film Badges:**

All dental hygiene faculty and students who routinely use ionizing radiation will wear dosimeter film badges that will be monitored monthly.

D. **Equipment Inspection: Refer to Radiology Manual**

E. **Apron & Shield Inspection:**

Annually, all lead aprons and cervical shields will be visually inspected for cracks or defects and replaced if necessary. However, students must immediately report to the clinical instructor if cracks or defects are found on lead aprons and thyroid collars. Aprons and shields will not be folded but hung when not in use.

Radiology Clinic Housekeeping

A. **Responsibilities:**

Cleanliness is very important in all aspects of dentistry, and radiology is not an exception. Radiology cubicles, hallway and processing areas reviewed by students, visitors and patients will be cleaned by the assigned students who use them throughout the day and the CA/RA.

B. **Cubicles:**

1. Floors should be free of film/sensor wrappers and tissue.
2. Lead aprons should be hung on their hangers.
3. Tissue and Stabe film holders should be kept available in the wall units in each cubicle for your use during the assignment.
4. Plastic headrest covers should be changed between patients.
5. X-ray units should be placed against the wall when not in use.
6. Remove all plastic wrapping from the X-ray machine and cubicle area after films have been evaluated, retakes completed, and patient dismissed.
7. Countertops should be clean, dry, and orderly.

C. **Panoramic Cubicles & Hallway Outside Cubicle:**

1. Floors should be kept free of all debris.
2. Lead aprons should be stored by hanging them on a wall hanger.
3. Bite guards should be kept cleaned and covered with barriers.
4. Counter tops should be clean, dry, and orderly.

D. **Scan-X Room:**

1. The student(s) will be responsible to maintain the cleanliness of the Scan-X processing area.
2. PSP sensors must be clean and dry before carrying these items into the Scan-X room.
3. Students must not deliver PSP sensors to the Scan-X room with soiled protective barriers.
4. All PSP sensors should be placed in the sensor transfer box before delivery to the Scan-x processing area.

E. **PeriPro:**

1. The student(s) will be responsible to maintain the cleanliness of the PeriPro.
2. The PeriPro will only be utilized during DEN 112 procedures for the purpose of learning how to process radiograph film.
3. Students will not utilize regular film for creating radiographs for patients during clinical courses.

Infection Control Guidelines in Dental Radiology

A. Preparation:

1. All non-disposable film holding devices (Rinn XCP, Snap-A-Ray) should be autoclaved prior to use. Rinn XCP set and Snap-A-Ray instruments may be signed out.
2. Hands should be washed with an appropriate disinfectant hand before and after glove use.
3. Gloves should be worn at all times when exposing and processing intra-oral radiographs.

B. Materials and Supplies:

1. Secure the patient record and desired number of film packets/sensors.
2. Review medical history.
3. Secure as many bite-wing tabs and STABE holders as needed from containers in each cubicle.
4. Place these on the counter in the radiology room, which should be covered with plastic or patient napkin.
5. Once the operator begins making radiographs, do not reach into these containers to secure additional supplies.
6. If additional supplies are needed, the operator should remove gloves, rewash hands and put on new gloves before reaching into the container.

C. Preparing Surfaces:

Surfaces that will be touched by the operator during treatment, including tubehead, cone, control panel, exposure button, and chair armrests should be covered with plastic barriers prior to seating the patient.

D. Preparing Instruments:

1. Film-holding devices (Rinn XCP) should be removed from the autoclave bag with gloved hands and placed on the covered countertop.
2. These instruments should go from the counter to the patient's mouth and back to the same counter.
3. Do not place used instruments on uncovered countertops or other areas in or out of the cubicle.
4. When work is completed, remove cotton rolls from XCP, wash, rinse, and dry instruments.
5. Place instruments in a new autoclave bag for sterilization or place them in plastic bag until they can be transferred to an autoclave bag.

6. Do not carry instruments in a lab coat.
7. Do not leave film-holding instruments on the counter in the viewing room or Scan-X room or darkroom.

E. Nomad Handheld X-ray Units:

Nomad Handheld X-ray units must be disinfected only with Optim 3TB disinfection wipes. The unit must be left wet for at least one minute to provide full disinfection. Do not use any other disinfection system. Manufacturer guidelines require that only the Optim wipes be used due to the reduced corrosive nature of the brand.

F. Additional Precautions:

All charts, books, and other material not essential in the delivery of treatment should be kept away from the treatment and darkroom/scan-x areas to avoid unnecessary contamination.

Step-By-Step Procedures

A. Intraoral Radiographs (PSP):

Preparation

1. Prepare the unit room by observing infection control procedures for this area. Make certain to use barriers on the PID, control panel keypad, and patient chair.
2. Check chart for proper forms with signatures or prescriptions from private dentist.
3. Use of Planmeca intraoral radiographic equipment:

    - The on/off button is located under the panel that is on the wall next to the patient chair.
    - The control panel keypad is located on the wall outside the operatory entryway.
    - Press the mode button to select type of system being used: d=digital, p=phosphor plate, and 0=film.
    - Rooms 1, 2, and 3 will require use of the phosphor plate sensor system. Room 4 may be utilized for both phosphor plates and digital sensors. Film will only be utilized during DEN 112 with the use of DXTRR.
    - The kVp and mA are pre-set and no adjustment can be made. Exposure times are pre-set.
    - Use the control panel keypad outside the room to make adjustments for the teeth you are exposing based on patient size.

4. Place sensors on a clean paper towel that lines the area where you will be working.
5. Make sure that the sensor transfer box is readily available so you may be able to insert EXPOSED sensors into the box for transport to the SCANX Imaging System.
6. Place the lead apron and thyroid collar on the patient. Check the adjustment of the headrest to be sure the patient's head is in a stable, comfortable position. Ask the patient to remove eye glasses. Wash hands and glove, and then ask the patient to remove any removable dental appliances. Place dental appliance(s) in a denture cup.

B. Activation of Radiation:

1. Before exposing films, CHECK setting on the x-ray unit to be sure it is set for the proper radiographic area of interest.
2. The exposure button should be held down long enough to make the exposure complete.
3. An audible signal can be heard when an exposure is being made.
4. If you remove your finger too soon, the exposure will not be complete, and the resulting image may be either non-existent or of a very light density.

C. Handling and Processing of Exposed Sensors

1. After removing the phosphor plate from the patient's mouth, place the plate in an area on the counter that will not be confused with the remaining unexposed film.
2. This may be in a plastic cup or on a clean paper towel.
3. This will prevent mixing exposed plates with unexposed plates.
4. Once all phosphor plates are exposed, carefully wipe down the plates with a Cavi Wipes.
5. Carefully tear open the phosphor plate covers and deposit the plates into the sensor transfer box.
6. Wash your hands.
7. Upon completion of the FMX, remove the lead apron and thyroid shield.
8. Take the full sensor transfer box to the Radiology Assistant and tell them that the radiology operatory will no longer be needed and that they may clean the operatory when available.
9. If the radiology area is not busy, the patient may wait in the radiology operatory while the Radiology Assistant develops the PSP sensors.
10. If the area is busy, escort your patient to your clinical operatory. (If using digital sensors, use appropriate protocol stated in the Radiology Manual.)
11. The Radiology Assistant will process the phosphor plates into the SCANX imaging system, mount the images in the proper mounting views, and deliver a printed copy of the images to a clinical instructor for review.
12. The instructor will initial the images upon approval and alert the Radiology Assistant as to whether or not retakes are required.
13. The Radiology Assistant will also count the PSP sensors and ensure that the plates are returned to the clinic for the instructor to count before returning to the PSP sensor holding area. (If using digital sensors, use appropriate protocol stated in the Radiology Manual.)

D. Escorting Patient and Sterilization of XCP Equipment

1. When escorting the patient to the dental hygiene clinic, the XCP equipment may be carried back to the clinic with a gloved hand.
2. **DO NOT** ask the patient to stand in the sterilization area while you handle equipment or perform sterilization procedures in the sterilization area.
3. This may result in a major error on your grade sheet.

E. Retrieval of Completed Radiographic Images

1. The radiology assistant will deliver the printed radiographs and a grade sheet to your operatory inbox to let you know that the radiographs have been safely entered into Eaglesoft.

2. The radiology assistant should let you know if retakes may be required and assist in bringing the patient back to the radiology lab for retakes.

F. Retaking Radiographs

1. If you believe that retakes are required at this point you will need to repeat the same steps of taking radiographs.
2. Ask the dentist/ radiology faculty/faculty to verify your conclusions.
3. Take only the retakes requested by the faculty/dentist.
4. If you administer retakes of radiographs without instructor approval, you will be subject to a "0" for the clinical session, as this will be considered a **critical error**.
5. Annotate retake in retake log.

G. Distribution of Radiographic Images

1. Print a copy of the radiographs for the patient so that the patient may take the radiographs to the dentist of their choice.
2. If a patient requests that electronic radiographs be sent his/her dentist, the office manager will help you with that process.
3. The office manager will need the name of the dental office and an email address will also be helpful.
4. When patients request to take the second set to their doctor, this must be documented in the patient's chart.
5. The clinical dentist should be asked to perform an exam and evaluate the radiographs.
6. Any clinical findings should be recorded in the clinical notes and in dental charting.
7. Clinical findings should also be recorded on a patient referral sheet to be taken to the dentist of their choice.
8. All patients are encouraged to establish a dental home elsewhere from the CCCC Dental Hygiene Clinic since CCCC is primarily providing educational experiences for students and not serving as a true healthcare provider.

H. Disinfection of Radiographic Operatory

1. The Radiology Assistant is responsible for cleaning the radiographic operatory.
2. The Radiology Assistant must wipe down lead apron and thyroid collar with Cavi Wipes and then hang these items on hooks behind chair.
3. The Radiology Assistant must then push the tubehead against the wall with extension arm closed and PID down.
4. This resting position will extend the life of the extension arm.
5. The Radiology Assistant should then sanitize and disinfect the area, removing and disposing of barriers and any debris properly.
6. Prepare any items for sterilization as appropriate.
7. If a dentist is not available for pathology evaluation an instructor will perform a preliminary evaluation while the patient is still in the chair.
8. The radiographs and noted pathology will be placed in the specified box in the clinic for the dentist to evaluate as soon as possible.
9. If the dentist finds additional pathology, the dental hygiene department will call the patient and relay the dentist's findings.

CCD Receptors

1. With clean hands place CCD receptor in protective cover and cover keyboard with plastic drape.
2. Wash hands. With gloved hands proceed with exam.
3. When exam is complete remove gloves and wash hands, dismiss patient.
4. Then re-glove hands to remove protective covers from sensor and keyboard.
5. Wipe sensor and cord with a paper towel wet with disinfectant.
6. Remove gloves and wash hands.
7. Prepare room for next patient.

I. Panoramic Images:

1. When taking panoramic radiographs, come to radiology with washed hands and no gloves.
2. There is no need to wrap anything in this space.
3. Cover PAN bite block with disposable plastic sheath barriers.
4. Clean the patient positioning area and wipe down the handles and temple holders of the panoramic unit after making the exposure.

J. Eaglesoft 16 Radiograph transfer procedures:

1. Right click over the radiograph set that needs to be transferred.
2. Select Transfer Exam.
3. Select patient that radiographs need to be transferred to.
4. Click “yes” to allow exam transfer.
5. Check to make sure proper transfer has happened.

Criteria for Radiographs

Only films necessary to complete the diagnosis should be ordered. The professional discretion of the faculty must be used to determine which films are needed based on the conditions found during the clinical examination.

Selection Criteria:

- Guidelines for Prescribing Dental Radiographs
- U.S. Department of Health and Human Services
- Public Health Services
- Food and Drug Administration
- Center for Devices and Radiological Health
- Rockville, Maryland
- HHS Publication FDA 88-8274

Suggested Guidelines for Prescribing Dental Radiographs

Guidelines for Prescribing Dental Radiographs
U.S. Department of Health and Human Services

PATIENT AGE AND DENTAL DEVELOPMENTAL STAGE					
TYPE OF ENCOUNTER	Child with Primary Dentition (prior to eruption of first permanent tooth)	Child with Transitional Dentition (after eruption of first permanent tooth)	Adolescent with Permanent Dentition (prior to eruption of third molars)	Adult, Dentate or Partially Edentulous	Adult, Edentulous
New Patient* being evaluated for oral diseases	Individualized radiographic exam consisting of selected periapical/occlusal views and/or posterior bitewings if proximal surfaces cannot be visualized or probed. Patients without evidence of disease and with open proximal contacts may not require a radiographic exam at this time.	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images.	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images. A full mouth intraoral radiographic exam is preferred when the patient has clinical evidence of generalized oral disease or a history of extensive dental treatment.		Individualized radiographic exam, based on clinical signs and symptoms.
Recall Patient* with clinical caries or at increased risk for caries**	Posterior bitewing exam at 6-12 month intervals if proximal surfaces cannot be examined visually or with a probe		Posterior bitewing exam at 6-18 month intervals		Not applicable
Recall Patient* with no clinical caries and not at increased risk for caries**	Posterior bitewing exam at 12-24 month intervals if proximal surfaces cannot be examined visually or with a probe		Posterior bitewing exam at 18-36 month intervals	Posterior bitewing exam at 24-36 month intervals	Not applicable
Recall Patient* with periodontal disease	Clinical judgment as to the need for and type of radiographic images for the evaluation of periodontal disease. Imaging may consist of, but is not limited to, selected bitewing and/or periapical images of areas where periodontal disease (other than nonspecific gingivitis) can be demonstrated clinically.				Not applicable

PATIENT AGE AND DENTAL DEVELOPMENTAL STAGE					
TYPE OF ENCOUNTER	Child with Primary Dentition (prior to eruption of first permanent tooth)	Child with Transitional Dentition (after eruption of first permanent tooth)	Adolescent with Permanent Dentition (prior to eruption of third molars)	Adult, Dentate or Partially Edentulous	Adult, Edentulous
Patient (New and Recall) for monitoring of dentofacial growth and development, and/or assessment of dental/skeletal relationships	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development or assessment of dental and skeletal relationships		Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development, or assessment of dental and skeletal relationships. Panoramic or periapical exam to assess developing third molars	Usually not indicated for monitoring of growth and development. Clinical judgment as to the need for and type of radiographic image for evaluation of dental and skeletal relationships.	
Patient with other circumstances including, but not limited to, proposed or existing implants, other dental and craniofacial pathoses, restorative/ endodontic needs, treated periodontal disease and caries remineralization	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of these conditions				

1. **Clinical situations for which radiographs may be indicated include:**

    a. Positive Historical Findings
    b. Previous periodontal or endodontic therapy
    c. History of pain or trauma

d. Familial history of dental anomalies
e. Postoperative evaluation of healing
f. Presence of implants

2. Positive Clinical Signs/Symptoms

a. Clinical evidence of periodontal disease
b. Large or deep restorations
c. Deep carious lesions
d. Malposed or clinically impacted teeth
e. Swelling
f. Evidence of facial trauma
g. Mobility of teeth
h. Fistula or sinus tract infection
i. Clinically suspected sinus pathology
j. Growth abnormalities
k. Oral involvement in known or suspected systemic disease
l. Positive neurologic findings in the head and neck
m. Evidence of foreign objects
n. Pain and/or dysfunction of the TMJ

The recommendations above are subject to clinical judgment and may not apply to every patient. They are to be used by dentists only after reviewing the patient's health history and completing a clinical examination.

Patients at high risk for caries may demonstrate any of the following:

1. High level of caries experience
2. History of recurrent caries
3. Existing restoration or poor quality
4. Poor oral hygiene
5. Inadequate fluoride exposure
6. Prolong nursing (bottle or breast)
7. Diet with high sucrose frequency
8. Poor family dental health
9. Developmental enamel defects
10. Developmental disability
11. Xerostomia
12. Genetic abnormality of teeth
13. Many multisurface restoration
14. Chemo/radiation therapy
15. Abutment teeth for fixed or removable partial prosthesis
16. Unexplained bleeding
17. Unexplained sensitivity of teeth
18. Unusual eruption, spacing or migration of teeth
19. Unusual tooth morphology, calcification or color
20. Missing teeth with unknown reason

The recommendations above are subject to clinical judgment and may not apply to every patient. They are to be used by dentists only after reviewing the patient's health history and completing a clinical examination. The recommendations do not need to be altered because of pregnancy.

SECTION 9 Radiology Forms

See Appendix D for the following forms:

1. Radiology Analysis & Grade-FMS/Individual Periapicals
2. Bitewing Analysis-4 HBWX, 4 VBWX
3. 7-Series Vertical Bitewing Analysis
4. Panoramic Analysis
5. Radiographic Interpretation

SECTION 10: Dental Materials Lab

Working in the Laboratory

A schedule will be posted on the lab door for times the lab is free for students. A dental faculty member must be available to supervise in order for a student to work in the lab. Always double check to be sure an instructor is here and knows you are in the lab. Each student must sign in and have an instructor check him/her out before leaving.

The lab must be thoroughly cleaned before leaving. If the lab is left dirty by any student, lab privileges for the student will be revoked for the 2 weeks. The use of the lab during the student's free time is a privilege. Don't abuse it.

Model Trimmers

Model trimmers are expensive pieces of equipment. The machines must be properly cared for if they are to be kept in running order. Each student should take the responsibility to keep them properly maintained.

Operation Instructions for Model Trimmers

The following procedures must be adhered to when operating the model trimmer:

1. Wear your safety glasses, lab apron and pull your hair back.
2. Make sure machine is plugged in.
3. Make sure wheel is clean.
4. Turn on water valve on side of machine.
5. Turn on machine.
6. Water should run over wheel at all times.
7. Adjust water spray so that water does not splash.
8. Let the machine and water run for two minutes.
9. After use, follow maintenance instructions.

Maintenance of Model Trimmer

The following guidelines should be used in the general care and maintenance of the model trimmer:

1. Use water freely to keep wheel clean and sharp; check the spray tube to be certain that it is not clogged.
2. Before use, allow machine to run for two minutes; machines will often vibrate when first started due to water settling in the lower portion of the wheel; running the machine for a short while counteracts the vibration.
3. If motor refuses to start properly or begins to smoke, turn the machine off; continued use will burn up the motor.
4. At the end of use, allow wheel to run for two minutes; gradually pour in two green rubber bowls full of water over wheel; stop machine, use nail brush to scrub angle plate and wheel; turn machine on and give final rinse with a little water from bowl; clean out stone/plaster trap on side of machine; wipe off thoroughly to make sure no stone or plaster is left on the machine.

Student Responsibilities

When a student uses the materials lab outside of class time, it is his/her responsibility to:

1. Put away supplies at end of each lab session.
2. Clean counters and lab benches in lab and prep room.
3. Replenish supplies such as model gloss, plaster, etc.
4. Clean model trimmers in lab and prep room.
5. Clean sinks in lab and prep room.
6. Clean lathes.
7. Sweep and mop floor in lab.

Please refer to the Sim Lab Assistant Evaluation form for detailed instructions to ensure lab cleanliness.

Key: Evaluate each step as: S = satisfactory or N = needs improvement
**SA=Student Self-Assessment FE=Faculty Evaluation

Beginning of Lab Session

	SA	FE	Tasks
1			SLA has arrived a minimum of 10 minutes prior to lab
2			Compressors and Air units are turned on
3			Sim Lab is clean and orderly
4			Annotate any dirty areas or items left out: • _____ • _____
5			Create list of items needed from supply room to restock disposable items. • Gloves • Gauze • Masks • Hand Sanitizer • Disinfecting Wipes/Spray
6			Maintains asepsis

Completion of Lab Session

	SA	FE	Tasks
1			Ensure that individual Sim Manikins and stations are clean, free of debris and fully operational (Classmates should annotate any problems with Sim

			Manikins)
2			Clean countertops (spray, wipe, spray, wipe until no smear layer)
3			Clean ALL cabinets of dust, debris
4			Put away any supply items used during the lab session
5			Sweep/Mop any areas that have debris
6			Ensure that ALL water bottles are emptied
7			Verify Sim manikins are shut off and equipment replaced to original position
8			All dust, debris cleaned from base and crevices of operator chairs
9			Clean sinks then wipe with baby oil or orange solvent
10			Turn off all model trimmers (including water)
11			Restock supplies using list and refill all disinfectant wipe containers
12			Verify simulation lab is clean/closed (Annotate names of students in lab)
13			Maintained asepsis

Individual students are responsible for maintaining Station Drawers and Sim Manikins

Emergency Gas Shut-Off

In the event that a student believes there is a gas leak, notify the instructor.

Supplies

The school provides for the students, at no additional charge, most of the materials needed for use in the dental materials lab. This is a privilege not to be abused. Supplies should not be wasted. Limits are not placed on the amount a student uses for the completion of a lab or to reach proficiency; however, we ask that the students be careful not to drop, spill, or contaminate materials. Tubes of materials should be wiped clean and returned to clean boxes. Molds should be left clean, free of stone and plaster. Bins of stone and plaster should be kept covered and scoops not transferred from one to another. When a student notices that supplies are running low, she should advise the instructor.

Lab Bench Requirements

Each student will be issued the following instruments and supplies. They are issued at no cost to the student, but in the event an instrument becomes lost, damaged, or stolen, it must be replaced by the student. These are to be kept locked in the drawers provided. Expendable items such as

cleaners will be continuously resupplied (upon request) by a lab instructor at the completion of a lab period.

Student Supplies Purchased by Students	
Protective lenses	Lab apron
Waterproof sandpaper	Ink pens
Pencils	Inch/cm ruler
Non-Expendable Items Furnished by Dental Department	
Green rubber bowl	Alginate mixing bowl
Powder measurer	Plaster spatula
Curing light	Wood-handled Spatula
Glass plates (2)	#7 wax spatula
Amalgam	Amalgam well
Glass slab	Small Cement Spatula
Parchment mixing pad	Composite mixing pad
Lab knife	Dappen dish
Cement spatula	Dentiform (maxillary)
Amalgam carrier	Dentiform (mandibular)
Cotton pliers	Lab pan
Ball burnisher	Carver
Black Spoon	Dycal Instrument
Condensor/Plugger	Composite Instrument
R-50 Cord Packer	Matrix Retainer
Mirror	Explorer
Expendable Items Furnished by Dental Department	
2 x 2 gauze squares	Paper cups
Alcohol Prep Pads	Articulating Paper
Orange Solvent	Cotton Rolls

SECTION 11: Clinical Rotations

There will be clinical rotations in DEN 221 and DEN 231. ***Each student's clinical rotation schedule is available on Eaglesoft. Please review your schedule and make note on your calendar when and where you are supposed to be at each site.*** Participation for each rotation is mandatory. Please make sure that you make every effort to attend and participate to the best of your ability at each clinical rotation. You may not switch rotation times with another student.
General Expectations

Never leave early. Students should never leave a rotation site early, even if a site worker states that there are no more patients for you to treat. You should fill your time helping in the sterilization area, etc. A student who leaves a site early will be given a critical error and a grade of "zero" will be given for that day. A student shall never leave a site early without faculty notification.

- Arrive in plenty of time to set up your unit and prepare for your patient that day. Traffic is congested, leave early.

- Take everything you use at CCCC to rotations. IE. Clinic Manual, BP cuff, stethoscope, drug book, lab coat, clinic shoes, specialty aids (Example: end tuft brush if needed).

- Wear your CCCC lab coat when you are in the rotation operatory treating patients. Policy prohibits you to walk out of the clinic with contaminated scrubs.

- All shoes must have closed toes, heels and be wipeable (no cloth, no laces)

See Appendix D for the Extramural Site Evaluation form

Appendix A: American Dental Hygienists' Association Code of Ethics

Code of Ethics for Dental Hygienists

1. Preamble

As dental hygienists, we are a community of professionals devoted to the prevention of disease and the promotion and improvement of the public's health. We are preventive oral health professionals who provide educational, clinical, and therapeutic services to the public. We strive to live meaningful, productive, satisfying lives that simultaneously serve us, our profession, our society, and the world. Our actions, behaviors, and attitudes are consistent with our commitment to public service. We endorse and incorporate the Code into our daily lives.

2. Purpose

The purpose of a professional code of ethics is to achieve high levels of ethical consciousness, decision making, and practice by the members of the profession. Specific objectives of the Dental Hygiene Code of Ethics are:

- To increase our professional and ethical consciousness and sense of ethical responsibility.
- To lead us to recognize ethical issues and choices and to guide us in making more informed ethical decisions.
- To establish a standard for professional judgment and conduct.
- To provide a statement of the ethical behavior the public can expect from us.

The Dental Hygiene Code of Ethics is meant to influence us throughout our careers. It stimulates our continuing study of ethical issues and challenges us to explore our ethical responsibilities. The Code establishes concise standards of behavior to guide the public's expectations of our profession and supports dental hygiene practice, laws and regulations. By holding ourselves accountable to meeting the standards stated in the Code, we enhance the public's trust on which our professional privilege and status are founded.

3. Key Concepts

Our beliefs, principles, values, and ethics are concepts reflected in the Code. They are the essential elements of our comprehensive and definitive code of ethics, and are interrelated and mutually dependent.

4. Basic Beliefs

We recognize the importance of the following beliefs that guide our practice and provide context for our ethics:

- The services we provide contribute to the health and wellbeing of society.
- Our education and licensure qualify us to serve the public by preventing and treating oral disease and helping individuals achieve and maintain optimal health.
- Individuals have intrinsic worth, are responsible for their own health, and are entitled to make choices regarding their health.
- Dental hygiene care is an essential component of overall health care and we function interdependently with other health care providers.
- All people should have access to health care, including oral health care.
- We are individually responsible for our actions and the quality of care we provide.

5. Fundamental Principles

These fundamental principles, universal concepts and general laws of conduct provide the foundation for our ethics.

Universality
The principle of universality expects that, if one individual judges an action to be right or wrong in a given situation, other people considering the same action in the same situation would make the same judgment.

Complementarity
The principle of complementarity recognizes the existence of an obligation to justice and basic human rights. In all relationships, it requires considering the values and perspectives of others before making decisions or taking actions affecting them.

Ethics
Ethics are the general standards of right and wrong that guide behavior within society. As generally accepted actions, they can be judged by determining the extent to which they promote good and minimize harm. Ethics compel us to engage in health promotion/disease prevention activities.

Community
This principle expresses our concern for the bond between individuals, the community, and society in general. It leads us to preserve natural resources and inspires us to show concern for the global environment.

Responsibility
Responsibility is central to our ethics. We recognize that there are guidelines for making ethical choices and accept responsibility for knowing and applying them. We accept the consequences of our actions or the failure to act and are willing to make ethical choices and publicly affirm them.

6. Core Values

We acknowledge these values as general for our choices and actions.

Individual autonomy and respect for human beings
People have the right to be treated with respect. They have the right to informed consent prior to treatment, and they have the right to full disclosure of all relevant information so that they can make informed choices about their care.

Confidentiality
We respect the confidentiality of client information and relationships as a demonstration of the value we place on individual autonomy. We acknowledge our obligation to justify any violation of a confidence.

Societal Trust
We value client trust and understand that public trust in our profession is based on our actions and behavior.

Non-maleficence
We accept our fundamental obligation to provide services in a manner that protects all clients and minimizes harm to them and others involved in their treatment.

Beneficence
We have a primary role in promoting the wellbeing of individuals and the public by engaging in health promotion/disease prevention activities.

Justice and Fairness
We value justice and support the fair and equitable distribution of health care resources. We believe all people should have access to high-quality, affordable oral healthcare.

Veracity
We accept our obligation to tell the truth and expect that others will do the same. We value self-knowledge and seek truth and honesty in all relationships.

7. Standards of Professional Responsibility

We are obligated to practice our profession in a manner that supports our purpose, beliefs, and values in accordance with the fundamental principles that support our ethics. We acknowledge the following responsibilities:

To Ourselves as Individuals:
- Avoid self-deception, and continually strive for knowledge and personal growth.
- Establish and maintain a lifestyle that supports optimal health.
- Create a safe work environment.
- Assert our own interests in ways that are fair and equitable.
- Seek the advice and counsel of others when challenged with ethical dilemmas.
- Have realistic expectations of ourselves and recognize our limitations.

To Ourselves as Professionals:
- Enhance professional competencies through continuous learning in order to practice according to high standards of care.
- Support dental hygiene peer-review systems and quality-assurance measures.
- Develop collaborative professional relationships and exchange knowledge to enhance our own lifelong professional development.

To Family and Friends:
- Support the efforts of others to establish and maintain healthy lifestyles and respect the rights of friends and family.

To Clients:

- Provide oral health care utilizing high levels of professional knowledge, judgment, and skill.
- Maintain a work environment that minimizes the risk of harm.
- Serve all clients without discrimination and avoid action toward any individual or group that may be interpreted as discriminatory.
- Hold professional client relationships confidential.
- Communicate with clients in a respectful manner.
- Promote ethical behavior and high standards of care by all dental hygienists.
- Serve as an advocate for the welfare of clients.
- Provide clients with the information necessary to make informed decisions about their oral health and encourage their full participation in treatment decisions and goals.
- Refer clients to other healthcare providers when their needs are beyond our ability or scope of practice.
- Educate clients about high-quality oral health care.

To Colleagues:

- Conduct professional activities and programs, and develop relationships in ways that are honest, responsible, and appropriately open and candid.
- Encourage a work environment that promotes individual professional growth and development.
- Collaborate with others to create a work environment that minimizes risk to the personal health and safety of our colleagues.
- Manage conflicts constructively.
- Support the efforts of other dental hygienists to communicate the dental hygiene philosophy and preventive oral care.
- Inform other health care professionals about the relationship between general and oral health.
- Promote human relationships that are mutually beneficial, including those with other health care professionals.

To Employees and Employers:

- Conduct professional activities and programs, and develop relationships in ways that are honest, responsible, open, and candid.
- Manage conflicts constructively.
- Support the right of our employees and employers to work in an environment that promotes Welles.
- Respect the employment rights of our employers and employees.

To the Dental Hygiene Profession:

- Participate in the development and advancement of our profession.
- Avoid conflicts of interest and declare them when they occur.
- Seek opportunities to increase public awareness and understanding of oral health practices.
- Act in ways that bring credit to our profession while demonstrating appropriate respect for colleagues in other professions.
- Contribute time, talent, and financial resources to support and promote our profession.
- Promote a positive image for our profession.

- Promote a framework for professional education that develops dental hygiene competencies to meet the oral and overall health needs of the public.

To the Community and Society:

- Recognize and uphold the laws and regulations governing our profession.
- Document and report inappropriate, inadequate, or substandard care and/or illegal activities by a health care provider, to the responsible authorities.
- Use peer review as a mechanism for identifying inappropriate, inadequate, or substandard care provided by dental hygienists.
- Comply with local, state, and federal statutes that promote public health and safety.
- Develop support systems and quality-assurance programs in the workplace to assist dental hygienists in providing the appropriate standard of care.
- Promote access to dental hygiene services for all, supporting justice and fairness in the distribution of healthcare resources.
- Act consistently with the ethics of the global scientific community of which our profession is a part.
- Create a healthful workplace ecosystem to support a healthy environment.
- Recognize and uphold our obligation to provide pro bono service.

To Scientific Investigation:

We accept responsibility for conducting research according to the fundamental principles underlying our ethical beliefs in compliance with universal codes, governmental standards, and professional guidelines for the care and management of experimental subjects.

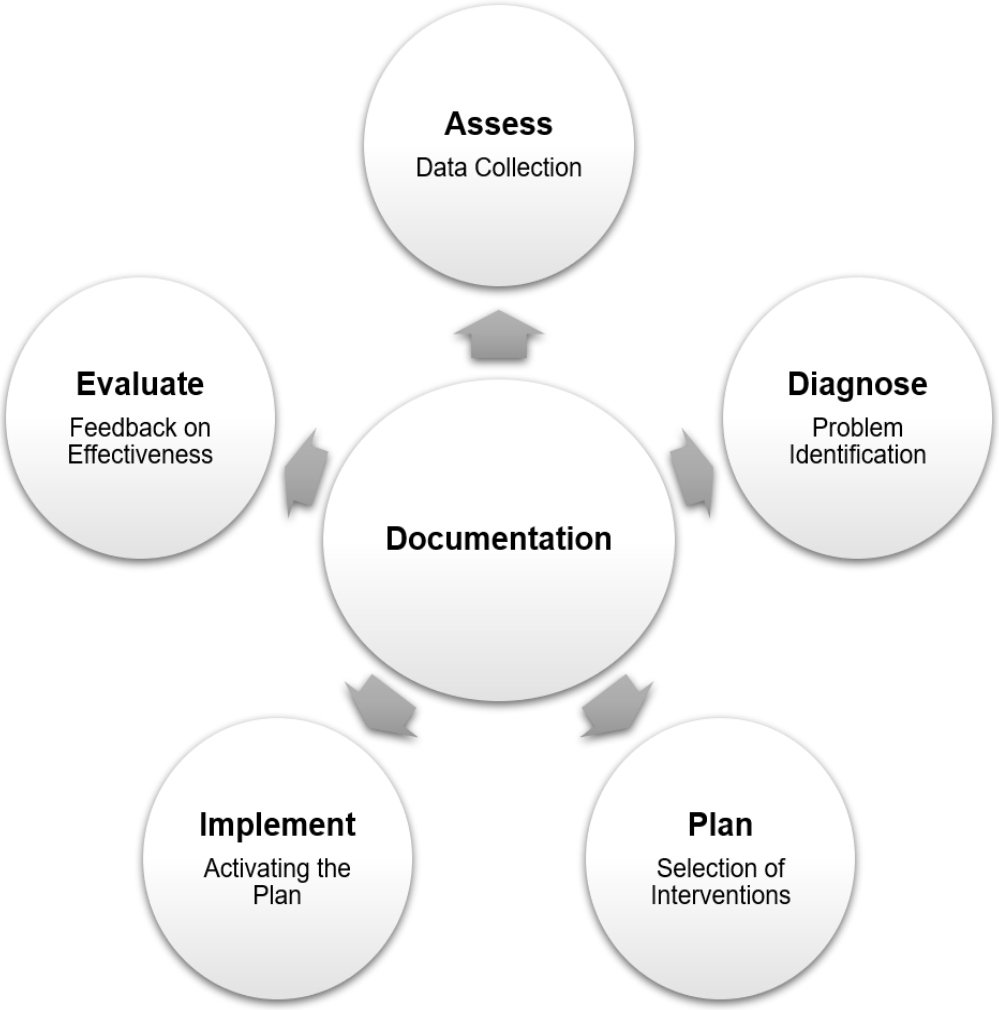
We acknowledge our ethical obligations to the scientific community:

- Conduct research that contributes knowledge that is valid and useful to our clients and society.
- Use research methods that meet accepted scientific standards.
- Use research resources appropriately.
- Systematically review and justify research in progress to insure the most favorable benefit-to-risk ratio to research subjects.
- Submit all proposals involving human subjects to an appropriate human subject review committee.
- Secure appropriate institutional committee approval for the conduct of research involving animals.
- Obtain informed consent from human subjects participating in research that is based on specification published in Title 21 Code of Federal Regulations Part 46.
- Respect the confidentiality and privacy of data.
- Seek opportunities to advance dental hygiene knowledge through research by providing financial, human, and technical resources whenever possible.
- Report research results in a timely manner.
- Report research findings completely and honestly, drawing only those conclusions that are supported by the data presented.
- Report the names of investigators fairly and accurately.
- Interpret the research and the research of others accurately and objectively, drawing conclusions that are supported by the data presented and seeking clarity when uncertain.
- Critically evaluate research methods and results before applying new theory and technology in practice.
- Be knowledgeable concerning currently accepted preventive and therapeutic methods, products, and technology and their application to our practice.

Appendix A

Dental Hygiene Process of Care

There are six components to the dental hygiene process of care. These include assessment, dental hygiene diagnosis, planning, implementation, evaluation, and documentation. The six components provide a framework for patient care activities.



Appendix B: Standards of Care

Standard 1: Assessment

The ADHA definition of assessment: The collection and analysis of systematic and oral health data in order to identify client needs.

I. HEALTH HISTORY

A health history assessment includes multiple data points that are collected through a written document and an oral interview. The process helps build a rapport with the patient and verifies key elements of the health status. Information is collected and discussed in a location that ensures patient privacy and complies with the Health Insurance Portability and Accountability Act (HIPAA).

Demographic information is any information that is necessary for conducting the business of dentistry. It includes but is not limited to address, date of birth, emergency contact information, phone numbers, and names and addresses of the referring/previous dentist and physician of record.

Vital Signs including temperature, pulse, respiration, and blood pressure provide a baseline or help identify potential or undiagnosed medical conditions.

Physical characteristics of height and weight provide information for drug dosing and anesthesia and indicate risk for medical complications. Disproportionate height and weight also combine as a risk factor for diabetes and other systemic diseases that impact oral health and should prompt the practitioner to request glucose levels for health history documentation.

Social history information such as marital status, children, occupation, cultural practices, and other beliefs might affect health or influence treatment acceptance.

Medical history is the documentation of overall medical health. This information can identify the need for physician consultation or any contraindications for treatment. This would include any mental health diagnosis, cognitive impairments (e.g., stages of dementia), behavioral challenges (e.g., autism spectrum), and functional capacity assessment. It would also include the patient's level of ability to perform a specific activity such as withstanding a long dental appointment as well as whether the patient requires modified positioning for treatment. Laboratory tests such as A1C and current glucose levels may need to be requested if they are not checked regularly.

Pharmacologic history includes the list of medications, including dose and frequency, which the patient is currently taking. This includes but is not limited to any over-the-counter (OTC) drugs or products such as herbs, vitamins, nutritional supplements, and probiotics. The practitioner should confirm any past history of an allergic or adverse reaction to any products.

II. CLINICAL ASSESSMENT

Planning and providing optimal care require a thorough and systematic overall observation and clinical assessment. Components of the clinical assessment include an examination of the head and neck and oral cavity including an oral cancer screening, documentation of normal or abnormal findings, and assessment of the temporomandibular function. A current, complete, and diagnostic set of radiographs provides needed data for a comprehensive dental and periodontal assessment. A comprehensive periodontal examination is part of clinical assessment. It includes

A. Full-mouth periodontal charting including the following data points reported by location, severity, quality, written description, or numerically:
    1. Probing depths
    2. Bleeding points
    3. Suppuration
    4. Mucogingival relationships/defects
    5. Recession
    6. Attachment level/attachment loss
B. Presence, degree, and distribution of plaque and calculus
C. Gingival health/disease
D. Bone height/bone loss
E. Mobility and fremitus
F. Presence, location, and extent of furcation involvement

A comprehensive hard-tissue evaluation that includes the charting of existing conditions and oral habits, with intraoral photographs and radiographs that supplement the data.

A. Demineralization
B. Caries
C. Defects
D. Sealants
E. Existing restorations and potential needs
F. Implants
G. Anomalies
H. Occlusion
I. Fixed and removable prostheses retained by natural teeth or implant abutments
J. Missing teeth

III. RISK ASSESSMENT

Risk assessment is a qualitative and quantitative evaluation based on the health history and clinical assessment to identify any risks to general and oral health. The data provide the clinician with the information to develop and design strategies for preventing or limiting disease and promoting health. Examples of factors that should be evaluated to determine the level of risk (high, moderate, low) include but are not limited to:

A. Fluoride exposure
B. Tobacco exposure including smoking, smokeless/spit tobacco and second-hand smoke
C. Nutrition history and dietary practices including consumption of sugar-sweetened beverages
D. Systemic diseases/conditions (e.g., diabetes, cardiovascular disease, autoimmune, etc.)
E. Prescriptions and over-the-counter medications, and complementary therapies and practices (e.g., fluoride, herbal, vitamin and other supplements, daily aspirin, probiotics)

F. Salivary function and xerostomia
G. Age and gender
H. Genetics and family history
I. Habit and lifestyle behaviors
    1. Cultural issues
    2. Substance abuse (recreational drugs, prescription medication, alcohol)
    3. Eating disorders/weight loss surgery
    4. Piercing and body modification
    5. Oral habits
    6. Sports and recreation (swimming, extreme sports [marathon, triathlon], energy drinks/ gels
J. Physical disability (morbid obesity, vision and/ or hearing loss, osteoarthritis, joint replacement)
K. Psychological, cognitive, and social considerations
    1. Domestic violence
    2. Physical, emotional, or sexual abuse
    3. Behavioral
    4. Psychiatric
    5. Special needs
    6. Literacy
    7. Economic
    8. Stress
    9. Neglect

Standard 2: Dental Hygiene Diagnosis

The ADHA defines dental hygiene diagnosis as the identification of an individual's health behaviors, attitudes, and oral health care needs for which a dental hygienist is educationally qualified and licensed to provide. The dental hygiene diagnosis requires evidence-based critical analysis and interpretation of assessments in order to reach conclusions about the patient's dental hygiene treatment needs. The dental hygiene diagnosis provides the basis for the dental hygiene care plan.

Multiple dental hygiene diagnoses may be made for each patient or client. Only after recognizing the dental hygiene diagnosis can the dental hygienist formulate a care plan that focuses on dental hygiene education, patient self-care practices, prevention strategies, and treatment and evaluation protocols to focus on patient or community oral health needs.

I. Analyze and interpret all assessment data.
II. Formulate the dental hygiene diagnosis or diagnoses.
III. Communicate the dental hygiene diagnosis with patients or clients.
IV. Determine patient needs that can be improved through the delivery of dental hygiene care.
V. Identify referrals needed within dentistry and other health care disciplines based on dental hygiene diagnoses.

Standard 3: Planning

Planning is the establishment of realistic goals and the selection of dental hygiene interventions that can move the client closer to optimal oral health.24 The interventions should support overall patient goals and oral health outcomes. Depending upon the work setting and state law, the dental

hygiene care plan may be stand-alone or part of collaborative agreement. The plan lays the foundation for documentation and may serve as a guide for Medicaid reimbursement. Dental hygienists make clinical decisions within the context of legal and ethical principles.

The dental hygiene care plan should be a vehicle for care that is safe, evidence-based, clinically sound, high-quality, and equitable. The plan should be personalized according to the individual's unique oral health needs, general health status, values, expectations, and abilities. When formulating the plan, dental hygienists should be sensitive and responsive to the patient's culture, age, gender, language, and learning style. They should demonstrate respect and compassion for individual patient choices and priorities.

I. Identify all needed dental hygiene interventions including change management, preventive services, treatment, and referrals.
II. In collaboration with the patient and/or caregiver, prioritize and sequence the interventions allowing for flexibility if necessary and possible.
III. Identify and coordinate resources needed to facilitate comprehensive quality care (e.g., current technologies, pain management, adequate personnel, appropriate appointment sequencing, and time management).
IV. Collaborate and work effectively with the dentist and other health care providers and community-based oral health programs to provide high-level, patient-centered care.
V. Present and document dental hygiene care plan to the patient/caregiver.
VI. Counsel and educate the patient and/or caregiver about the treatment rationale, risks, benefits, anticipated outcomes, evidence-based treatment alternatives, and prognosis.
VII. Obtain and document informed consent and/ or informed refusal.

Standard 4: Implementation

Implementation is the act of carrying out the dental hygiene plan of care.24 Care should be delivered in a manner that minimizes risk; optimizes oral health; and recognizes issues related to patient comfort including pain, fear, and/or anxiety. Through the presentation of the dental hygiene care plan, the dental hygienist has the opportunity to create and sustain a therapeutic and ethically sound relationship with the patient.

Depending upon the number of interventions, the dental hygiene care plan may implemented in one preventive/wellness visit or several therapeutic visits before a continuing or maintenance plan is established. Health promotion and self-care are integral aspects of the care plan that should be customized and implemented according to patient interest and ability.

I. Review and confirm the dental hygiene care plan with the patient/caregiver.
II. Modify the plan as necessary and obtain any additional consent.
III. Implement the plan beginning with the mutually agreed upon first prioritized intervention.
IV. Monitor patient comfort.
V. Provide any necessary post-treatment instruction.
VI. Implement the appropriate self-care intervention; adapt as necessary throughout future interventions.
VII. Confirm the plan for continuing care or maintenance.
VIII. Maintain patient privacy and confidentiality.
IX. Follow-up as necessary with the patient (post-treatment instruction, pain management, self-care).

Standard 5: Evaluation

Evaluation is the measurement of the extent to which the client has achieved the goals specified in the dental hygiene care plan. The dental hygienist uses evidence-based decisions to continue, discontinue, or modify the care plan based on the ongoing reassessments and subsequent diagnoses. The evaluation process includes reviewing and interpreting the results of the dental hygiene care provided and may include outcome measures that are physiologic (improved health), functional, and psychosocial (quality of life, improved patient perception of care). Evaluation occurs throughout the process as well as at the completion of care.

I. Use measurable assessment criteria to evaluate the tangible outcomes of dental hygiene care (e.g., probing, plaque control, bleeding points, retention of sealants, etc.).
II. Communicate to the patient, dentist, and other health/dental care providers the outcomes of dental hygiene care.
III. Evaluate patient satisfaction of the care provided through oral and written questionnaires.
IV. Collaborate to determine the need for additional diagnostics, treatment, referral, education, and continuing care based on treatment outcomes and self-care behaviors.
V. Self-assess the effectiveness of the process of providing care, identifying strengths and areas for improvement. Develop a plan to improve areas of weakness.

Standard 6: Documentation

The primary goals of good documentation are to maintain continuity of care, provide a means of communication between/among treating providers, and to minimize the risk of exposure to malpractice claims. Dental hygiene records are considered legal documents and as such should include the complete and accurate recording of all collected data, treatment planned and provided, recommendations (both oral and written), referrals, prescriptions, patient/client comments and related communication, treatment outcomes and patient satisfaction, and other information relevant to patient care and treatment.

I. Document all components of the dental hygiene process of care (assessment, dental hygiene diagnosis, planning, implementation, and evaluation) including the purpose of the patient's visit in the patient's own words. Documentation should be detailed and comprehensive; e.g., thoroughness of assessment (soft-tissue examination, oral cancer screening, periodontal probing, tooth mobility) and reasons for referrals (and to whom and follow-up). Treatment plans should be consistent with the dental hygiene diagnosis and include no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
II. Objectively record all information and interactions between the patient and the practice (e.g., telephone calls, emergencies, prescriptions) including patient failure to return for treatment or follow through with recommendations.
III. Record legible, concise, and accurate information. For example, include dates and signatures, record clinical information so that subsequent providers can understand it, and ensure that all components of the patient record are current and accurately labeled and that common terminology and abbreviations are standard or universal.
IV. Recognize ethical and legal responsibilities of recordkeeping including guidelines outlined in state regulations and statutes.
V. Ensure compliance with the federal Health Information Portability and Accountability Act (HIPAA). Electronic communications must meet HIPAA standards in order to protect confidentiality and prevent changing entries at a later date.

VI. Respect and protect the confidentiality of patient information.

Summary

The Standards for Clinical Dental Hygiene Practice are a resource for dental hygiene practitioners seeking to provide patient-centered and evidence-based care. In addition, dental hygienists are encouraged to enhance their knowledge and skill base to maintain continued competence.27-28 These Standards will be modified based on emerging scientific evidence, ADHA policy development, federal and state regulations, and changing disease patterns as well as other factors to assure quality care and safety as needed.

KEY TERMS

Client: The concept of client refers to the potential or actual recipients of dental hygiene care, and includes persons, families, groups and communities of all ages, genders, socio-cultural and economic states.

Cultural Competence: the awareness of cultural difference among all populations, respect of those differences and application of that knowledge to professional practice.

Dental Hygiene Care Plan: an organized presentation or list of interventions to promote the health or prevent disease of the patient's oral condition. The plan is designed by the dental hygienist and consists of services that the dental hygienist is educated and licensed to provide.

Evidence-Based Practice: the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual clients. The practice of evidence-based dental hygiene requires the integration of individual clinical expertise and client preferences with the best available external clinical evidence from systematic research.

Intervention: dental hygiene services rendered to clients as identified in the dental hygiene care plan. These services may be clinical, educational, or health promotion related.
Interprofessional Team: a group of health care professionals and their patients who work together to achieve shared goals. The team can consist of the dental hygienist, dentist, physician, nutritionist, smoking cessation counselor, nurse practitioner, etc.

Outcome: result derived from a specific intervention or treatment.

Patient: the potential or actual recipient of dental hygiene care, including persons, families, groups, and communities of all ages, genders, and socio-cultural and economic states.

Patient-Centered: approaching services from the perspective that the client is the main focus of attention, interest, and activity. The client's values, beliefs, and needs are of utmost importance in providing evidence-based care.

Risk Assessment: an assessment based on characteristics, behaviors, or exposures that are associated with a particular disease; e.g., smoking, diabetes, or poor oral hygiene.

Appendix C: Dental Clinic Quality Assurance Plan

Overview

The provision of quality care is an expectation of the public and assuring that quality dental hygiene care will be provided is a major responsibility of the individual dental hygienist. As direct providers of care, dental hygienists are accountable for their actions. The purpose of the dental program's quality assurance plan is to establish standards and policies for evaluating the quality and appropriateness of oral health care provided by Central Carolina Community College's Dental Department.

The Dental Department stresses the importance of quality patient care through the Program's Philosophy Statement, Program Goals and Competencies, Statement of Patient Rights, Standards of Care, Clinic Policies, and Professional Responsibility Point System. Throughout the student's program enrollment, faculty encourages students to place patient needs over the completion of clinical requirements.

The quality assurance plan has been designed to provide a comprehensive framework for continuous review of established standards of patient care. By establishing high standards of care, as well as a system for monitoring and evaluating care, the program can identify continuous improvement goals.

Purpose

The purpose of monitoring a process of care is to determine the quality of the dental procedures performed, the appropriateness of the treatment performed, the responsiveness of the treatment to the patient's needs, and the thoroughness of the documentation. The quality assurance plan serves as an assessment tool through which the dental hygiene program can determine strengths and areas needing improvement in the delivery of patient care.

Standards of Care

Central Carolina Community College's Dental Program has adopted the Standards for Clinical Dental Hygiene Practice as defined by the American Dental Hygienist's Association. These standards focus on the provision of patient centered comprehensive care and evidence-based practice. To ensure the standards are properly communicated, they are included in the Dental Hygiene Clinic Manual, which is distributed to all students, faculty, and staff.

Annual Review of Standards of Care

Annually, the faculty reviews the Standards of Care, the Policy and Procedures Manual, the Dental Hygiene Clinic Manual, and the Infection Control, Hazard Control, and Radiation Protection Manuals to determine any necessary modifications and/or additions.

The following are sources utilized in determining the need for changes in the Standard of Care:

- Applicable federal, state and level statutes and regulations that define and guide professional practice.
- Updates provided by the American Dental Hygienist's Association.
- Accreditation Standards • Employer, Graduate, and Patient Surveys

- Advisory Committee
- Peer Review
- Clinical Site Evaluations
- Information obtained from dental meetings, conferences, and professional development.
- Feedback from adjunct faculty employed in private practices in the community.
- Student Evaluations

Quality Assurance in the Clinic

Numerous quality assurance procedures are implemented in the clinic to ensure high quality delivery of patient care. These procedures include the following:

- Dental Hygiene Clinic Manual
- Faculty oversight and review of patient care.
- Chart Audits
- Patient Satisfaction Surveys

Dental Hygiene Clinic Manual

The Dental Hygiene Clinic Manual is reviewed and revised as necessary on an annual basis. The Dental Hygiene Clinic Manual is distributed to all students and faculty and serves as a guide in the delivery of patient care in the clinic. The program's Standards of Care are included in the Dental Hygiene Clinic Manual. Standards of Care are stressed and reinforced in all clinical and didactic courses as noted in the course syllabi.

Faculty Oversight and Review

Faculty oversees and supervises all patient care provided by students in the clinic. A faculty member signs the medical questionnaire and drug summary, reviews the oral inspection and all charting, and approves the treatment plan. A patient classification system is utilized to ensure students do not perform patient care on patients whose needs are beyond the student's competency level.

During the treatment phase, an instructor is available to assist the student, observe clinical skills and interact with the patient. In the clinic, a flag system is utilized to indicate the student needs an instructor's assistance.

In the clinic, a flag system is used to indicate that students have completed a required task or need the help of an instructor.

Flag System

- Black- student is ready to have their Health Questionnaire and Drug Summary checked. A black flag is also used to request X-Rays.
- Blue- student is ready to have their Intraoral/Extraoral Exam checked.
- Blue/Green- Treatment Plan checked.
- Yellow- student is ready to have a scale check.
- Green- student is ready to have a polish check.
- Yellow/Green-student needs scale and/or polish assistance from faculty.

- White- student requests the help of DDS for anesthesia, dental charting, to check for decay, to evaluate X-Rays, to evaluate Heath History, to request sealants, and/or to request dental/medical referral.
- Red-Medical emergency.
- Blue/Yellow- indicate student is ready to have a proficiency/competency graded.
- All-Faculty review of clinical notes.
- A plastic patient cup placed on top of your cabinet indicates you need help from the CA-screener.

This flag system provides the quality assurance that the student's work is checked and evaluated throughout the delivery of patient care.

Evaluation Criteria, Tutorials, and Proficiencies

Process evaluation is an evaluation that tests a particular skill independent of other skills being learned and demonstrated. When evaluating a procedure by process, each defined step of the procedure is personally observed by the assigned faculty member, ensuring that the student has properly executed each step. Examples of process evaluation include the tutorial, proficiencies, and the adjunctive service evaluations. Section 2 of the Clinic Manual addresses Evaluation Criteria, Tutorials and Proficiencies. Standards are established for the evaluation of each skill and guidelines are communicated to the students concerning the requirements for meeting the required proficiency. Through direct observation of proficiencies, faculty ensure the students are adhering to standards in the delivery of patient care.

Clinic Privileges

It is a privilege to provide oral health care to the public. As such, students must be compliant with the standards of care and rules and regulations. Given the trust of the public for the profession, the faculty plays a fundamental role in overseeing the treatment of any patient. As part of the partnership between the faculty and students, faculty continually monitor student performance in the clinic and gauge the well-being of patients. Faculty are expected to withdraw the privilege of patient care at any time a student does not demonstrate skills and/or a level of knowledge that is necessary for the well-being of patients.

Clinic Privileges Beyond Graduation:

- Sterilization of instruments used during their clinical board examinations.
- Students have access and liability insurance 30 days after graduation, so they may screen board patients.
- Students must coordinate dates and times for clinic privileges and clinic access with the DEN 231 course director.
- Students will have access to the CCCC student call log for 30 days beyond graduation for screening purposes. After 30 days students will no longer have access to the CCCC patient call log or CCCC dental clinic.
- Once 30 days has passed, students must enroll in the current clinical course as an audit.
- Students must adhere to faculty requirements for the clinical course, so they may be more successful on their clinical board examinations.
- Students will be required to follow all syllabus guidelines, clinic manual guidelines, and infection control protocols.
- Students are to follow ALL CITA/ADEX and any other board manual guidelines.

Medical and Dental Referrals

In the Clinic Manual, section 5, provides comprehensive guidance concerning the necessity for the student to determine that the patient should receive a medical or dental referral. In reviewing the patient's health questionnaires, the student is presented with many conditions which require them to decide whether treatment should be rendered or a medical consultation is indicated. Guidelines are provided for the students in order to assist with this decision. In reviewing a patient's restorative charting, periodontal charting or radiographs, many conditions present themselves that need to be referred back to the patient's dentist. In the clinical procedures, the student is provided guidance in making the decision that a dental referral is necessary. The faculty provides oversight and the final decision that medical and/or dental referrals are necessary.

Monitoring the Completion of Patient Treatment

Completion of patient treatment is an essential element of delivering quality patient care. The Dental Scoring Spreadsheet (DSS), utilized in the clinic, tracks completed and non-completed patients. Grade sheets of incomplete patients are transferred one semester to the next to indicate to faculty which patients have not been complete. Once a patient is accepted for treatment, all treatment must be completed before the student completes the program. Students must not allow for a large quantity of incomplete patients to accumulate. It is the students' responsibility to ensure that all patients are complete before completing the dental hygiene program. Students must submit to the faculty the rationale for any incomplete patient treatment, as well as a plan for completion. The instructor discusses any issues and or concerns with the student. Students must discuss their completion plan with the Clinic Coordinator. In May, a final incomplete patient print-out is obtained and the student is required to discuss their plans to complete the patient. If necessary, a system is in place whereby the patient could be re-assigned to the second-year student's "little sister", who is currently a first-year student.

Chart Audit

The dental record serves as the primary source of information documenting the care provided to the patient. On a regular basis, charts are audited based on the departments' standards of care. The faculty member conducts the chart audits using the Record Repair Form and notates the number of charts audited, the number of charts with discrepancies, and the number of charts with no discrepancies. The faculty member notates any discrepancy and discusses the chart audit report in a faculty meeting. Faculty provides suggestions and strategies to prevent the discrepancies in the future. The goal of evaluation through chart audits is to identify any problems and deficiencies in the provision of dental care, ascertain the cause of treatment deficiencies, and then inform faculty and students of these deficiencies so the department can improve their practice. Records containing deficiencies are identified to the student with a record repair form and the student must correct the chart entry by addendum and return record repair form annotating corrections to the instructor within 48 hours. Chart audit results and strategies are emailed to all faculty and results are reviewed with the students. The results are compared with those from previous semesters to document improvements or to identify the need for additional interventions.

Patient Satisfaction Surveys

Patient's perceptions of quality of care are documented by the Patient Satisfaction Surveys and through daily interaction in the clinic. Patient Satisfaction Surveys are requested after each patient

has been treated in the clinic. The department head and faculty appropriately handle legitimate complaints and regularly interact with patients to ensure their satisfaction with patient care services. At the end of the semester, patient satisfaction surveys are summarized, and data is shared with faculty and students to facilitate the ongoing improvement of services and professionalism.

Quality Assurance for Radiography

Quality Assurance is included as part of the Radiation Protection Manual as follows:

1. Film Processing and Quality Assurance:

    Basic Procedures

    a. Unexposed film is stored in the storage unit and filing cabinet located in the radiology viewing area. Do not take film without an instructor's permission.
    b. Process films according to the specifications that is located above the processors in the darkroom.
    c. Always check expiration dates on film and the chemicals used in the processor. Do not use films or chemicals after the expiration date.
    d. If you find film or chemicals with expired expiration dates, give them to the Radiation Safety Officer (RSO). Also, when you notice that the supply of film or chemicals is low, notify the RSO.
    e. When using an automatic processor:
        i. The clinical assistant in charge of the darkroom will turn the processors on and perform routine maintenance and quality control procedures at the beginning of each clinic. Do not process until quality control procedures have been performed and a notice has been placed on the darkroom door.
        ii. The RSO is in charge of maintaining the processor according to the manufacturer's instructions. Do not open the processor or change settings without the permission of an instructor.

2. Quality Assurance (QA) Tests

    a. QA procedures for the automatic processor will be performed at each lab or clinic session. The clinic assistant will utilize the visual image comparison method daily to test the automatic processor. If a problem occurs, the RSO should be notified immediately.
    b. QA procedures for the dental x-ray machines will be performed each semester by the RSO. The visual image comparison method will be used on the first clinic day of each semester.
    c. Safelight/darkroom checks will be performed on the first clinic day of each semester by the RSO.
    d. Records of the QA tests designated above, and other services are located in the Radiology Viewing Area.

Summary

The Dental Department at Central Carolina Community College strives to provide opportunities for dental students to discover their talents and abilities and to achieve individual excellence in the delivery of patient care. The faculty and staff continuously encourage high ethical and

professional behavior. Patient centered services are delivered from the perspective that the patient is the main focus of attention, interest and activity, and that the patient's needs are of utmost importance in providing care. The Quality Assurance Plan is designed to provide a framework for the assessment and evaluation of this high-quality delivery of patient care.

This version of the Central Carolina Community College Dental Hygiene Clinic Manual was updated as of July 31, 2018. The guidelines and changes that have occurred in this version apply to both First Year and Second Year Dental Hygiene Students of the Central Carolina Dental Hygiene Program as decided upon by the Dental Hygiene Faculty.

Appendix D: Forms