Table of Contents
<table>
<thead>
<tr>
<th>SECTION 1: DENTAL HYGIENE SEQUENCE OF CLINICAL PROCEDURES</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>GENERAL CLINIC POLICIES</td>
<td>1</td>
</tr>
<tr>
<td>ETHICS, CONDUCT, AND CLINIC ATTENDANCE</td>
<td>1</td>
</tr>
<tr>
<td>ETHICS</td>
<td>1</td>
</tr>
<tr>
<td>CONDUCT</td>
<td>1</td>
</tr>
<tr>
<td>PATIENT POOL</td>
<td>2</td>
</tr>
<tr>
<td>SCHEDULING PATIENTS</td>
<td>2</td>
</tr>
<tr>
<td>EAGLESOFT SCHEDULING</td>
<td>4</td>
</tr>
<tr>
<td>BLOCK SCHEDULING</td>
<td>6</td>
</tr>
<tr>
<td>BEFORE YOU SEE ANY PATIENT</td>
<td>8</td>
</tr>
<tr>
<td>PROCEDURES BEFORE SEATING PATIENT</td>
<td>8</td>
</tr>
<tr>
<td>PATIENT PRIVACY ACT (HIPAA)</td>
<td>9</td>
</tr>
<tr>
<td>PATIENT RIGHTS AND RESPONSIBILITIES</td>
<td>11</td>
</tr>
<tr>
<td>SEATING THE PATIENT – BEFORE CHECK-IN</td>
<td>13</td>
</tr>
<tr>
<td>CANCELLED OR FAILED APPOINTMENTS</td>
<td>13</td>
</tr>
<tr>
<td>CHANGING A SCHEDULED APPOINTMENT</td>
<td>14</td>
</tr>
<tr>
<td>SIGNIFICANCE OF FLAGS</td>
<td>14</td>
</tr>
<tr>
<td>CHECK-IN</td>
<td>15</td>
</tr>
<tr>
<td>REVIEW OF THE HEALTH QUESTIONNAIRE (MEDICAL HISTORY) - BLACK</td>
<td>16</td>
</tr>
<tr>
<td>DENTAL CONSENT/INTERVIEW – BLACK</td>
<td>22</td>
</tr>
<tr>
<td>EXTRAORAL/INTRAORAL INSPECTION - BLUE</td>
<td>22</td>
</tr>
<tr>
<td>PERIODONTAL CHARTING – BLUE</td>
<td>24</td>
</tr>
<tr>
<td>CLASSIFICATION OF PATIENTS</td>
<td>25</td>
</tr>
<tr>
<td>RESTORATIVE CHARTING – WHITE</td>
<td>28</td>
</tr>
<tr>
<td>DENTAL EXAM – WHITE</td>
<td>28</td>
</tr>
<tr>
<td>THE TREATMENT PLAN WORKSHEET- BLUE/GREEN</td>
<td>29</td>
</tr>
<tr>
<td>THE DENTAL HYGIENE CARE PLAN AND DIAGNOSIS – BLUE/GREEN</td>
<td>29</td>
</tr>
<tr>
<td>PATIENT EDUCATION</td>
<td>30</td>
</tr>
<tr>
<td>DENTAL HYGIENE TREATMENT</td>
<td>31</td>
</tr>
<tr>
<td>CALCULUS REMOVAL</td>
<td>31</td>
</tr>
<tr>
<td>STAIN AND SOFT DEPOSIT REMOVAL</td>
<td>31</td>
</tr>
<tr>
<td>DOCUMENTATION – ALL FLAGS</td>
<td>33</td>
</tr>
<tr>
<td>FIRST YEAR HATEN EXAMPLE</td>
<td>35</td>
</tr>
<tr>
<td>SECOND YEAR HATEN EXAMPLE:</td>
<td>36</td>
</tr>
<tr>
<td>REQUEST FOR ANESTHESIA-WHITE</td>
<td>37</td>
</tr>
<tr>
<td>PERIODONTAL RE-EVALUATION</td>
<td>38</td>
</tr>
</tbody>
</table>
SECTION 2: CLINICAL REQUIREMENTS AND DISCIPLINARY POLICY

PRE-Clinic/Clinic Evaluation Definitions ................................................................................. 45
Central Carolina Community College Dental Hygiene Clinic Requirements .................................. 47
Clinical Competencies and Process Evaluations Per Clinical Course ........................................... 48
Disciplinary Procedures/Policies of the Dental Hygiene Program ................................................ 49
   Critical Error Policy for Clinics and Labs ................................................................................. 49
Non-Cumulative Critical Errors Penalties do Not Carry Over From 1st Year to 2nd Year ............ 49
Cumulative Critical Errors; Penalties Carry Over From 1st Year to 2nd Year ............................. 50
Penalties for Critical Errors of Clinical Training ...................................................................... 50
   Non-Cumulative Critical Errors: ............................................................................................. 50
   Cumulative Critical Errors: ..................................................................................................... 51
Grounds for Dismissal .................................................................................................................. 52

SECTION 3 CLINICAL EVALUATION OF STUDENT PERFORMANCE ................................ 53

How to Complete a Grade Sheet in Clinic ................................................................................... 53
Clinical Evaluation Criteria ........................................................................................................ 54
   Goal Setting ............................................................................................................................ 54
   Written Assignments .............................................................................................................. 54
   Clinical Requirements ............................................................................................................. 54
   Mastery Level .......................................................................................................................... 54
   End Product Evaluation ......................................................................................................... 54

Evaluating Each Clinic Session, Per Patient ............................................................................ 55
   Aseptic Technique .................................................................................................................... 55
   Area/Post Appointment .......................................................................................................... 55
   Instrumentation: Adaptation .................................................................................................. 55
      Instrumentation: Condition .................................................................................................. 56
      Instrumentation: Fulcrum ..................................................................................................... 57
      Instrumentation: Grasp ......................................................................................................... 57
      Instrumentation: Selection .................................................................................................. 57
      Instrumentation: Stroke ....................................................................................................... 57
      Instrumentation: Sharpening ............................................................................................... 58
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHEMICAL STERILIZATION/DISINFECTION</td>
<td>76</td>
</tr>
<tr>
<td>MAINTENANCE</td>
<td>76</td>
</tr>
<tr>
<td>BIOHAZARD OR MEDICAL WASTE DISPOSAL</td>
<td>76</td>
</tr>
<tr>
<td>EXPOSURE INCIDENT/ACCIDENTS</td>
<td>77</td>
</tr>
<tr>
<td>BLOOD-BORNE INCIDENTS/SHARPS EXPOSURE:</td>
<td>77</td>
</tr>
<tr>
<td>SPLASH ON TO ORAL, NASAL, OR EYE MUCOSA</td>
<td>78</td>
</tr>
<tr>
<td>EYEWASH STATION:</td>
<td>78</td>
</tr>
<tr>
<td>DENTAL PROGRAMS HAZARD CONTROL POLICY</td>
<td>78</td>
</tr>
<tr>
<td>ACCIDENTS/CROSS-CONTAMINATION INCIDENTS OCCURRING OFF CAMPUS</td>
<td>79</td>
</tr>
<tr>
<td>CLINICAL ROTATIONS:</td>
<td>79</td>
</tr>
<tr>
<td>MEDICAL EMERGENCY PROCEDURES</td>
<td>80</td>
</tr>
<tr>
<td>SERIOUS INJURIES/MEDICAL EMERGENCIES (GENERAL LOCATIONS)</td>
<td>80</td>
</tr>
<tr>
<td>SERIOUS INJURIES TO PATIENTS/MEDICAL EMERGENCIES IN THE CLINICAL SETTING</td>
<td>80</td>
</tr>
<tr>
<td>UPON ARRIVAL OF THE SUPERVISING DENTIST</td>
<td>81</td>
</tr>
<tr>
<td>IF AN AMBULANCE IS NEEDED</td>
<td>81</td>
</tr>
<tr>
<td>UPON ARRIVAL OF EMS PERSONNEL</td>
<td>81</td>
</tr>
<tr>
<td>MISCELLANEOUS</td>
<td>81</td>
</tr>
<tr>
<td>EMERGENCY EQUIPMENT: LOCATION</td>
<td>82</td>
</tr>
<tr>
<td>FIRST AID KITS ARE LOCATED</td>
<td>82</td>
</tr>
<tr>
<td>OXYGEN TANKS AND MASKS ARE LOCATED</td>
<td>82</td>
</tr>
<tr>
<td>EMERGENCY DRUG KIT IS LOCATED</td>
<td>82</td>
</tr>
<tr>
<td>EYEWASH STATION IS LOCATED</td>
<td>82</td>
</tr>
<tr>
<td>EVALUATION OF EMERGENCY INVENTORY</td>
<td>82</td>
</tr>
<tr>
<td>EMERGENCY CART CONTENTS</td>
<td>83</td>
</tr>
<tr>
<td>FOREIGN OBJECT POLICY</td>
<td>84</td>
</tr>
<tr>
<td>STEPS FOR FILING ACCIDENT CLAIMS</td>
<td>89</td>
</tr>
<tr>
<td>AVOIDING LIGATION</td>
<td>92</td>
</tr>
<tr>
<td>TREATMENT AREA</td>
<td>92</td>
</tr>
<tr>
<td>EMERGENCY</td>
<td>92</td>
</tr>
<tr>
<td>ABANDONMENT</td>
<td>93</td>
</tr>
<tr>
<td>BEFORE DISMISSAL</td>
<td>93</td>
</tr>
<tr>
<td>ADEQUACY OF RECORDS</td>
<td>93</td>
</tr>
<tr>
<td>CONSENT</td>
<td>93</td>
</tr>
<tr>
<td>LATE ENTRY OR ADDENDUM PROTOCOL</td>
<td>94</td>
</tr>
<tr>
<td>CORRECTING AN ERROR IN CHARTING</td>
<td>94</td>
</tr>
<tr>
<td>GUIDELINES FOR MANAGING PATIENTS WHO MAY BE SEEKING PROFESSIONAL OR LEGAL CONDEMNATION OF PREVIOUS DENTAL TREATMENT</td>
<td>94</td>
</tr>
</tbody>
</table>
POSSIBLE ROTATION SITES:.......................................................................................................................... 140
GENERAL EXPECTATIONS: ............................................................................................................................... 140
FORT BRAGG/POPE AAF PAPERWORK ........................................................................................................ 141
HARNETT CORRECTIONAL INSTITUTE ........................................................................................................ 146
APPENDIX A: AMERICAN DENTAL HYGIENIST’S ASSOCIATION CODE OF ETHICS........................................ 149
APPENDIX B AMERICAN DENTAL HYGIENIST’S ASSOCIATION STANDARDS OF CARE.............................. 156
APPENDIX C DENTAL CLINIC QUALITY ASSURANCE PLAN........................................................................ 160
SECTION ONE: Dental Hygiene Sequence of Clinical Procedures
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 in regard to 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. 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); and 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. Don’t 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.

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 “Screening/Due to be Seen 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 Record of Treatment. It may be helpful to have a notebook to record entries at home then transfer them into EagleSoft once you arrive at school. Select your patient in EagleSoft. Select “notes” and then create the appropriate entry as a GENERAL 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. It is unprofessional to bother 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 phone number. It would be a good idea to mail them a note welcoming them to your family of patients and confirming their appointment by including an appointment card with your name and number on the back.

2. **THE LOCATION OF THE DENTAL CLINIC:** Patients are only allowed to park in Visitor’s parking (side and back of WB Wicker).

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!

4. **WHAT MEDICATIONS OR MEDICAL CONDITIONS ARE PRESENT:** It saves clinic time if you can look things up before hand 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 and your grade/requirements may suffer.

6. Ask if they have ever been seen in the dental hygiene clinic before so a duplicate record will not be made.
EagleSoft Scheduling

The dental clinic is using EagleSoft, a powerful dental practice management software system, to keep track of all patients, appointments 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, a full-time instructor can provide it for you. However, twenty professional responsibility points will be assessed.

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. ° = 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}.
Section 1

Dental Hygiene Sequence of Clinical Procedures

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 Record of Treatment and signed by an instructor.

Sample Scheduling with Codes-2nd Year Students Only

EXAMPLE:

**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**
1. Only appoint Class I and Class II screened patients with 01 or 02 calculus.
2. Only appoint Class I and Class II re-care patients with 01 or 02 calculus.
3. 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.

4. **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 hygiene student or save the patient until you are more experienced.

**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 personal appointment book to see who you have scheduled.
2. Review the patient's record 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 and general DDS, research radiographic history. Make sure they understand about the length of appointment, parking, premedication, know 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 end doors only.

3. The office manager/CA will check in your patient in the following manner:
   a. At 8:45 or 12:45 the clinic assistant is 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 clip boards 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.

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.

   e. When the Health Questionnaire and HIPAA are completed, the clinic assistant will bring your clipboard to you.

   f. 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.

   g. Student clinicians may not leave the clinic floor without permission from an instructor.
Central Carolina Community College Dental Hygiene Program
HIPAA
Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosures of my protected health information by the Central Carolina Dental Center for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Central Carolina Dental Center. My “protected health information” means medical, billing and demographic information about me collected from me and created or received by the Central Carolina Dental Center for treatment, payment and health care operations. I understand that diagnosis or treatment of me by the Central Carolina Dental Center may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Central Carolina Dental Center is not required to agree to the restrictions that may request. However, if Central Carolina Dental Center agrees to a restriction that I request, the restriction is binding on the Central Carolina Dental Center.

I have the right to revoke this consent, in writing, at any time. The revocation will be effective upon receipt, except to the extent that Central Carolina Dental Center has taken action in reliance on this consent.

I understand I have a right to review Central Carolina Dental Center’s Notice of Privacy Practices prior to signing this document. Central Carolina Dental Center’s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Central Carolina Dental Center. The Notice of Privacy Practices for Central Carolina Dental Center is also provided on the Central Carolina Community College Dental Programs website under patient admissions at www.cccc.edu. This Notice of Privacy Practices also describes my rights and Central Carolina Dental Center’s duties with respect to my protected health information.

Central Carolina Dental Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Central Carolina Community College website, calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Date

Description of Personal Representative’s Authority
Central Carolina Community College
Dental Hygiene Program

PATIENT RIGHTS AND RESPONSIBILITIES

Central Carolina Community College Dental Programs is a teaching institution with a commitment to the education of health care professionals. Adults and children who receive care in our clinical programs are vitally important participants in this process. For that reason, we expect to make your experience a healthy and satisfying one.

We are committed to the highest quality of care. To do this, the patient or parents of the patients, and dental professionals must work together to develop the best relationships. A better understanding of your oral condition and your rights and responsibilities in the treatment of that condition will contribute to better care and greater satisfaction for all concerned. We realize that no set of guidelines can ever fully describe the special relationship that exists between you and your student dental hygiene provider. The purpose of this brochure is to enhance the mutual trust, cooperation, and respect which surround that relationship.

YOUR RIGHTS AS A PATIENT

YOU AS A PERSON – We are not only interested in providing you with dental hygiene services, but also in recognizing and respecting your dignity as a human being. You may expect to be treated with consideration and respect regardless of your race, creed, national origin, age, handicap, or sex.

SERVICES YOU NEED – We will inform you about what we can and cannot provide and help in making referrals for treatment elsewhere. You will also be informed of the need for and availability of appointments. When your relationship with the school ends, for whatever reason, we will tell you about your further treatment needs.

UNDERSTANDING YOUR PLAN OF CARE – You are entitled to a clear explanation of your dental problems, what treatment is recommended, what the alternatives are as well as any risks involved, who will provide your care, and approximately how long it may take. Complications encountered during therapy that may alter your plan of care or affect the outcome of your treatment will also be explained to you. If you are receiving dental hygiene services from our school, you can expect at least one recall appointment a few months after treatment is completed. This is our way of assuring that treatment is rendered at the dental hygiene school in a satisfactory manner, and to see if further care is needed.

CONSENT AND REFUSAL OF TREATMENT – You have the right to participate in decisions about your dental treatment and to have any questions answered before making a decision. Any treatment you receive will meet appropriate standards of care. You may also refuse treatment and expect to be informed of the possible consequences of your decision. If your refusal is not congruent with good standards of care, it may be left to your discretion to seek treatment outside the Dental Hygiene Clinic, and you could be considered for dismissal as a patient.

CONFIDENTIALITY – Discussions about your care will be done with as much consideration for
your privacy as possible. A copy of your treatment record will not be released without your written permission, except as required through an insurance contract or by law.

**YOUR RESPONSIBILITIES AS A PATIENT**

As a patient or the parent of a patient in our program, your responsibilities are:

To share honestly and completely information about your medical and dental history, previous illnesses, hospitalizations, exposure to communicable diseases, information about medications you are taking, allergies, and your current medical care.

To let us know when there are changes in your general health condition, or if you should experience complications or unusual discomfort following a treatment procedure.

To ask questions so that you can better understand the nature of your dental condition and the treatment provided.

To follow the instructions you are given, be available for services you need, and keep your scheduled appointments.

To be available at least one-half-day a week, starting at either 9:00 a.m. for a morning appointment or 1:00 p.m. for an afternoon appointment; and if you are the parent of a patient under the age of 18, to be available during the entire treatment appointment.

To give at least 24 hours notice when canceling an appointment.

To be prompt in attendance for you, or your child’s dental visit.

To seek routine care from another source (such as a dentist in private practice), once the course of prescribed treatment and recall are complete. You may, of course, seek dental hygiene treatment here later if needed.

To be considerate and respectful of other patients, and of students, faculty and staff of Central Carolina Community College.

If you have any questions, concerns or problems with your treatment, please call (919) 777-7780, Monday through Thursday, from 8:00 a.m. to 4:00 p.m.

__________________________
Signature of Patient/Parent or Legal Guardian

__________________________
Date

__________________________
Witness
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. 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 and adjust chair and head rest for maximum comfort of patient and operator.
2. Have patient rinse for 30 seconds with chlorhexidine mouth rinse, or Listerine and use saliva ejector.
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 X-Rays.
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 X-Rays, 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 14 MUST have a parent or guardian in reception area during treatment.
   c. Patients 14 and older must have a notarized letter dated for the appointment stating YOU may act in their behalf if the parent leaves the reception area. You must also have cell phone # where they may be reached at all times during the appointment.
   d. 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 and having a notarized letter.

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 at the desk to discuss.
   c. Once you have completed the Health/Dental Questionnaire, Drug Summary and vital signs, put up a **Black** flag 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 x-rays” compete your Health Questionnaire, Drug Summary, and necessary forms for x-rays, and then put up your Black flag.

f. When you have completed your Intraoral/Extraoral Inspection and Restorative charting, put up your Blue flag to have an instructor check. {TMJ, OCCLUSION, HEAD}

g. When you have completed your Treatment Plan put up a Blue/Green flag for an instructor to check.

h. To have your scaling checked put up a Yellow flag.

i. If you need help with scaling, root planing, Cavitron, or Prophy Jet, put up your Yellow/Green flag for a Dental Hygiene instructor only.

j. If you need to have your patient anesthetized, have questions about decay, X-Rays, questions about sealants, or questions about drugs or the Health Questionnaire, put up a White flag 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. Have a red pen ready to make notations, 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 in ink 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 reference books such as the PDR and 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 health history form at every appointment and when changes are indicated. (ie: medication, illness, etc.)

4. Evaluation of Health Questionnaire
   a. After patient has answered the health questionnaire questions, circle significant "yes" answers in red. 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 Record of Treatment. Include any additional information that is deemed necessary.
      Example: Pt. took premed.
   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.
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. Also, if the patient is under 14, the parent must remain in the reception area.

i. If a minor is not accompanied by his/her parent, a notarized letter signed by the parent stating permission to be treated by whomever is accompanying the child or the student to act in their behalf. All paperwork requiring parental signatures must be signed by the parent or guardian and presented at the time of check in.

5. Significant Health Questionnaire Findings. 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. But the dental hygiene clinic at CCCC does not maintain medications for patients.

   2. Inhalers and/or nitroglycerin are required to be readily accessible during treatment. Will be a critical error 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 ecchymoses, 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 world-wide. Laboratories report their results either at the PT or 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.

   iii. Identify possible medical emergencies related to the blood pressure and be prepared to handle the emergency should it occur.
SIGNIFICANT HYPERTENSION IN CHILDREN

<table>
<thead>
<tr>
<th>AGE</th>
<th>SYSTOLIC</th>
<th>DIASTOLIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-5</td>
<td>&gt;116</td>
<td>&gt;76</td>
</tr>
<tr>
<td>6-9</td>
<td>&gt;122</td>
<td>&gt;78</td>
</tr>
<tr>
<td>10-12</td>
<td>&gt;126</td>
<td>&gt;82</td>
</tr>
<tr>
<td>13-15</td>
<td>&gt;136</td>
<td>&gt;86</td>
</tr>
<tr>
<td>16-18</td>
<td>&gt;142</td>
<td>&gt;92</td>
</tr>
</tbody>
</table>

CLASSIFICATION OF BLOOD PRESSURE FOR ADULTS AGE 18 & OLDER**

<table>
<thead>
<tr>
<th>Category</th>
<th>Systolic (mm Hg) (SBP)</th>
<th>Diastolic (mm Hg) (DBP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>&lt;120 and</td>
<td>&lt;80</td>
</tr>
<tr>
<td>Prehypertension</td>
<td>120-139 or</td>
<td>80-89</td>
</tr>
<tr>
<td>Stage 1 Hypertension †</td>
<td>140-159 or</td>
<td>90-99</td>
</tr>
<tr>
<td>Stage 2 Hypertension †</td>
<td>&gt;160 or</td>
<td>&gt;100</td>
</tr>
</tbody>
</table>

** 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 2 hypertension, and 174/120 mm Hg should be classified as stage 3 hypertension. Isolated systolic hypertension is defined as SBP of 140 mm Hg or greater and DBP below 90 mm Hg and staged appropriately (e.g., 170/82 mm Hg is defined as stage 2 isolated systolic hypertension).

† Based on the average of two or more readings taken at each of two or more visits after an initial screening.
<table>
<thead>
<tr>
<th>Normal/High Normal</th>
<th>Systolic 139 or lower or Diastolic 89 or lower</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. No contraindications to elective dental treatment.</td>
</tr>
<tr>
<td>Stage 1 HTN</td>
<td>Systolic 140-159 or Diastolic 90 – 99</td>
</tr>
<tr>
<td></td>
<td>1. Retake and confirm blood pressure.</td>
</tr>
<tr>
<td></td>
<td>3. Monitor blood pressure during appointment.</td>
</tr>
<tr>
<td>Stage 2 HTN</td>
<td>Systolic 160 or higher or Diastolic 100 or higher</td>
</tr>
<tr>
<td></td>
<td>1. Retake and confirm blood pressure.</td>
</tr>
<tr>
<td></td>
<td>2. Emergency or non-invasive elective treatment only.</td>
</tr>
<tr>
<td></td>
<td>3. Monitor blood pressure during appointment.</td>
</tr>
<tr>
<td></td>
<td>4. Refer patient to physician for medical evaluation.</td>
</tr>
<tr>
<td></td>
<td>5. <strong>Medical consult required prior to elective dental treatment.</strong></td>
</tr>
<tr>
<td>Systolic &gt; 210 or Diastolic &gt; 120</td>
<td>1. Retake and confirm with alternative device, such as mercurymanometer type sphygmomanometer.</td>
</tr>
<tr>
<td></td>
<td>2. If blood pressure is unchanged, consider <strong>immediate</strong> referral of the patient to a physician or emergency room for evaluation.</td>
</tr>
<tr>
<td></td>
<td>3. No treatment of any type should be undertaken.</td>
</tr>
<tr>
<td></td>
<td>4. <strong>Medical consult required prior to any dental treatment</strong></td>
</tr>
</tbody>
</table>

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**

- Fasting Blood Glucose (Glucometer) reading
  - <70 mg/dl: defer elective treatment or give
  - >200 mg/dl: defer elective treatment give

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

**End-Product Evaluation Criteria**
1. Each student is required to complete health questionnaire 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.

**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. Using data gathered by a previous clinician is cheating and is cause of dismissal from the program.
Sequence of Procedure:

Open a new clinical exam tab in Eagle Soft

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, tonsilar 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 Oral Inspection 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.
Annotatee in Eaglesoft notes that referral was made and a copy was given to the patient. Place copy in Office Manager’s in box for Eaglesoft Smartdocs scan of document.

**Required Evaluations:**
A proficiency on the extra and intra oral inspection is done in DEN 131 - Dental Hygiene Clinic

I. 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 14 years old, 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 14 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 will result in dismissal from the program. In EagleSoft:

1. Place patient’s most recent radiographs on the view box/screen.
2. Complete the Perio tab (all boxes) in Eaglesoft. Record the CCCC perio and calculus classification in the comments box at the bottom of the page.
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 under 14. 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 critical 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 II-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- Special needs patients are 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 (I-IV)

<table>
<thead>
<tr>
<th>Type</th>
<th>Classification</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Negative</td>
<td>No inflammation or loss of function due to destruction of supporting tissues.</td>
</tr>
<tr>
<td>I</td>
<td>Gingivitis</td>
<td>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.</td>
</tr>
<tr>
<td>II</td>
<td>Slight Chronic Periodontitis</td>
<td>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%.</td>
</tr>
<tr>
<td>III</td>
<td>Moderate Chronic Periodontitis</td>
<td>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%.</td>
</tr>
<tr>
<td>IV</td>
<td>Advanced Chronic Periodontitis</td>
<td>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 &gt; or CAL of 8 mm or &gt;, recession of 5mm or &gt;, bone loss of 50% or &gt;.</td>
</tr>
<tr>
<td>V</td>
<td>Recurrent Chronic or Aggressive Periodontitis</td>
<td>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.</td>
</tr>
</tbody>
</table>
## Calculus Classifications (0-05)

<table>
<thead>
<tr>
<th>Type 0</th>
<th>Little or no calculus present; minimal scaling.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 01</td>
<td>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.</td>
</tr>
<tr>
<td>Type 02</td>
<td>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.</td>
</tr>
<tr>
<td>Type 03</td>
<td>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.</td>
</tr>
<tr>
<td>Type 04</td>
<td>Very heavy, hard, tenacious subgingival calculus generalized throughout the mouth. Accessibility may be difficult due to pockets or tooth alignment.</td>
</tr>
<tr>
<td>Type 05</td>
<td>(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.</td>
</tr>
</tbody>
</table>

## Stain Classifications (L, M, H, X)

<table>
<thead>
<tr>
<th>Class L</th>
<th>Light Stain</th>
<th>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.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class M</td>
<td>Moderate Stain</td>
<td>Stain, if present, is moderate limited to the cervical third of the teeth and involving not more than half of the teeth.</td>
</tr>
<tr>
<td>Class H</td>
<td>Heavy Stain</td>
<td>Stain, if present, is heavy and generalized throughout the mouth, covering at least half the exposed tooth surfaces.</td>
</tr>
<tr>
<td>Class X</td>
<td>Extra Heavy Stain</td>
<td>Stain, if present, is very heavy, tenacious (such as pipe stain which appears to be &quot;baked-on&quot;). Scaling is generally required to remove stain.</td>
</tr>
</tbody>
</table>

**Calculus ratings of 02 and 03/04 must be determined between 2 faculty.**
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 121.
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. You may only update Restorative Charting on your 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 DEN 131 and DEN 141, 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 student’s 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.

- In DEN 221 and DEN 231 the treatment plan worksheet will not be required unless the patients’ periodontal class is a 3 or 4 and/or the calculus classification is a 03 or 04. The Care Plan, diagnosis statement and required signatures are all the same as in DEN 131, DEN 141.

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 prior to presentation to 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 Worksheet and Care Plan and to be checked. The instructor will give you a cleaning assignment after this is completed.

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)

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 Record of Treatment the kind of toothbrush, floss, or other dental aids you dispensed.
8. Reevaluate and update home care at every appointment.
DENTAL HYGIENE TREATMENT

A. 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 which is smooth when explored, and creating an environment which promotes a soft tissue wall that does not bleed upon probing and is normal in color.
4. All teeth must be scaled to completion.

Required Evaluation:

1. End-product evaluation is done after every oral prophylaxis procedure. DEN 131 and 141- 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 a 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.

2. DEN 221, DEN 231- surface errors (supra and subcalculus and stain) are counted after initial instructor evaluation and after reevaluation. For 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.

3. End product self-evaluation is also recorded by the student. Student will record areas missed on the electronic patient assessment form.

4. All 02 & 03/04 calculus rating patients will be determined by two faculty.

B. 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.
Required Evaluations:
1. The student must complete teaching/proficiency evaluations on the use of the slow speed handpiece in DEN 131.

2. In 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.

3. End-product evaluation is done after every stain, supragingival calculus and soft deposit removal procedure. During DEN 221 and 231, surface errors are counted after the initial instructor's evaluation and after reevaluation. (For example, if the instructor finds three surface errors during initial examination and one of those deposits remains after the student-instruments, this would be counted as four total surface errors).

4. End-product evaluation is also recorded by the student on the Assessment Worksheet.

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 Record of Treatment in the appropriate EagleSoft template.
   a. The written Record of Treatment 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 plaque 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, ie UL, LL quads). Example Palmer method on treatment plan as it relates to words used in Eaglesoft:

   i. scaled (means you plan to scale maxillary and mandibular left quadrants)
      
      | ✓ |
      | ✓ |

   ii. complete scale & polish (means you plan to scale and polish the entire mouth)
      
      | ✓ | ✓ |
      | ✓ | ✓ |

j. If you use the cavitron 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). Example:

   N.V. scale & polish ✓ , APF, check HCI (home care instruction)

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.

q. *Type of radiographs - record under Assessment column. Example: 4-BW, 1-
PA, 14- FMS, digital BWX, digital Pan …… and indicate the number of retakes.

r. *Classification” of patient is under Assessment

s. Review patient education (rev. pt. ed.) - do this at each appointment after initial appointment. Calculate a PCR before your begin patient education so that the patient is aware of their status.

t. If patient was given a prescription, record the drug, dose and number of tablets. Example: Rx: Amoxicillin 500 mg, 4 tabs.

u. Note that patient took premedication. Example: Pt took 4 tabs of 500 mg Amoxicillin premed at 6:30 AM (time).

v. Date and Dentist’s name of where radiographs are being sent (via email or U.S. Postal Service).

IMPORTANT: The Record of Treatment must be written and signed by the student before operatory clean up is completed. It is the student's responsibility to make sure the information is complete and an instructor signs the Record of Treatment before leaving the operatory. Points will be deducted for not having the Record of Treatment completed before asking for a checkout.

**Points will be assessed for a record of treatment 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.**


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. __________.

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, scolloped 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%. Perio II loc III. Calc 01.**
**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 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. Place a small amount of topical anesthetic at each injection site! The topical needs approximately 4 minutes for best results.
4. Assist DDS and rinse the patient’s mouth after the injection.
5. Document on the treatment record:
   a. Type of topical anesthetic placed (Hurricane, benzocaine)
   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.

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 RE-EVALUATION

Sequence of Procedure:

1. Who?
   A. Patients receiving clinical care in the CCCC Dental Clinic:
      1. Verify need with your clinical instructor at the time your dental hygiene care plan is graded
      2. List the re-evaluation appointment on the care plan
         a. Failure to do so is 1 error
   B. Patients demonstrating severe gingivitis
      1. Perio Case Type I or II
      2. 03-04 calculus rating {CCCC classification in clinic manual}

   C. Patients demonstrating early periodontitis with severe gingivitis
      1. Perio Case Type II
      2. Severe gingivitis modified by
         a. Endocrine system
         b. Medications
         c. Viral – fungal infections
         d. Systemic conditions

   D. Patients demonstrating moderate to severe periodontitis
      1. New to CCCC- Perio Case Type III or IV
      2. Continued care Perio Case Type III or IV patients
         a. Unstable perio status
            1. Increasing probing depths
            2. BOP or suppuration present
         b. 01-02-03-04 calculus
      3. Do NOT schedule Perio Case Type III or IV patients who are in the perio maintenance phase of care
         a. Stable perio status
b. In compliance with 3 or 4 month perio re-care appointments

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

d. These patients will remain on 3-4 month perio maintenance re-care

2. When?
   A. Four to six weeks after completion of initial therapy/scaling appointment.
   B. Schedule an appointment for approximately 1-1.5 hours.

3. What?
   A. 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\}.
      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
   B. Receive credit for this patient as a completed patient
      1. Their perio status should improve
      2. You will receive credit for this patient as re-classified at the re-evaluation appointment
         a. A II-03-M may be reclassified as a II-01-L
   C. Receive credit for the following:
      1. Medical history
      2. Periodontal exam
      3. DH treatment plan
      4. Calculus removal
      5. Stain-plaque removal
      6. Credit for completed patient
      7. Credit for re-evaluation patient
         a. This is adjunctive service requirement for graduation
b. Make sure your faculty member checks and signs the appropriate information on the grade sheet so you receive proper credit.

D. Document the following:
   1. Medical history update
      a. Use previous medical history form
   2. Medication update
   3. Vital signs
   4. 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)
   5. Gingival exam – Perio tab of EagleSoft
      a. Describe soft tissue status
      b. Calculate findings from Perio exam
   6. 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.
      h. RECLASSIFY this patient.
   7. Self-care evaluation:
      a. PCR %
   8. All clinical care delivered.
   9. What next:
      a. Continue perio maintenance re-care
      b. Refer to dentist of record for perio referral

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!

2. 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.

3. Make sure have the correct # of teeth scaled and polished as well as the correct total # of teeth on the grade sheet.

4. 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.

5. Be ready to record any areas you have missed in scaling or polishing on the assessment form electronically.

6. If areas are missed, you will be asked to remove them and be rechecked. An instructor will recheck the areas missed.

7. Apply fluoride if indicated.

8. An instructor will complete your grade sheet. They will also review your Record of Treatment and sign. Record of Treatment 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. **Record of Treatment** - make sure the instructor signs this. It is your responsibility to make sure your record of treatment 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 your 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**

- Follow steps outlined in the Infection Control Section for disinfection of unit and sterilization of instruments.
- Students are expected to leave clinic area clean with unit turned off. Restock your unit drawers each day. 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.
- Turn off the monitor. Swing the monitor out of the way of the dental chair.
- If there are any problems with your unit, record what is wrong on the dental *maintenance work order form* located with the other clinical forms. 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 office manager.

- 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 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 be assessed professional responsibility points.

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

CANCELLATIONS AND FAILED APPOINTMENTS

- Students should call to confirm all patients seven days before their appointment and again 24 hours before. If the patient says 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.

- 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.

- If your patient fails to come by twenty 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.

- 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.

- This is a good time to practice your team player skills.
CLINIC ORGANIZATION CHART

Vicky Wesner
Program Director

Whitney Simonian
First Year Instructor

Jessica Scott
Second Year Instructor

Terri McKone
OFFICE MANAGER
SECTION TWO: Clinical Requirements and Disciplinary Procedures
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.

1. Teaching is a "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.

2. Proficiency is a "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.

3. 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 you 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%)
## CENTRAL CAROLINA COMMUNITY COLLEGE
### DENTAL HYGIENE CLINIC REQUIREMENTS

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Clinic I</th>
<th>Clinic II</th>
<th>Clinic III</th>
<th>Clinic IV</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Focus</strong></td>
<td>AAP I, Calculus 0 &amp; 01</td>
<td>AAP II, Calculus 1 &amp; 2</td>
<td>AAP III, Calculus 2 &amp; 3 Recare Patients-Total Care</td>
<td>AAP III &amp; IV, Calculus 3 &amp; 4 Recare Patients-Total Care</td>
</tr>
<tr>
<td><strong>Adult Patient Completion</strong></td>
<td>5 complete treatment (max. of 2 Calculus 0)</td>
<td>5 complete treatment (max. of 2 Calculus 01)</td>
<td>8 complete treatment (max. of 1 Calculus 01, 3 Calculus 02)</td>
<td>9 complete treatment (max. 1 Calculus 01, 3 Calculus 02)</td>
</tr>
<tr>
<td>(min. grade of 3)</td>
<td></td>
<td></td>
<td>8 quads need to be calculus 03/04 2 recare patient</td>
<td>8 quads need to be calculus 03 or 04 3 recare patients (will count as 2 of 9 complete)</td>
</tr>
<tr>
<td><strong>Child &amp; Adolescent Patients</strong></td>
<td>3 (at least 1 mixed dentition)</td>
<td>4 (at least 1 mixed dentition)</td>
<td>2 (at least 1 mixed dentition)</td>
<td>2 (at least 1 mixed dentition)</td>
</tr>
<tr>
<td><strong>4-6 week re-eval</strong></td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Geriatric</strong></td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Medically Compromised Patients</strong></td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Radiographs (min=85%)</strong></td>
<td>FMX-2 Panoramic-1 Adult BWX-3</td>
<td>FMX-2 Panoramic-1 Adult BWX-2</td>
<td>FMX-2 Panoramic-1 Adult BWX-4</td>
<td>FMX-2 Panoramic-1 Adult BWX-4</td>
</tr>
<tr>
<td>(Special Population)</td>
<td>Adult BWX-2 Pedo BWX-1 (1 HBWX, 1 VBWX)</td>
<td>Adult BWX-2 Pedo BWX-1 (2 HBWX, 2 VBWX)</td>
<td>Adult BWX-4 Pedo BWX-1 (2 HBWX, 2 VBWX)</td>
<td>Adult BWX-4 Pedo BWX-1 (2 HBWX, 2 VBWX)</td>
</tr>
<tr>
<td><strong>Intraoral Camera</strong></td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Study Models</strong></td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Pit &amp; Fissure Sealants</strong></td>
<td>0</td>
<td>1</td>
<td>8 teeth by end of Clinic IV</td>
<td></td>
</tr>
<tr>
<td><strong>Nutritional Counseling</strong></td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Appliance Cleaning</strong></td>
<td></td>
<td></td>
<td></td>
<td>4 appliances by end of Clinic IV</td>
</tr>
<tr>
<td><strong>Local Drug Delivery</strong></td>
<td></td>
<td></td>
<td>1 patient by end of Clinic IV</td>
<td></td>
</tr>
<tr>
<td><strong>Healthcare Provider Communication</strong></td>
<td></td>
<td></td>
<td></td>
<td>3 patients by end of Clinic IV</td>
</tr>
</tbody>
</table>

Updated July 15, 2015
### Clinical Competencies and Process Evaluations per Clinical Course

<table>
<thead>
<tr>
<th>Clinical Course</th>
<th>Process Evaluations</th>
<th>Practical/Competencies</th>
</tr>
</thead>
</table>
| DEN 121         | Refer to Course Syllabus (Total of 37) | UNC 15 Probe  
ODU 11/12 Explorer  
Area-Specific Curets  
Scalers  
Universal Curets  
Polishing |
| DEN 131         | Appliance Care  
PSR  
Gingival & Periodontal Exam Instrumentation  
Instrument Sharpening  
Oxygen Use  
Patient Education  
Dental Charting  
Coronal Polishing  
Fluoride Application  
Syringe Set Up  
HealthCare Provider Communication* | 3 Assessments  
2 Dental Hygiene Treatment  
(healthy patient, simple case 0 or 1) |
| DEN 141         | Instrument Sharpening  
PSR  
Periodontal Instrumentation (1 quad – Type II or higher and 02 or higher)  
Sealants  
Treatment Planning  
Radiographic Interpretation  
Oraqix Delivery  
Emergency Procedures  
Nutritional Counseling  
Study Model  
Scalers  
Universal Curetes  
Area specific Curetes  
Explorers | 2 Assessments  
- 2 calculus 02 (or higher)  
1 DH Treatment (02 or higher) |
| DEN 221         | 2 quads perio instrumentation (moderate deposit)  
Local Drug Delivery  
Preventive Counseling  
Ultrasonic Instrumentation  
Air Abrasive Polish  
Desensitization  
1 Nutritional Counseling  
Radiographic Interpretation | 3 Assessments (1 - 3 or 4 calculus case)  
1 DH Treatment (1 - 3 calculus case)  
3 DH Treatment (2 - 01 or 02 calculus case, 1-3 or 4 calculus case)  
2 Sealants |
| DEN 231         | 1 Perio Instrumentation  
1 Bleaching/Fluoride Tray Fabrication | 3 Comprehensive DH care, includes assess, plan, DH treatment, supportive treatment and evaluation, and documentation (at least 2 patients with complex conditions & perio and 1 maintenance)  
1 Nutritional Counseling  
1 Local Drug Delivery  
1 Re-Evaluation  
1 Air Abrasive Polish  
1 Ultrasonic Instrumentation  
1 Radiographic Interpretation |
DISCIPLINARY PROCEDURES/POLICIES OF THE DENTAL HYGIENE PROGRAM

Students enter into the Dental Hygiene Program for the purpose of learning course information and skills necessary to become a well-trained dental professional. CCCC Dental Hygiene faculty are dedicated to providing students access to all information needed to accomplish that goal; however, they cannot achieve an optimum learning environment when students fail to comply with training procedures. Compliance to all policies, rules, regulations, and course requirements helps ensure that each student is offered the best opportunity to be competent in all areas of dental training.

Disciplinary procedures are designed to:
- Realign a noncompliant student into the proper training form.
- Reinforce compliance for chronic disregard of Program policies.
- Provide safety mechanism for patients by applying a grade reflective of the severity of the violation.

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:

NON-CUMULATIVE CRITICAL ERRORS; PENALTIES DO NOT CARRY OVER FROM 1ST YEAR TO 2ND YEAR

- All infection control errors; however, mass asepsis errors are cumulative errors (see next section)
- 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
CUMULATIVE CRITICAL ERRORS; PENALTIES CARRY OVER FROM 1\textsuperscript{ST} YEAR TO 2\textsuperscript{ND} YEAR

- 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.

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**

\textit{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.

PENALTIES FOR CRITICAL ERRORS OF CLINICAL TRAINING

NON-CUMULATIVE CRITICAL ERRORS: The student will be required to comply with the following penalties/reprimands:

\textbf{1\textsuperscript{st} offense:}
- A grade of ZERO (0) for that patient will be given.
- Remediation with clinical coordinator.

\textbf{2\textsuperscript{nd} offense:}
- A grade of ZERO (0) for that patient will be given.
- Remediation with clinical coordinator.
- Student will receive a letter of warning.
- Student must meet with the Dental Hygiene faculty and sign an Admission of Critical Error Form that states his/her knowledge of the repercussions of a 3rd offense: (signature denotes acknowledgement not always agreement)
- 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.
Section 2  Clinical Requirements and Disciplinary Policy

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 non-cumulative critical errors/semester prior to dismissal**

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 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 will receive a letter of warning.
- Student must meet with the Dental Hygiene faculty and sign an Admission of Critical Error Form that states his/her knowledge of the repercussions of a 3rd offense: (signature denotes acknowledgement not always agreement)
- 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.

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 critical errors over the course of the entire program prior to dismissal**

ALL INFRACTIONS ARE CONSIDERED ON A CASE-BY-CASE BASIS AND FACULTY DISCRETION MAY BE USED.

Updated July 15, 2015
GROUNDED FOR DISMISSAL*

Upon proof of any of the following, 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 dismissed from the program.

- 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 Offense Mass Asepsis Errors
- Insufficient grades
- Excessive absences
- Stealing
- Cheating on quizzes, tests, or exams
- Plagiarism
- 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 THREE: Clinical Evaluation of Student Performance
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**- 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 every one 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 in order to receive credit is the mastery level. The mastery level is 85%. See clinic grade scale section to determine 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 grade to be rendered. Refer to course syllabi.

**Clinical Promotion Policies**
A student must successfully pass all clinical courses in the dental hygiene curriculum to 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**
   i. Differentiate between the different instruments and select the appropriate instrument for the task.
   ii. Select the correct working end of the instrument.
   iii. Keep tip in contact with tooth surface by rolling handle.
iv. Direct tip apically toward the junctional epithelium.

v. Establish angulation appropriate for type of stroke.

vi. Maintain parallelism by pivoting on the fulcrum.

b. Instrumentation: Condition

i. 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.

ii. 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.

iii. 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.

iv. The following criteria must be used in determining proper instrument condition:

1. 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.

2. 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.

v. 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 HuFriedy 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 and there is an approximate charge of $8.50. The following is the mailing address to Hu-Friedy:

Hu-Friedy Mtg. Co, INC.
Technical Services
3232 N. Rockwell
Chicago, IL 60618-5982
c. Instrumentation: Fulcrum
   i. Use tip of ring finger.
   ii. Ring finger is straight and supports weight of hand.
   iii. Placement is close to working area.
   iv. Appropriate palm direction.
   v. Appropriate pressure for stabilization.
   vi. Placement on an incisal or occlusal surface or embrasure, or use of an extraoral fulcrum in the posterior segments.

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

e. Instrumentation: Selection
   i. Each instrument is designed for a specific purpose and is intended to be used for the purpose for which it was designed.
   ii. The student will be able to differentiate between the different instruments and select the appropriate instrument for the task.
   iii. The following characteristics should be considered when selecting instruments:
      1. The anatomy of the tooth; root curvatures and furcations. Location and extent of calculus deposits. Anatomy of the sulcus or pocket.

f. Instrumentation: Stroke
   i. Activate instrument with a unified wrist-forearm motion; use a rocking or rotating motion.
   ii. Pivot from the fulcrum.
   iii. Direct stroke to protect soft tissue from trauma and to preserve tooth structure and margins of restorations.
   iv. Use an exploratory stroke to insert to junctional epithelium or to most apical extent of deposit.
   v. Use short, controlled strokes.
Section 3  Clinical Evaluation of Student Performance

vi. Cover circumference of teeth.

vii. Overlap line angles and proximal mid-lines.

viii. Execute controlled stroke with appropriate length, pressure and speed for the task.

ix. Use a systematic approach to instrumentation, completing each tooth, surface by surface, before proceeding to the next.

g. Instrumentation: Sharpening

i. Produce and maintain a sharp cutting edge.

ii. Sharpen instruments according to technique taught in DEN 130.

1. Evaluation

a. During DEN 131 and 141 each student must complete an instrument sharpening proficiency for a universal curette, sickle scaler and Gracey.

b. During DEN 221, only a proficiency at mastery level will be required. The student must demonstrate mastery on all instruments as verified by end product.

4. 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.

5. Patient Education

a. Oral Hygiene instruction performed.

b. Appropriate aids taught and demonstrated.

c. Plaque Control Record performed, calculated, and recorded before the clinician begins to deliver clinical services.

6. Patient/Operator Position

a. Appropriate chair positions for operator obtained for appropriate instrumentation.

b. Appropriate chair positions for patient obtained for appropriate instrumentation.

7. 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.

8. Clinical Judgment

a. Utilize critical thinking skills and demonstrate ethical behavior in delivering clinical/educational services to the patient. Ex: if a patient needs 4 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.

9. **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.

---

**EVALUATION CRITERIA (Major, Minor, Critical Errors)**

**ASSESSMENT & DH DIAGNOSIS**

<table>
<thead>
<tr>
<th>ASSESSMENT</th>
<th>MAJOR ERROR</th>
<th>MINOR ERROR</th>
</tr>
</thead>
</table>
| Medical History     | **Critical Errors:**
   Fails to communicate med. hx. with faculty, fails to get 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 computer.  
   Fails to follow-up to yes responses.  
   Fails to determine patient compliance of medications. |
|                     | Does not record amount, type, etc. of medication taken.  
   Does not update demographic section.  
   Does not determine if prescriptions are expired/obtained (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.                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                             |
<table>
<thead>
<tr>
<th>EOE/IOE</th>
<th>Critical Errors:</th>
<th>Does not perform</th>
<th>Does not perform</th>
<th>Does not perform</th>
<th>Does not document findings correctly (i.e. size, shape, proper terminology)</th>
<th>Does not utilize correct technique.</th>
<th>Does not explain technique to patient prior to beginning procedure.</th>
<th>Fails to detect minor abnormalities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teeth/Occlusion</td>
<td>Fails to perform an occlusal assessment.</td>
<td>Does not detect apparent caries or faulty restorations.</td>
<td>Fails to integrate current radiographs during caries assessment.</td>
<td>Fails to chart existing restorations, missing teeth, etc.</td>
<td>Does not correctly identify occlusion.</td>
<td>Does not document findings correctly.</td>
<td>Does not use proper technique for caries assessment (i.e. air, transillumination, instrument selection).</td>
<td>Fails to detect conditions of teeth (i.e. attrition, fluorosis).</td>
</tr>
<tr>
<td>Periodontal Status</td>
<td>Does not probe.</td>
<td>Causes tissue trauma during periodontal probing.</td>
<td>Incorrectly measures four (4) or more probing depths by greater than 1mm.</td>
<td>Fails to identify an area of obvious deep periodontal pocketing.</td>
<td>Incorrectly manages patient (i.e. determining use of topical anesthetic)</td>
<td>Does not use correct technique.</td>
<td>Makes inappropriate decision (ie. PSR vs. standard probing)</td>
<td>Incorrectly measures up to three (3) probing depths by greater than 1 mm.</td>
</tr>
<tr>
<td>Diagnosis/Calculus Classification</td>
<td>Causes tissue trauma during exploring.</td>
<td>Fails to detect gross supragingival and/or subgingival deposits.</td>
<td>Does not explore to determine type and amount of deposits.</td>
<td>Fails to utilize radiographs.</td>
<td>Utilizes incorrect instrument and/or technique to determine calculus type.</td>
<td>Does not document type and amount of deposit correctly.</td>
<td>Fails to detect fine deposits.</td>
<td></td>
</tr>
<tr>
<td>Restorative Charting</td>
<td>Does not dental chart.</td>
<td>Fails to identify an area of obvious decay.</td>
<td>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.</td>
<td>Incorrectly records findings.</td>
<td>Does not use correct terminology.</td>
<td>Does not clean mirror for faculty/dentist use.</td>
<td>Does not clean mirror for faculty/dentist use.</td>
<td>Does not clean mirror for faculty/dentist use.</td>
</tr>
</tbody>
</table>
### DH CARE PLAN & PRESENTATION

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

### DH TREATMENT

<table>
<thead>
<tr>
<th>DH Treatment</th>
<th>MAJOR ERROR</th>
<th>MINOR ERROR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fails to do preventive counseling.</td>
<td>Inappropriate use of detection skills (i.e. air syringe, explorer, disclosing, indirect vision).</td>
</tr>
<tr>
<td></td>
<td>Generalized soft tissue trauma evident as a result of removal of hard and soft deposits.</td>
<td>Inappropriate deposit removal technique (i.e. instrument technique, instrument selection, instrument sharpness, handpiece technique).</td>
</tr>
<tr>
<td></td>
<td>Localized or generalized severe tissue trauma evident as a result of deposit removal.</td>
<td>Slight tissue trauma evident in localized areas following instrumentation.</td>
</tr>
<tr>
<td></td>
<td>Four (4) or more hard deposits remaining after instrumentation (1 major error for each set of 4)</td>
<td>Up to three (3) hard deposits remaining after instrumentation.</td>
</tr>
<tr>
<td></td>
<td>Four (4) or more soft deposits remaining after instrumentation (1 major error for each set of 4).</td>
<td>Up to three (3) soft deposits remaining after instrumentation.</td>
</tr>
<tr>
<td></td>
<td>Does not re-assess following instrumentation.</td>
<td>Fails to get 2 faculty to confirm diagnosis of calculus classification of 03 or 04.</td>
</tr>
</tbody>
</table>
### MANAGEMENT

<table>
<thead>
<tr>
<th>MANAGEMENT</th>
<th>MAJOR ERROR</th>
<th>MINOR ERROR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Judgment</td>
<td>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.</td>
<td>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).</td>
</tr>
<tr>
<td>CRITICAL ERROR:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fails to obtain appropriate signatures.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection Control</td>
<td>All infection control errors are critical if not identified by the student. Examples not all inclusive:</td>
<td></td>
</tr>
<tr>
<td>CRITICAL ERRORS:</td>
<td>Fails to follow Universal Health Precaution Procedures.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fails to properly prepare clinical unit.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fails to follow clinical protocol for handling “sharps”.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fails to follow clinical protocol for post-exposure evaluation and treatment when an exposure incident occurs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fails to place internal indicator on keyboard at medical history</td>
<td></td>
</tr>
<tr>
<td>Time Management</td>
<td>Use of inordinate amount of time during any phase of treatment.</td>
<td>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.</td>
</tr>
<tr>
<td>Preparation/Organization</td>
<td>Prepares for clinic at time patient should be seated.</td>
<td>Fails to review previous treatment. Fails to review active treatment plan.</td>
</tr>
<tr>
<td>CRITICAL ERRORS:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prepares for clinic at time patient should be seated.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fails to determine and assess most recent/appropriate radiographs and have them up on viewbox or computer.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fails to review patient chart prior to appointment.</td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>Fails to provide patient with treatment planned, individualized oral hygiene instructions.</td>
<td>Fails to solicit assistance for non-cooperative patient if own efforts are unsuccessful in obtaining control (i.e. sexual harassment, talkative patient,</td>
</tr>
<tr>
<td>Fails to provide consulting faculty with appropriate information regarding patient treatment (i.e. perio consultation, referral)</td>
<td>to faculty, patients, peers, health professionals, supportive staff (i.e. confrontational, displays negative personal feelings or behaviors)</td>
<td>“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/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.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>

**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 lacks 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.

<table>
<thead>
<tr>
<th>Clinic Grading System</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1st year</strong>*</td>
</tr>
<tr>
<td>5 = 100</td>
</tr>
<tr>
<td>4 = 89</td>
</tr>
<tr>
<td>3 = 79</td>
</tr>
<tr>
<td>2 = 69</td>
</tr>
<tr>
<td>1 = 59</td>
</tr>
<tr>
<td>0 = 0</td>
</tr>
<tr>
<td><strong>2nd year Fall</strong>**</td>
</tr>
<tr>
<td>5 = 100</td>
</tr>
<tr>
<td>4 = 86</td>
</tr>
<tr>
<td>3 = 76</td>
</tr>
<tr>
<td>2 = 66</td>
</tr>
<tr>
<td>1 = 56</td>
</tr>
<tr>
<td>0 = 0</td>
</tr>
<tr>
<td><strong>2nd year Spring</strong>*</td>
</tr>
<tr>
<td>5 = 100</td>
</tr>
<tr>
<td>4 = 83</td>
</tr>
<tr>
<td>3 = 73</td>
</tr>
<tr>
<td>2 = 63</td>
</tr>
<tr>
<td>1 = 53</td>
</tr>
<tr>
<td>0 = 0</td>
</tr>
</tbody>
</table>
### CLINICAL EVALUATION CRITERIA & GRADING SYSTEM

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

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

Updated July 15, 2015
# Clinical Evaluation of Student Performance

## Section 3

### DENTAL HYGIENE CLINICAL EVALUATION

<table>
<thead>
<tr>
<th>MN</th>
<th>MJ</th>
<th>C</th>
<th>HEALTH HISTORY</th>
<th>Date</th>
<th>Faculty/Appt.#</th>
<th>Date</th>
<th>Faculty/Appt.#</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>1. Medical/Dental History</td>
<td>Time In:</td>
<td>Faculty/Appt.#</td>
<td>Time In:</td>
<td>Faculty/Appt.#</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. EOE/OOE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3. Periodontal Evaluation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>a. Gingival Description</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4. Dental Evaluation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>a. Radiographs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>b. Charting Dentist Initials:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5. Occlusion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>6. DH Diagnosis: Periodontal, Calculus &amp; Stain Classification</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total # Errors: ___

### RE-EVALUATION

<table>
<thead>
<tr>
<th>Date</th>
<th>Faculty/Appt.#</th>
<th>Date</th>
<th>Faculty/Appt.#</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total # Errors: ___

### DH CARE PLAN & PRESENTATION

<table>
<thead>
<tr>
<th>Date</th>
<th>Faculty/Appt.#</th>
<th>Date</th>
<th>Faculty/Appt.#</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total # Errors: ___

### MANAGEMENT

<table>
<thead>
<tr>
<th>Date</th>
<th>Faculty/Appt.#</th>
<th>Date</th>
<th>Faculty/Appt.#</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total # Errors: ___

### Treatment Completed:

Next Visit:

COMMENTS:

---

Student Signature: ___________________________  Form Revised 2/26/2014

Updated July 15, 2015  66
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 or critical errors. The student will be assessed only 1 minor error instead of 5 minor errors.

<table>
<thead>
<tr>
<th>AAP Case Type</th>
<th>Case Points DEN 131/141</th>
<th>Case Points DEN 221/231</th>
<th># Minor Errors</th>
<th>Errors Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>1</td>
<td>0</td>
<td>0-1 no major/critical errors</td>
<td>0/1</td>
</tr>
<tr>
<td>II</td>
<td>2</td>
<td>0</td>
<td>0-2 no major/critical errors</td>
<td>0/2</td>
</tr>
<tr>
<td>III</td>
<td>3</td>
<td>1</td>
<td>0-3 no major/critical errors</td>
<td>0/2</td>
</tr>
<tr>
<td>IV</td>
<td>4</td>
<td>2</td>
<td>0-4 no major/critical errors</td>
<td>0/2</td>
</tr>
</tbody>
</table>

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 student 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.

<table>
<thead>
<tr>
<th>CCCC Calculus Rating</th>
<th>Competency Points DEN 131/141</th>
<th>Competency Points DEN 221/231</th>
<th># Minor Errors</th>
<th>Errors Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>2</td>
<td>0</td>
<td>0-2 no major/critical errors</td>
<td>0/2</td>
</tr>
<tr>
<td>02</td>
<td>4</td>
<td>2</td>
<td>0-4 no major/critical errors</td>
<td>0/2</td>
</tr>
<tr>
<td>03</td>
<td>6</td>
<td>4</td>
<td>0-6 no major/critical errors</td>
<td>0/2</td>
</tr>
<tr>
<td>04</td>
<td>8</td>
<td>6</td>
<td>0-8 no major/critical errors</td>
<td>0/2</td>
</tr>
</tbody>
</table>

**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. All case/competency points will be deducted for any major/critical errors.

Created February 11, 2014
SECTION FOUR: Preclinical, Clinical and Laboratory Infection Control and Risk Management Protocol
SECTION 4 Preclinical, Clinical and Laboratory Infection Control and Risk Management Protocol

Goals:
Provide safe environment for our students, faculty, staff and patients that is in accordance with OSHA standards and supported by sound biological principles.

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).

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.

I. Infection Control Protocol

A. 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.

B. 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 a 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.

C. 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.

    a. Hair must be neat, pulled back, and away from the face (no loose ends).
    b. Facial hair will be covered with a face mask or shield.
c. Wearing of jewelry during treatment procedures: follow guidelines as specified in current course syllabus and/or Dental Hygiene/Assisting Orientation Handbook and Manual.

d. Fingernails will be kept short and well-manicured (no colored polish or artificial nails, tips or gels)

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.

a. **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.

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

b. **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.

3. 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 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.

4. 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).

<table>
<thead>
<tr>
<th>SURFACE</th>
<th>PROTOCOL &amp; FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Touch &amp; Transfer Surfaces: light handles/switch, main body of unit and cradles, hoses/nozzles, bracket tray handles, stool adjustment levers, patient head rest adjustment</td>
<td>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.</td>
</tr>
<tr>
<td>Spatter Surfaces: painted surfaces of unit, ie. Tray arms, patient chair back and seat, seat and back of operator stool, counter top, sinks</td>
<td>Use surface disinfectant. Some splatter surfaces may be barriered, such as patient chair, back of operator stool, and bracket tray, if desired.</td>
</tr>
</tbody>
</table>

D. 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.
2. **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.**

3. **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.

4. **Radiographic Procedures:**

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

5. **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.

6. **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.)

7. **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.

8. **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.
E. 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.

F. 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.
G. 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.

H. 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.

1. 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.
I. **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 do the following:

For each of the following types of exposure you should:

1. **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*
2. **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.

3. **Eyewash Station:** What Every Employee/Student Should Know
   1. Where the station is located in the clinic and laboratory
   2. How to use the station
      a. Lift the dust covers off the spray heads.
      b. Push against foot pedal to start the flow. If no water comes out, be sure the water flow is turned on from the wall.
      c. Lift the hand lever to turn the unit off.
   3. When to use the station – when any potentially hazardous material contacts the eye(s)
   4. 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
   5. Basic Treatment for the Eye
      a. Flush with water using a mild flow from the eyewash station and continue for at least 15 minutes.
      b. 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).
      c. DO NOT let the victim rub his/her eye(s).
      d. DO NOT let the victim keep his/her eye(s) tightly shut.
      e. DO NOT introduce oil or ointment into the eye(s).
      f. DO NOT use hot water.
      g. Notify medical authorities when someone is injured.
      h. Use the incident report form to record details of the injury

**J. 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).

K. 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).
   - Notified the instructor and extra-mural site of the cross-contamination and follow-up steps taken immediately following the incident.

L. 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 picking an Insurance Claim form to turn into place where services were rendered.
II. 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:

A. 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 ____. 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.

DO NOT:

- Allow movement of the victim if head, neck, or spinal injury is suspected.
- Attempt to place anything into the victim’s mouth.
- 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, Administrative Assistant to the VP of Student Services, Controller, and Safety Coordinator.

B. 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.

C. 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.

D. If an ambulance is needed:

• The dentist will direct a student or instructor to call 911, then the Switchboard Operator at ext. _____
• Advise the 911 operator that an ambulance is needed immediately at WB Wicker CCCC Dental Clinic. (Give address, etc.) 900 S. Vance St. Room 220E Sanford, NC 27330
• 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.

E. 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, 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).

F. 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.
III. EMERGENCY EQUIPMENT: LOCATION

A. First Aid Kits are Located:
   - Dental Clinic, end of clinic near Operatory 5/6 on emergency cart
   - Dental Materials/Simulation Laboratory Classroom: hung on wall near door
   - Dental Radiology Clinic

B. Oxygen Tanks and Masks are located:
   - Dental Clinic, middle near Operatory 10

C. Emergency Drug Kit is located:
   - Dental Clinic, Dental Clinic, end of clinic near Operatory 5/6 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

IV. EVALUATION OF EMERGENCY INVENTORY:

- Medical supplies should be updated routinely, at least once every three (3) months.
- The Program Director will appoint a faculty member 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.

A. 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.*

<table>
<thead>
<tr>
<th>Medical Emergency</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjacent to Op 10</td>
<td></td>
</tr>
<tr>
<td>Oxygen Tank Portable on a Cart</td>
<td>2</td>
</tr>
<tr>
<td>First Aid Kits</td>
<td>1</td>
</tr>
<tr>
<td>CPR masks w/ 1 way valve, filter, O2</td>
<td>2</td>
</tr>
<tr>
<td>Thermometer</td>
<td>1 Box</td>
</tr>
<tr>
<td>BP cuff – adult</td>
<td>2</td>
</tr>
<tr>
<td>BP cuff – child</td>
<td>2</td>
</tr>
<tr>
<td>Item Description</td>
<td>Quantity</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>BP cuff - obese</td>
<td>1</td>
</tr>
<tr>
<td>BP monitor</td>
<td>1</td>
</tr>
<tr>
<td>Stethoscopes</td>
<td>5</td>
</tr>
<tr>
<td>Digital BP cuff - wrist</td>
<td>1</td>
</tr>
<tr>
<td>Glucometer</td>
<td>1</td>
</tr>
<tr>
<td>Glucose lancets</td>
<td>1 box</td>
</tr>
<tr>
<td>Glucose strips</td>
<td>1 box</td>
</tr>
<tr>
<td>Ammonia inhalants</td>
<td>3 boxes</td>
</tr>
<tr>
<td>Cold compresses</td>
<td>2</td>
</tr>
<tr>
<td>Master spill kit</td>
<td>1</td>
</tr>
<tr>
<td>OSHA Compliance System (MSDS)</td>
<td>1</td>
</tr>
<tr>
<td>Eyewash stations</td>
<td>2</td>
</tr>
<tr>
<td>AED 10 with accessories</td>
<td>1</td>
</tr>
<tr>
<td>Alcohol prep pads</td>
<td>1 box</td>
</tr>
<tr>
<td>Poison antidote kit</td>
<td>1</td>
</tr>
<tr>
<td>Blanket – 70% wool 62x80 gray item B2186</td>
<td>1</td>
</tr>
<tr>
<td>Pillow-waterproof/reusable item B2183</td>
<td>2</td>
</tr>
<tr>
<td>Disposable pen light</td>
<td>2</td>
</tr>
</tbody>
</table>

**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
First Aid Kit Contents

1- 16” latex-free tourniquet

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
Antisptic handwipes

V. 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 AN 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.
CENTRAL CAROLINA DENTAL PROGRAMS
BLOOD OR BODY FLUID EXPOSURE INCIDENT REPORT

INCIDENT:

DATE:______________ TIME:___________ am □ pm □ LOCATION:____________

Please Circle One:

Needlestick  Instrument Puncture  Bur Puncture  Blood Spatter/Mucous Membrane Exposure

Other (Specify)________________________________________________________________

DESCRIBE: Route of exposure (nature/location of injury):

_____________________________________________________________________________________

Circumstances under which exposure occurred:

_____________________________________________________________________________________

_____________________________________________________________________________________

EXPOSED PERSON:

Name:________________________________ Hepatitis B Vaccination Series Completed? Yes □ No □

 DH Student □ DA Student □ Dental Faculty □

SOURCE INDIVIDUAL: If source individual is unknown, check here:

Name of Source Person:________________________ Age:________ M/F_______

Record #________________ Phone:________________ County of Residence:_______________

Name of Physician or Provider of Medical Care:__________________________________________

City/Town:________________________ Phone:________________

The statements below should be read to, or read by, the source individual before answering the last question on this form. If source person is unavailable at time of exposure, check here □ and contact individual as soon as possible to obtain answer to last question.

1. You have reason to believe you have been exposed to hepatitis or AIDS.
2. You have had serum hepatitis (B or C) or yellow jaundice.
4. You have hemophilia, or have received blood products before 1985.
5. You have tested positive or have TB or tuberculosis.
6. You have taken illegal drugs by needle at any time since 1977.
7. You are a man who has had sex with another man at some time since 1977, even one time.
8. You have had syphilis, gonorrhea (clap) or another sexual disease since 1977.
9. You have had sex for money or drugs at any time since 1977.
10. You have had multiple anonymous sex partners since 1977.
11. You have had sex with prostitutes, even one time, since 1977.
12. You have been infected with HIV or have AIDS.
13. You have been with a sex partner who would answer “yes” to any one of the above questions.

Is any one of the above statements true for you? .......Yes ☐ No ☐ Don’t Know ☐

SIGNATURE OF SOURCE
INDIVIDUAL_________________________________________________________
CENTRAL CAROLINA DENTAL PROGRAMS
Foreign Object/Incident Report

INCIDENT:

DATE:___________________ TIME:____________ am□ pm□ LOCATION:_____________________

Please Circle One:
Needlestick Instrument Puncture Bur Puncture
Other (Specify)_____________________________________________________________________

DESCRIBE: Route of exposure or object swallowed (nature/location of injury):
_________________________________________________________________________________

Circumstances under which exposure/ incident occurred:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

PERSON INCIDENT OCCURRED:

Name:_______________________________________ Hepatitis B Vaccination Series Completed?
Yes □ No □

Last Tetanus Shot: _________________________________
DH Student □ DA Student □ Dental Faculty □ Patient □

CONSENT TO BE X-RAYED AND FURTHER TREATMENT:

I consent to be taken to the hospital for necessary x-rays and treatment for the described incident that occurred while receiving treatment at the Central Carolina Dental Center.

Signature of Patient:_____________________________________________________________
Witness: ___________________________________________________________________

REFUSED TO X-RAYS AND FURTHER TREATMENT:

I refuse to be taken to the hospital for necessary x-rays and treatment for the described incident that occurred while receiving treatment at the Central Carolina Dental Center.

Signature of Patient:_____________________________________________________________
Witness: _____________________________________ 
______________________________
STEPS FOR FILING ACCIDENT CLAIMS
Revised 4/14

1. The Student Accident Report form is to be filled out by instructor and student. Return this form to SDS with both signatures as soon as possible.

2. The student or someone needs to take the insurance claim form to the place where services were rendered (hospital, drug store, doctor’s office). Most of the time the medical offices will file the insurance form for the student.

3. **This is secondary insurance.** Coverage is an excess policy unless there is no other insurance in place. Other insurance includes, but is not limited to: Group Health Policies, Individual Health Policies and medical provision provided under any other insurance policies. Attach the primary carrier’s Explanation of Benefits (EOB) showing payment or denial of each bill. “Primary Carrier” would include any and all other coverage that a participant may have.

4. **DO NOT PUT THE COLLEGE NAME ON THE INVOICE AT THE HOSPITAL OR DOCTOR’S OFFICE, THE BILL OR INVOICE SHOULD BE IN THE NAME OF THE STUDENT. THE INSURANCE COMPANY, (NOT THE COLLEGE) IS RESPONSIBLE FOR ALL CLAIMS.**

5. The instructor will forward the Student Accident Report form to Student Services. Student invoices will be sent to Stephanie Whitaker and patient invoices will be forwarded to Laura Musselwhite by faculty.
Central Carolina Community College

Student Accident Report

This Student Accident Report is for school use only. (An injured employee should contact the Business Office.) The staff member in charge of the student at the time of the accident should assist the student in completing this form. Copies should be sent to the Supervisor and Vice President of Student Services within twelve hours of the accident. Unsupervised off-campus accidents should be reported by the Department Chairperson as soon as information is known.

The injured student or other appropriate person should secure a Claim Form in Student Development Services for submission to the medical agency supplying treatment.

Name of injured: ___________________________ Curriculum: ________________
( Last ) ( First ) ( Middle )
Address: ___________________________________ Phone number: ________________
Date injured: ________________ Time injured: ________________ Age: ________________
Description of Accident: ________________________________
Where did it occur? ___________________________________________
How did it occur? ___________________________________________
Activity engaged in: ___________________________ Under school supervision? Yes No
Nature of injury: ___________________________________________

Description of accident and injury: (Check all items that apply)

<table>
<thead>
<tr>
<th>Part of body injured</th>
<th>Type of injury</th>
<th>Extent of injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>() Foot () Leg () Eye</td>
<td>() Burn () Bruise</td>
<td>() First Aid () Doctor</td>
</tr>
<tr>
<td>() Arm () Neck () Mouth</td>
<td>() Cut () Strain</td>
<td>() Lost time () Hospital</td>
</tr>
<tr>
<td>() Hand () Chest () Mouth</td>
<td>() Fall () Foreign Body</td>
<td>() No time lost () Other</td>
</tr>
<tr>
<td>() Back () Finger</td>
<td>() Slip () Other</td>
<td>() Sent home</td>
</tr>
</tbody>
</table>

Description of accident: ___________________________________________

Description of group activity, if any, engaged in at time of accident:
______________________________________________________________

Name of Doctor: ___________________________ City: ______________________
Remarks: ________________________________________________________

(Student’s Signature) ___________________________ (Date) ________________

To be completed by staff member

Check main cause of accident and explain:
Failure of equipment: () ___________________________________________
Failure of machine: () ___________________________________________
Personal error: () ___________________________________________
Other cause: () ___________________________________________

Staff Member’s Signature ___________________________ Date ________________

(Use back of form for additional comments)
## Section 4
Risk Management, Preclinical, Clinical and Laboratory Infection Control

---

**ACCIDENT CLAIM FORM**

<table>
<thead>
<tr>
<th>TO BE COMPLETED BY PARENT/PARTICIPANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME OF PARTICIPANT (Last Name)</td>
</tr>
<tr>
<td>PARTICIPANT ADDRESS (Street)</td>
</tr>
<tr>
<td>PHONE NUMBER</td>
</tr>
<tr>
<td>DATE OF INJURY</td>
</tr>
<tr>
<td>PLEASE MARK:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

**DESCRIBE FULLY HOW AND WHERE THE INJURY OCCURRED**

---

**PARENT/GUARDIAN NAME**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>ADDRESS (Street)</th>
<th>(City)</th>
<th>(State)</th>
<th>(Zip)</th>
</tr>
</thead>
</table>

---

**AUTHORIZATION TO RELEASE INFORMATION**

I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information, to Summit America Insurance Services, L.C., the Plan Administrator, or their employees and authorized agents for the purpose of validating and determining benefits payable. A photo copy of this authorization shall be as valid as the original.

Signature ___________________________ Date ______________

**AUTHORIZATION TO PAY PROVIDER**

I authorize payment of charges associated with this incident directly to the physicians or providers. I further certify that the foregoing information is true and correct.

Signature ___________________________ Date ______________

---

**TO BE COMPLETED BY ADMINISTRATOR**

<table>
<thead>
<tr>
<th>NAME OF GROUP POLICYHOLDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS OF POLICYHOLDER</td>
</tr>
<tr>
<td>TELEPHONE NUMBER OF POLICYHOLDER</td>
</tr>
</tbody>
</table>

I certify that the foregoing information is true and correct.

Authorized Signature ___________________________ Date ______________

Title ___________________________
VI. AVOIDING LIGATION

A. 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.

B. 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.
C. 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**

D. 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.

E. 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.

F. 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".

G. 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.

H. 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.

I. 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. On a monthly basis, faculty will randomly select a chart from each student and audit the chart thoroughly with the Quality Assurance chart auditing form. Students will be informed of monthly errors found during the process. Errors will be addressed with the entire class as a means of correcting potential errors.

VII. GUIDELINES FOR MANAGING PATIENTS WHO MAY BE SEEKING PROFESSIONAL OR 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 local Dental Society who can assist him/her. This may be done by contacting the local dental society office.
VIII. Additional Policies

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

A. **Cell phones:**
   Cell phones, tablets, pagers and PDA’s must be turned off during preclinic, clinic and lab sessions unless faculty approves use.

B. **No Food in any clinic or lab area:**
   a. No food, drink or gum chewing in teaching laboratories or clinic areas.
   b. Everyone should clean his/her own lunch or snack debris by depositing it in the appropriate waste receptacles.
   c. Exercise care when transporting food and drink through the halls.
SECTION FIVE: Referrals
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 Record of Treatment that a dental referral was made and WHY.
6. Give the patient a copy
7. Place a copy in the Office Manager’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 record of treatment, 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.

I. 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

II. Medical Consultation
Patients with the following conditions will require a medical consultation record from his/her physician:

1. Stage II 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 ie. 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 erythematosus
23. Any immunosuppressed patient such as those with acquired immune deficiency syndrome (AIDS)
24. Pregnant patient requiring anesthesia or any other medication
25. Organ transplant

A. CONSULTATION LETTERS

Indications for Physician:
The following is a listing of conditions found during medical histories in which a consultation with the physician will generally be indicated. This is not a total list of conditions needing consultation. Also, patients with these conditions will not always have to have a consultation letter sent. The evaluation of the doctors present will determine the specific times that consultation is necessary.

1. Rheumatic Fever:
A history of rheumatic fever when it is not known whether there is residual rheumatic heart disease (or a heart murmur). Information needed from the physician should include whether a murmur is present or not and, if present, the type. Treatment may be rendered with prophylactic antibiotic coverage.

2. 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.

3. 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?
4. **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.

5. **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.

6. **Congenital Heart Defects**
   Physicians should be asked what type of defect is present.

7. **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.

8. **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.

9. **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.

10. **Pregnancy:**
    b. Anesthesia: Consult with attending dentist. A consultation letter is sent primarily to inform the obstetrician that dental treatment is being rendered.

11. **AIDS, HIV**
    Determine the stage of the patient's disease, the opportunistic infections the patient has and what other associated conditions are present.

12. **Splenectomy**
    Determine if the patient has had a splenectomy and the reason for the procedure, specifically if the patient has sickle cell anemia.
13. 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.

14. 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**

III. Antibiotic Prophylaxis

A. Premedication Procedures

In your Preclinic and Pharmacology courses, you are given information on when to premedicate 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.

B. Premedication with Antibiotics

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:
   - Unrepaired or incompletely repaired cyanotic congenital heart disease, including those with palliative shunts and conduits
   - 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
   - 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.

C. 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.

This recommendation has changed and is much simpler. Now antibiotics are only recommended for these cardiac conditions:

- A prosthetic heart valve or a heart valve repaired with prosthetic material
- A history of endocarditis
- Heart transplant patients who develop abnormal heart valve function
- Certain congenital heart defects including:
  - Cyanotic congenital heart disease (birth defects with oxygen levels lower than normal), that has not been fully repaired, including children who have had a surgical shunts and conduits;
  - A congenital heart defect that’s been completely repaired with prosthetic (artificial) material or a device (either placed by surgery or by catheter intervention) for the first six months after the repair procedure;
  - Repaired congenital heart disease with residual defects (persisting leaks or abnormal flow) at the site or adjacent to the site of a prosthetic patch or prosthetic device.

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.

D. Bacteremia:
Certain cardiac conditions are more often associated with endocarditis than others (see chart). 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.

1. 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.

2. Clinical Judgment:
This statement represents the recommended guidelines to supplement the practitioner in his/her clinical judgement 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.

E. 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.

1. Edentulous Patients:
Edentulous patients may develop bacteremia from ulcers caused by ill-fitting dentures; therefore, denture wearers should be encouraged to have periodic examinations or to return if soreness develops. When new dentures are inserted it is advisable to have the patient return to correct any overextension to avoid
mucosal ulceration.

F. On-Site Pre-Medication: None
There will not be any dispensing of pre-medication on-site. Some dental practices will have on-site medications.

IV. Prescription Medication Contraindications
A. Phen-Fen (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 (feluramine and phentermine) or dexfenfluramine of fenflurameine alone receive a complete physical examination and echocardiogram to determine if they have any adverse heart conditions.

B. 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 echymoses, hematuria (bleeding into the urine), or hemorrhage.

C. 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.

**This list is not all inclusive, always review every medical condition, medication and consult with faculty**
SECTION SIX:

Screener, Clinical Assistant, Radiology and Infection Control Duties
SECTION 6 Screener, Clinical Assistant, Radiology and Infection Control Duties

Screening Appointments

**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.
Screening Appointment Information Form

Name__________________________________________________________

Address______________________________ City:____________________ Zip code:______________

Home Phone_________________ Cell Phone____________ Date of Birth____________ Male___ Female___

Premedication: Yes____ No ____ Heart conditions: Yes____ No ____ Cold Sores: Yes____ No ____

Last Dental Exam? ____ 6 months ____ 1 year ____ 2 years ____ 3 years ____ 4 years ____ Other_____

Last Dental X-Rays? ____ 6 months ____ 1 year ____ 2 years ____ 3 years ____ 4 years ____ Other_____

Last Dental Cleaning? ____ 6 months ____ 1 year ____ 2 years ____ 3 years ____ 4 years ____ Other_____

Are you willing to be a same day call-in patient? ____ Yes ____ No

If yes, is there any day or clinic session time you cannot be a fill-in patient? _______________________

<table>
<thead>
<tr>
<th>Fall Semester Hours (August - December)</th>
<th>Spring Semester Hours (January - May)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuesday 9:00-12:00 and 1:00-4:00 pm</td>
<td>Monday 9:00-12:00 and 1:00-4:00 pm</td>
</tr>
<tr>
<td>Thursday 9:00-12:00 and 1:00-4:00 pm</td>
<td>Tuesday 9:00-12:00 pm</td>
</tr>
<tr>
<td></td>
<td>Wednesday 9:00-12:00 and 1:00-4:00 pm</td>
</tr>
<tr>
<td></td>
<td>Thursday 9:00-12:00 and 1:00-4:00 pm</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Summer Semester Hours (May-July)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuesday 9:00-11:30 and 1:00 – 3:30 pm</td>
</tr>
<tr>
<td>Thursday 9:00-11:30 and 1:00 – 3:30 pm</td>
</tr>
</tbody>
</table>

Information for New and Returning Patients

a. The Dental Clinic at Central Carolina Community College is a supervised learning facility.

b. The care in the clinic is given by students in the Dental Hygiene program. Professional faculty assesses the procedures to ensure quality. A supervising dentist also provides screening exams to ensure that you will be able to get comprehensive care through your family dentist. Students and faculty will also recommend a maintenance schedule that should be completed in cooperation with your family dentist.

c. New patients are typically scheduled with our 2nd year students while returning patients will be scheduled with 1st year students, unless they are a re-care patient for a 2nd year student.

i. The appointment will last about 45 minutes.

ii. Arrive 15 minutes early to complete a health questionnaire and a HIPAA form.

iii. Patients will receive a Patient Responsibilities Form, Scope of Comprehensive DH Care Form and a Patient Information Form.

Signed: ____________________________ Date: __________
Screener Responsibilities

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. Record the date on the health questionnaire.
   b. Call to the prompt attention of the instructor any unusual variation from normal. A medical referral may be indicated.
   c. Blood pressure reading of 140/90 or over is considered stage 1 hypertension, 160/100 is stage 2 hypertension. Pre-hypertension is 120-139/80-89.
   d. It is permissible to treat a patient with systolic < 160 and/or diastolic <99 (159/99). If all readings continue to fall outside these limits, advise patient to consult their physician. Make a note on record of treatment of your conversation with patient and give a medical referral form.
   e. If systolic is above 159 and/or diastolic above 99, check blood pressure in five (5) minutes. If pressure is still elevated, no dental treatment should be performed until the blood pressure problem is corrected. The Medical Referral form from the patient's physician must be placed in the record stating that dental procedures may be performed.
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**

<table>
<thead>
<tr>
<th>Date</th>
<th>Progress Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/17/15</td>
<td>Screening Appt.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>N: Reve Med Hx, EOE/IOE with 2nd Year DH Student.</td>
</tr>
</tbody>
</table>

Student Name/Faculty Name

<table>
<thead>
<tr>
<th>PSR</th>
<th>Date</th>
<th>5/17 (In Eaglesoft)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>
The Screener and CA will also be responsible for organizing student use of radiology for each clinic session.
Assign students requesting radiographs to a clean room
Ensure cleanliness of each radiology room after use by assigned student
Assist the CA in processing Scan-X
Students should leave the appropriate radiology grade sheet with all appropriate information with exposed Scan-X phosphor plates
After processing
Bring phosphor plates, grade sheet and copy of radiographs to faculty for retake approval and sign in of phosphor plates.
Faculty will place in student boxes after approval.

Clinical Assistant Responsibilities

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

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

<table>
<thead>
<tr>
<th></th>
<th>SA</th>
<th>FE</th>
<th>Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td>Maintains asepsis throughout clinical session(s).</td>
</tr>
</tbody>
</table>

**Beginning of Clinical Session**

<table>
<thead>
<tr>
<th></th>
<th>SA</th>
<th>FE</th>
<th>Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td>CA has arrived a minimum of 45 minutes prior to clinic</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td><strong>Compressors and Air units are turned on</strong></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td>Ultrasonics on and solutions ready for cassettes (4 gallons of water, 4 scoops of powder)</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td>Autoclaves: water reservoirs are filled with <strong>distilled water</strong></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td>Clean all countertops (including sterilizer countertops), cabinets, sinks and drawers.</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td><strong>Radiology:</strong> Clean both Scan X machines, Turn all units on and set up rooms and processors for initial use. <strong>Clinical Lab:</strong> Assess for cleanliness/orderly appearance Annotate on back of this sheet</td>
</tr>
</tbody>
</table>

**During Clinical Session**

<table>
<thead>
<tr>
<th></th>
<th>SA</th>
<th>FE</th>
<th>Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td>Create list of items needed from supply room to restock sterilization and units.</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td>Process radiographs, return radiograph grade sheet and phosphor plates to instructor for signature for sign in and retakes.</td>
</tr>
</tbody>
</table>
### Screener, Clinic Assistant, and Infection Control Duties

#### Section 6

<table>
<thead>
<tr>
<th></th>
<th>Tasks</th>
</tr>
</thead>
</table>
| 3 | 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  
   ✓ Ensure that internal indicators are in sterilizers/cassettes/bags  
   ✓ Load into the Lisa or Midmark |
| 4 | Run a fully loaded Lisa/Midmark-verify that all contaminated instruments are processed by peers, empty as needed |
| 5 | Empty Statim reservoir bottle as needed- **check daily, maintain min.**                                |
| 6 | **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 Dry Erase Board. |
| 7 | Stock sterilization supplies-Distribute supplies (student request form)                                 |
| 8 | Create pre-labeled bags for student use (LIDS)                                                          |
| 9 | Distill water daily.                                                                                     |
| 10| Collect & fill unit disinfectant bottles and PD Care wipes                                              |
| 11| Clean/oil handpieces prior to sterilization (DO NOT place handpieces in the ultrasonic)                |
| 12| Maintain lab and sterilization areas—clean and organized                                                |
| 13| Prepare containers of Or-Evac (clean suction lines) for use at end of clinic, will stain counters, keep paper towels under them |
| 14| All other duties as assigned-make/request copies of forms                                                |

#### Completion of Clinical Session

<table>
<thead>
<tr>
<th></th>
<th>Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Set out containers of Or-Evac</strong> (clean suction lines) for use at end of clinic</td>
</tr>
<tr>
<td>2</td>
<td><strong>Verify</strong> all cassettes/equipment are sterilized by classmates</td>
</tr>
<tr>
<td>3</td>
<td>Clean/oil handpieces prior to sterilization (<strong>Do not</strong> ultrasonic)</td>
</tr>
</tbody>
</table>
| 4 | Run contaminated instruments through ultrasonic for 10 minutes  
   ✓ Rinse cassettes/instruments thoroughly with water & Dry  
   ✓ Bag/wrap cassettes/instruments: initial, date and identify sterilizer numbers on bags  
   ✓ Ensure that internal indicators are in sterilizers/cassettes/bags  
   ✓ Load into the Lisa/Midmark |
| 5 | Prepare mop water for daily clinical session (complete toward end)  
   ✓ Sweep/Mop the common areas  
   ✓ Verify that peer students sweep/mop individual operatories |
| 6 | **Verify** units are shut off & equip. replaced to original position                                      |
| 7 | **Verify** radiology rooms are closed down & equip. off (processors)  
   ✓ place tubeheads against the wall with arm closed |
| 8 | **Verify** clinical lab is clean/closed (Annotate names of students in lab)                             |
| 9 | Turn off/drain ultrasonic, turn off Lisa/Midmark (if cycle completes)                                   |
| 10| **Verify** sinks are clean and wiped with baby oil or orange solvent                                    |
| 11| **Verify** dust, debris cleaned from dental chair base, arms & crevices                                 |
| 12| **Verify** all trash has been taken out in the clinic and radiology.                                     |
| 13| **Empty mop water, replace containers of Or-Evac**                                                      |
| 14| **Turn off suction/vacuum pumps system**                                                               |

#### Weekly

<table>
<thead>
<tr>
<th></th>
<th>Tasks</th>
</tr>
</thead>
</table>
| 1 | **Monday:** Refill water bottles with ICX, Check and document Spore Test from previous week  
   **Tuesday:** Clean & lubricate O-rings in suction |
### Last Clinic of the week:
Run Spore Test, EMPTY water bottle-purge lines-store bottle in cabinet

### Monthly

<table>
<thead>
<tr>
<th></th>
<th>SA</th>
<th>FE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Quarterly

<table>
<thead>
<tr>
<th></th>
<th>SA</th>
<th>FE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Assigned Student Duties

Throughout different semesters students are assigned various clinic duties to help maintain our clinic readiness. It is YOUR responsibility to complete your duty daily, weekly or as needed. Students are required to initial and date duty sheet in that area.
SECTION SEVEN: Supplies
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
Section 7

Supplies

Front Cabinet (Bottom Middle)
- Ultrasonic (Cavitron)

Front Cabinet (Bottom Right)
- Topical anesthetic
- Needles
- Protectors
- Fluoride Trays

Side Cabinet (Top Glass Cabinets-OHI Items)
- Polident
- Biotene
- Glide Floss
- Toothpaste
- Kids toothbrushes
- Floss threaders
- Floss
- Reach flosser
- Sensodyne
- Adult toothbrushes

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)
- Peridex (top shelf)
- 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 CA and notify the CA that you are requesting items to be pulled by 8:45. The CA 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 store room, please fill out the request form for the item(s) you removed out of the store room and turn it in to the secretary.

Example Form:

**Inventory Request Form**

Name: __________________________
Date of Request: __________________________

<table>
<thead>
<tr>
<th>ITEM REQUESTED (PLEASE BE SPECIFIC)</th>
<th>QUANTITY NEEDED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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
SECTION EIGHT: GUIDELINES AND POLICIES REGARDING THE USE OF IONIZING RADIOGRAPHS
GUIDELINES AND POLICIES REGARDING THE USE OF IONIZING RADIOGRAPHS

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.

I. SELECTION CRITERIA

A. Films & Frequency:

The following selection criteria will be utilized by Central Carolina Dental Center CCCC Dental Programs to determine films 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 films 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 films or duplicates 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.
2. Retakes will not be permitted until after the radiographs have been reviewed by the faculty.

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.**

II. 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, will not hold films for patients, and will observe patients through the leaded glass shields so that no unnecessary retakes occur as the result of tube, film or patient movement.

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.

III. 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.

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 dried 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 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. Dark Room:

1. The student(s) will be responsible to maintain the cleanliness of the darkroom.
2. The darkroom 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.

IV. 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. 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.

V. STEP-BY-STEP PROCEDURES FOR TAKING RADIOGRAPHS DURING CLINICAL COURSES

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 I, II, and III will require use of the phosphor plate sensor system. Room IV 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 4x4 piece of gauze soaked with disinfectant.
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 Clinical 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 Clinical 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 Clinical 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 Clinical Assistant as to whether or not retakes are required.

13. The Clinical 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 clinical 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 clinical 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 instructor/faculty to verify your conclusions.

3. Take only the retakes requested by the instructor/dentist.

4. If you administer retakes of radiographs without instructor approval, you will be subject to a “0” for the clinical session.

5. Inform the Screener that retakes will need to be added to the previous FMX taken that day. The Screener will follow the same protocol as utilized earlier.
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 patients 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 Clinical Assistant is responsible for cleaning the radiographic operatory.
2. The Clinical Assistant must wipe down lead apron and thyroid collar with 4x4 gauze saturated with disinfecting solution and then hang these items on hooks behind chair.
3. The Clinical 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 Clinical 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.

I. 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.

J. 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. Disposable bite blocks will be used. There is no need to cover bite blocks.
4. Clean the patient positioning area and wipe down the handles and temple holders of the panoramic unit after making the exposure.

K. 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.

VI. 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
# A. SUGGESTED GUIDELINES FOR PRESCRIBING DENTAL RADIOGRAPHS

<table>
<thead>
<tr>
<th>Patient Category</th>
<th>Child</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Dentition</strong> (prior to eruption of first permanent tooth)</td>
<td><strong>Transitional Dentition</strong> (following eruption of first permanent tooth)</td>
</tr>
<tr>
<td><strong>NEW PATIENT * All New Patients to Assess Dental Diseases and Growth and Development</strong></td>
<td><strong>Individualized radiographic examination consisting of periapical/occlusal views &amp; posterior bitewings or panoramic examination &amp; posterior bitewings</strong></td>
</tr>
<tr>
<td><strong>Posterior bitewing examination if proximal surfaces of primary teeth cannot be visualized or probed</strong></td>
<td><strong>Posterior bitewing examination at 6-month intervals or until no carious lesions are evident</strong></td>
</tr>
<tr>
<td><strong>RECALL PATIENT * Clinical caries or high-risk factors for caries</strong> <strong>No clinical caries and no high-risk factors for caries</strong></td>
<td><strong>Posterior bitewing examination at 12-24 month intervals if proximal surfaces of primary teeth cannot be visualized or probed</strong></td>
</tr>
<tr>
<td><strong>Posterior bitewing examination at 12-24 month intervals</strong></td>
<td><strong>Posterior bitewing examination at 12-24 month intervals</strong></td>
</tr>
<tr>
<td><strong>Periodontal disease or a history of periodontal treatment</strong></td>
<td><strong>Individualized radiographic examination consisting of selected periapical and/or bitewing radiographs of areas where periodontal disease (other than nonspecific gingivitis) can be demonstrated clinically</strong></td>
</tr>
<tr>
<td><strong>Growth and development assessment</strong></td>
<td><strong>Individualized radiographic examination consisting of a periapical/occlusal or panoramic examination</strong></td>
</tr>
</tbody>
</table>

* Clinical situations for which radiographs may be indicated include:

**A. Positive Historical Findings**
1. Previous periodontal or endodontic therapy
2. History of pain or trauma
3. Familial history of dental anomalies
4. Postoperative evaluation of healing
5. Presence of implants

**B. Positive Clinical Signs/Symptoms**
1. Clinical evidence of periodontal disease
2. Large or deep restorations
   1. Deep carious lesions
   2. Malposed or clinically impacted teeth
5. Swelling
6. Evidence of facial trauma
7. Mobility of teeth
8. Fistula or sinus tract infection
9. Clinically suspected sinus pathology
10. Growth abnormalities
11. Oral involvement in known or suspected systemic disease
12. Positive neurologic findings in the head and neck
13. Evidence of foreign objects
14. Pain and/or dysfunction of the TMJ
The recommendations in this chart 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.

<table>
<thead>
<tr>
<th>Adolescent</th>
<th>Adult</th>
<th>Edentulous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent Dentition (prior to eruption of third molars)</td>
<td>Dentulous</td>
<td>Full mouth intraoral radiographic examination or panoramic examination</td>
</tr>
<tr>
<td>Individualized radiographic examination consisting of posterior bitewings &amp; selected periapicals. A full mouth intraoral radiographic examination is appropriate when the patient presents with clinical evidence of generalized dental disease or a history of extensive dental treatment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posterior bitewing examination at 6-12 month intervals or until no carious lesions are evident</td>
<td>Posterior bitewing examination at 12-18 month intervals</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Posterior bitewing examination at 18-36 month intervals</td>
<td>Posterior bitewing examination at 24-36 month intervals</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Individualized radiographic examination consisting of selected periapical and/or bitewing radiographs for areas where periodontal disease (other than nonspecific gingivitis) can be demonstrated clinically</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>Periapical or panoramic examination to assess developing third molars</td>
<td>Usually not indicated</td>
<td>Usually not indicated</td>
</tr>
</tbody>
</table>

16. Abutment teeth for fixed or removable partial prosthesis
17. Unexplained bleeding
18. Unexplained sensitivity of teeth
19. Unusual eruption, spacing or migration of teeth
20. Unusual tooth morphology, calcification or color
21. Missing teeth with unknown reason

**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
SECTION NINE:
Radiology Forms
SECTION 9  Radiology Forms

RF 1: Radiology Analysis & Grade-FMS/Individual Periapicals

RF 2: Bitewing Analysis-4 HBWX, 4 VBWX

RF 3: 7-Series Vertical Bitewing Analysis

RF 4: Panoramic Analysis

RF 5: Occlusal Analysis

RF 6: Radiographic Interpretation
# Radiographic Analysis & Grade

**FMX#_____  Radiology Room #_____**

**Student:**

**Date Exposed:**

**Date Submitted:**

**Patient:**

**Age:**

**Type of Radiographs:** FMS, Individual Pedodontics

<table>
<thead>
<tr>
<th>Radiographic Area</th>
<th>Technique Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAXRT MOLAR</td>
<td></td>
</tr>
<tr>
<td>MAXRT PREMOLAR</td>
<td></td>
</tr>
<tr>
<td>MAXRT LAT/CANINE</td>
<td></td>
</tr>
<tr>
<td>MAXCENTRALES</td>
<td></td>
</tr>
<tr>
<td>MAXLAT LAT/CANINE</td>
<td></td>
</tr>
<tr>
<td>MAXLAT PREMOLAR</td>
<td></td>
</tr>
<tr>
<td>MANLAT MOLAR</td>
<td></td>
</tr>
<tr>
<td>MANLAT PREMOLAR</td>
<td></td>
</tr>
<tr>
<td>MANLAT LAT/CANINE</td>
<td></td>
</tr>
<tr>
<td>MANCENTRALES</td>
<td></td>
</tr>
<tr>
<td>MANRT LAT/CANINE</td>
<td></td>
</tr>
<tr>
<td>MANRT PREMOLAR</td>
<td></td>
</tr>
<tr>
<td>MANRT MOLAR</td>
<td></td>
</tr>
<tr>
<td>RT MOLAR RW</td>
<td></td>
</tr>
<tr>
<td>RT PREMOLAR BW</td>
<td></td>
</tr>
<tr>
<td>LFT PREMOL BW</td>
<td></td>
</tr>
<tr>
<td>LFT MOLAR BW</td>
<td></td>
</tr>
</tbody>
</table>

**Deductions**

**Paperwork**

**Technique**

**Analysis**

**Final Grade**

**Permission:** Consult with your instructor concerning retakes. Penalty of 5 points for needed retakes are applied at the discretion of the instructor. Retake without instructor approval = 0 points earned and radiology remediation.

**Instructor Retake Signature:**

**Instructor Grade Signature:**

**Comments:**

Updated July 15, 2015
# BITEWING ANALYSIS

<table>
<thead>
<tr>
<th>BWX#</th>
<th>Radiology Room #</th>
</tr>
</thead>
<tbody>
<tr>
<td>STUDENT:</td>
<td>DATE EXPOSED:</td>
</tr>
<tr>
<td>PATIENT:</td>
<td>DATE SUBMITTED:</td>
</tr>
</tbody>
</table>

**TYPE OF RADIOGRAPHS:** 4 HBWX, 4 VBWX  
(Circle one)

MG Magnified image  
OC Overlap of contact areas  
IDD Incorrect density - too dark  
OB Open bite, patient not biting  
N No film present  
BW Backwards film  
UD Unequal distribution of teeth (BWX only)  
A Angled occlusal plane (arch not parallel to floor or film angled in mouth)  
ME Mounting Error  
H Handling error (fingerprints, scratches, spots, etc.)

<table>
<thead>
<tr>
<th>STUDENT'S SECTION TECHNIQUE ANALYSIS</th>
<th>RADIOGRAPHIC AREA</th>
<th>INSTRUCTOR'S SECTION TECHNIQUE ERRORS &amp; PTS</th>
<th>ANALYSIS ERRORS &amp; PTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retakes</td>
<td>RT MOLAR BITEWING</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>RT PREMOL BITEWING</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>LFT PREMOL BITEWING</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>LFT MOLAR BITEWING</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DEDUCTIONS**

PAPERWORK = 5 points Total  
EACH FILM = 5 points per film  
TOTAL = 100%  
TECHNIQUE = 1 point each error  
ANALYSIS = 1 point each error

**FINAL GRADE**

Example: 5 films (5 films x 5 points = 25 points)  
4 errors (4 errors x -3 points = -12 points)  
40 earned points / 100 possible points = 40%  

**RETAKE POLICY:** Consult with your instructor concerning retakes. Penalty of -5 points for needed retakes are applied at the discretion of the instructor. Retake without instructor approval = 0 points earned and radiology remediation.

Instructor Retake Signature:  
Instructor Grade Signature:  
COMMENTS:

Rev 05/13
# 7-SERIES VERTICAL BITEWING ANALYSIS

<table>
<thead>
<tr>
<th>STUDENT:</th>
<th>DATE EXPOSED:</th>
<th>DATE SUBMITTED:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT:</td>
<td>AGE:</td>
<td>TYPE OF RADIOGRAPHS: 7 VBWX</td>
</tr>
</tbody>
</table>

- MO: Magnified Image
- OC: Overlap of contact areas
- ID: Incorrect density - too dark
- OB: Open bite, patient not biting tab
- N: No film present
- BW: Backwards film
- UD: Unequal distribution of teeth (BW only)
- A: Angled occlusal plane (arch not parallel to floor, or film angled in mouth)
- ME: Mounting Error
- H: Handling error (fingerprints, scratches, spots, etc.)

<table>
<thead>
<tr>
<th>STUDENT'S SECTION</th>
<th>TECHNIQUE ANALYSIS</th>
<th>RADIOGRAPHIC AREA</th>
<th>INSTRUCTOR'S SECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Retakes</td>
<td></td>
<td>ERRORS &amp; PTS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ERRORS &amp; PTS</td>
</tr>
<tr>
<td>1. RT MOLAR BITEWING</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. RT PREMOL BITEWING</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. RT CANINELATERAL BW</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. CENTRAL BITEWING</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. LFT CANINELATERAL BW</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. LFT PREMOL BITEWING</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. LFT MOLAR BITEWING</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DEDUCTION S**

**PAPERWORK**

**FINAL GRADE**

**RETAKE POLICY:** Consult with your instructor concerning retakes. Penalty of -5 points for needed retakes are applied at the discretion of the instructor. Retake without instructor approval=0 points earned and radiology remediation.

**Instructor Retake Signature:**

**Instructor Grade Signature:**

**COMMENT S:**

---

*Updated July 15, 2015*
# PANORAMIC ANALYSIS

**STUDENT:** ____________ **PATIENT:** ____________ **AGE:** _____ **DATE:** ____________

**PANOREX GENERAL CRITERIA:**
1. Image should be properly recorded in Eaglesoft patient record.
2. Image should be centered on film.
3. Density of film should be neither too dark or too light.
4. Overall image or any part of image should not be blurred.
5. Maxillary and mandibular teeth should not overlap occlusally.
6. No foreign object should be superimposed on the film.

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>RESULTING ERROR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Lips not closed or tongue not on palate</td>
</tr>
<tr>
<td>2.</td>
<td>Chin too high, Frankfort plane angled upward</td>
</tr>
<tr>
<td>3.</td>
<td>Chin too low, Frankfort plane angled downward</td>
</tr>
<tr>
<td>4.</td>
<td>Ant teeth too forward on bite block, out of focal trough</td>
</tr>
<tr>
<td>5.</td>
<td>Ant teeth too far back on bite block, out of focal trough</td>
</tr>
<tr>
<td>6.</td>
<td>Mid sag plane tipped (perpendicular light not centered)</td>
</tr>
<tr>
<td>7.</td>
<td>Spine not straight, patient slumped or neck bent</td>
</tr>
<tr>
<td>8.</td>
<td>Incorrect density (light or dark)</td>
</tr>
<tr>
<td>9.</td>
<td>Ghost images or superimposed images</td>
</tr>
<tr>
<td>10.</td>
<td>Lead apron</td>
</tr>
<tr>
<td>11.</td>
<td>Image not centered</td>
</tr>
<tr>
<td>12.</td>
<td>Entry of data in all places</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>RESULTING ERROR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Dark shadow over anteriors teeth, &amp; max apices</td>
</tr>
<tr>
<td>2.</td>
<td>Palate and floor of nose over roots of max teeth &amp;/or max incisors blurred and magnified &amp;/or &quot;REVERSE SMILE&quot;</td>
</tr>
<tr>
<td>3.</td>
<td>Max incisors blurred &amp;/or CONDYLE'S missing &amp;/or &quot;EXAGERATED SMILE&quot; &amp;/or Inferior border of max missing</td>
</tr>
<tr>
<td>4.</td>
<td>Ant teeth buried &amp;/or appear &quot;skinny&quot; &amp; out of focus</td>
</tr>
<tr>
<td>5.</td>
<td>Teeth blurred &amp;/or Ant tooth appear &quot;fat&quot; &amp; out of focus</td>
</tr>
<tr>
<td>6.</td>
<td>Side of head farthest from film appears magnified, side closest appears smaller</td>
</tr>
<tr>
<td>7.</td>
<td>Cervical spine obscures center of film</td>
</tr>
<tr>
<td>8.</td>
<td>Selected wrong patient type</td>
</tr>
<tr>
<td>9.</td>
<td>Failure to remove earrings, other head/neck jewelry or dental appliances</td>
</tr>
<tr>
<td>10.</td>
<td>Incorrectly places apron, or uses a thyroid collar</td>
</tr>
<tr>
<td>11.</td>
<td>Head not centered, slanted to the side</td>
</tr>
<tr>
<td>12.</td>
<td>Pt data not complete on Pan. exam. or record</td>
</tr>
</tbody>
</table>

1. **TOTAL POSSIBLE (120) - POINTS DEDUCTED = TOTAL EARNED**
2. **TOTAL POSSIBLE = TOTAL EARNED x 100 = GRADE**

**COMMENTS:**

---

Updated July 15, 2015


## Occlusal Analysis

**Student:**

**Patient:**

**Age:**

**Date:**

### Occlusal General Criteria:

1. Type of radiograph taken should be properly recorded in notes.
2. Image should be centered on film.
3. Density of film should be neither too dark nor too light.
5. No foreign object should be superimposed on the film.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Resulting Error</th>
<th>Student Analysis</th>
<th>Value 0 to 10</th>
<th>Instructor Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Correct size sensor not used</td>
<td>Maxillary and/or mandibular teeth not imaged. Excessive cone cut.</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>2. Central ray not directed toward the midline of the arch toward the center of the film</td>
<td>Teeth not centered on sensor. Excessive overlap/blurred image</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>3. Central ray is not directed at ±90 degrees toward the center of the film (Maxillary Topographic), ±60 (Maxillary Lateral Occlusal, Pediatric), ±45 (Mandibular Topographic, Pediatric), ±90 (Mandibular Cross-Sectional)</td>
<td>Excessive cone cut, overlap, necessary maxillary/mandibular teeth not imaged.</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>4. All removable appliances/objects not removed from mouth</td>
<td>Ghost image or superimposed images</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>5. Incorrect density (light or dark)</td>
<td>Selected wrong kVp, mA, time.</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>6. Processing or handling errors</td>
<td>Finger prints, scratches, exposed film etc.</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>7. Entry of data not in all places</td>
<td>Type of radiograph not recorded in notes</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

1. TOTAL POSSIBLE (70) - POINTS DEDUCTED = TOTAL LEARNED
2. TOTAL POSSIBLE = TOTAL LEARNED x 100 = GRADE

GRADE  =  

**Comments:**

---

Updated July 15, 2015
Radiographic Interpretation
Central Carolina Community College

List radiopaque and radiolucent landmarks for each radiograph:

Maxilla:
- R. Molar
- R. Premolar
- R. Lateral/Canine
- Central
- L. Lateral/Canine
- L. Premolar
- L. Molar

Mandible:
- L. Molar
- L. Premolar
- L. Lateral/Canine
- Central
- R. Lateral/Canine
- R. Premolar
- R. Molar

Bitewings:
- R. Molar
- R. Premolar
- L. Premolar
- L. Molar

Draw a line for alveolar bone to represent height of bone.
Annotate carious lesions in red. Draw a blue c to represent calculus.
Anomalies: __________________

July 30, 2014
RF 6
SECTION TEN: Dental Materials Lab
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 quarter. 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.

**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 out, 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.

<table>
<thead>
<tr>
<th>Student Supplies Purchased By Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protective lenses</td>
</tr>
<tr>
<td>Waterproof sandpaper</td>
</tr>
<tr>
<td>Pencils</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-Expendable Items Furnished by Dental Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green rubber bowl</td>
</tr>
<tr>
<td>Powder measurer</td>
</tr>
<tr>
<td>Curing light</td>
</tr>
<tr>
<td>Glass plates (2)</td>
</tr>
<tr>
<td>Amalgam</td>
</tr>
<tr>
<td>Glass slab</td>
</tr>
<tr>
<td>Parchment mixing pad</td>
</tr>
<tr>
<td>Lab knife</td>
</tr>
<tr>
<td>Cement spatula</td>
</tr>
<tr>
<td>Amalgam carrier</td>
</tr>
<tr>
<td>Cotton pliers</td>
</tr>
<tr>
<td>Ball burnisher</td>
</tr>
<tr>
<td>Black Spoon</td>
</tr>
<tr>
<td>Condensor/Plugger</td>
</tr>
<tr>
<td>R-50 Cord Packer</td>
</tr>
<tr>
<td>Mirror</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expendable Items Furnished by Dental Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 x 2 gauze squares</td>
</tr>
<tr>
<td>Alcohol Prep Pads</td>
</tr>
<tr>
<td>Orange Solvent</td>
</tr>
</tbody>
</table>
### Key: Evaluate each step as:  
S = satisfactory  or  N = needs improvement

**FE=Faculty Evaluation   SA=Student Self-Assessment**

**Individual students are responsible for maintaining Station Drawers and Sim Manikins**

### Beginning of Lab Session

<table>
<thead>
<tr>
<th>SA</th>
<th>FE</th>
<th>Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>SLA has arrived a minimum of 10 minutes prior to lab</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td><strong>Compressors and Air units are turned on</strong></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Sim Lab is clean and orderly</td>
</tr>
</tbody>
</table>
| 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

<table>
<thead>
<tr>
<th>SA</th>
<th>FE</th>
<th>Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>Ensure that individual Sim Manikins and stations are <strong>clean</strong>, free of debris and fully operational (Classmates should annotate any problems with Sim Manikins)</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Clean countertops (spray, wipe, spray, wipe until no smear layer)</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Clean ALL cabinets of dust, debris</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>Put away any supply items used during the lab session</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>Sweep/Mop any areas that have debris</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>Ensure that ALL water bottles are emptied</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td><strong>Verify</strong> Sim manikins are shut off &amp; equip. replaced to original position</td>
</tr>
<tr>
<td>8</td>
<td></td>
<td>All dust, debris cleaned from base and crevices of operator chairs</td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>Clean sinks then wipe with baby oil or orange solvent</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>Turn off all model trimmers (including water)</td>
</tr>
<tr>
<td>11</td>
<td></td>
<td>Restock supplies using list and refill all disinfectant wipe containers</td>
</tr>
<tr>
<td>12</td>
<td></td>
<td><strong>Verify</strong> simulation lab is clean/closed (Annotate names of students in lab)</td>
</tr>
<tr>
<td>13</td>
<td></td>
<td>Maintained asepsis</td>
</tr>
</tbody>
</table>

Comments: ________________________________________________________________

___________________________  _____________________________
Instructor Signature                                               Date      Sim Lab Assistant Signature  Date
SECTION ELEVEN: Clinical Rotations
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.

Possible Rotation Sites:
- Fort Bragg/Pope AAF
- Piedmont Health Moncure
- FirstHealth
- Harnett Correctional
- Womack Army Medical Center

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.

- Have your pass and ID card if applicable for entrance to building on Fort Bragg/Pope Army Air Field.

- 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. Base 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).
**Required Items-Civilians**

(*Items must be in 15-20 working days prior to rotation*)

<table>
<thead>
<tr>
<th>Required Item</th>
<th>Completed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original Birth Certificate, OR Certified Copy of Birth Certificate (1st Day of Rotation)</td>
<td>Check Off</td>
</tr>
<tr>
<td>Current Immunizations:</td>
<td></td>
</tr>
<tr>
<td>Influenza, MMR, PPD, HEP B series, Varicella (Chicken Pox), TD is recommended</td>
<td></td>
</tr>
<tr>
<td>Latex Sensitivity Form 736</td>
<td></td>
</tr>
<tr>
<td>Current CPR/BLS card copy</td>
<td></td>
</tr>
<tr>
<td>Completed SF 85P (Questionnaire for Public Trust Positions)</td>
<td></td>
</tr>
<tr>
<td>Form 1602 DA Civilian ID-Post Access Badge</td>
<td></td>
</tr>
<tr>
<td>Wearing of the WAMC ID Badge</td>
<td></td>
</tr>
<tr>
<td>*DOD HIPAA training (on-line) <a href="https://mhslearn.csd.disa.mil">https://mhslearn.csd.disa.mil</a></td>
<td></td>
</tr>
<tr>
<td>Fire Safety Test</td>
<td></td>
</tr>
<tr>
<td>Infection Control Test</td>
<td></td>
</tr>
<tr>
<td>Ancillary Clinical</td>
<td></td>
</tr>
<tr>
<td>Standards of Conduct</td>
<td></td>
</tr>
<tr>
<td>Ch 8 Monitoring Medication Use</td>
<td></td>
</tr>
<tr>
<td>Joint Commission Do Not Use List</td>
<td></td>
</tr>
<tr>
<td>Medical Staff Summary Health Care Trainees</td>
<td></td>
</tr>
<tr>
<td>General Safety</td>
<td></td>
</tr>
<tr>
<td>Hazardous Chemicals and Materials</td>
<td></td>
</tr>
<tr>
<td>Infection Control Information</td>
<td></td>
</tr>
<tr>
<td>Needlestick/Bloodborne Pathogens</td>
<td></td>
</tr>
<tr>
<td>Parking Policy Memo</td>
<td></td>
</tr>
<tr>
<td>Health Care Trainee Rotations</td>
<td></td>
</tr>
<tr>
<td>Documentation of Volunteer Service</td>
<td></td>
</tr>
<tr>
<td>Dental Hygienist (Supervision)</td>
<td></td>
</tr>
<tr>
<td>Declaration for Federal Employment</td>
<td></td>
</tr>
</tbody>
</table>

**On last day of rotation:**

**Report back to GME office.**

**Turn in:**

1. Hospital Badge
2. Post Access Badge
3. Copy of rotation evaluation

---

**Fort Bragg/Pope AAF Paperwork**

**Medical History**
## Fort Bragg/Pope AAF Paperwork

**Record of Treatment 603 Side 1**

---

### DENTAL PATIENT MEDICAL HISTORY

<table>
<thead>
<tr>
<th>NAME (Last, First, Middle Initial)</th>
<th>SPONSOR'S SSN</th>
<th>AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ORGANIZATION (Active Duty or Home Address)**

**DUTY PHONE**

**HOME PHONE**

**FLYING STATUS?**

**SDP (PRP, SCI, or PES)**

The Answers To The Following Questions Will Assist The Dentist In Evaluating Your General Health Prior To Providing your Dental Treatment. PLEASE READ CAREFULLY AND ANSWER EACH QUESTION AS ACCURATELY AS POSSIBLE.

1. **WHAT IS YOUR IMPRESSION OF YOUR PRESENT OVERALL REALITY?**

2. **2. YEAR OF LAST MEDICAL PHYSICAL?**

<table>
<thead>
<tr>
<th>Heart Disease or Condition</th>
<th>Rheumatic Fever</th>
<th>Arthritis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angina Pectoris</td>
<td>Stroke</td>
<td>Asthma</td>
</tr>
<tr>
<td>Frequent Chest Pain</td>
<td>Homophobia</td>
<td>Hay Fever</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>Bronchitis</td>
<td>Employees</td>
</tr>
<tr>
<td>Shortness of Breath</td>
<td>Prolonged or Unusual Bleeding</td>
<td>Tuberculosis (TB)</td>
</tr>
<tr>
<td>Swollen Ankles</td>
<td>Anemia</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Artificial Heart Valve</td>
<td>Blood Transfusion</td>
<td>Ulcers</td>
</tr>
<tr>
<td>Congenital Heart Disease</td>
<td>Sickle Cell Disease</td>
<td>Kidney Trouble</td>
</tr>
<tr>
<td>Heart Murmur</td>
<td>Anemia</td>
<td>Liver Disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Insufficiency (Catar then birth)</td>
</tr>
</tbody>
</table>

**CIRCLE YES OR NO FOR THE FOLLOWING QUESTIONS (If Yes, Circle Yes; If Yes, Please Give Details). CONTINUE COMMENTS ON BACK IF NECESSARY.**

4. **ARE YOU PRESENTLY, OR HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN IN THE PAST YEAR?**

5. **ARE YOU PRESENTLY TAKING ANY MEDICINE OR DRUGS (OVER-THE-COUNTER / PRESCRIPTION / HERBAL SUPPLEMENTS)?**

6. **ARE YOU ALLERGIC TO ANY MEDICINE OR MATERIALS (INCLUDING LATEX)?**

7. **HAVE YOU EVER HAD A REACTION TO LOCAL ANESTHETIC?**

8. **HAVE YOU EVER EXPERIENCED ANY COMPLICATION OR ILLNESS FOLLOWING DENTAL TREATMENT?**

9. **DO YOU HAVE ANY DISEASES OR CONDITIONS NOT MENTIONED ABOVE?**

10. **HAVE YOU EVER BEEN TOLD YOU WERE NOT ELIGIBLE TO BE A BLOOD DONOR?**

11. **HAVE YOU EVER BEEN TOLD TO TAKE ANTIBIOTICS PRIOR TO DENTAL CARE?**

12. **DO YOU USE TOBACCO?**

13. **WOMEN — ARE YOU PREGNANT?**

**SIGNATURE OF PATIENT (Or Legal Guardian If Patient is a Minor)**

---

**DENTIST COMMENTS**

**REVIEWER/DATE**

---

**APMT 696, 2007/2010 INTERIM**

**PREVIOUS EDITION IS OBSOLET**
### SECTION II. CHRONOLOGICAL RECORD OF DENTAL CARE

#### 8. RESTORATIONS AND TREATMENTS (Completed during service)

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
</tr>
</thead>
</table>

#### 9. SUBSEQUENT DISEASES AND ABNORMALITIES

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
</tr>
</thead>
</table>

#### REMARKS

- **Pen**
- **Pencil**

#### 10. SERVICES PROVIDED

<table>
<thead>
<tr>
<th>DATE</th>
<th>SYMPTOMS, DIAGNOSIS, TREATMENT, PROVIDER, TREATMENT FACILITY (Sign each entry)</th>
<th>CLASS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PATIENT’S NAME:** Tosis, Hali

**SSN:** 123-45-6789

---

**Fort Bragg/Pope AAF Paperwork**  
**Record of Treatment 603a Side 1**
### Section 11: Base Clinical Rotations

#### Fort Bragg/Pope AAF Paperwork

**Record of Treatment 603a Side 2**

---

**HEALTH RECORD**

<table>
<thead>
<tr>
<th>SECTI</th>
<th>OI</th>
<th>MATT</th>
<th>EENT</th>
<th>NER</th>
<th>MUS</th>
<th>GAST</th>
<th>REN</th>
<th>CIR</th>
<th>OTH</th>
<th>FNA</th>
<th>LIG</th>
<th>NEU</th>
<th>ORTH</th>
<th>PATH</th>
<th>PSYCH</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1</td>
<td>C2</td>
<td>C3</td>
<td>C4</td>
<td>C5</td>
<td>C6</td>
<td>C7</td>
<td>C8</td>
<td>C9</td>
<td>C10</td>
<td>C11</td>
<td>C12</td>
<td>C13</td>
<td>C14</td>
<td>C15</td>
<td>C16</td>
</tr>
</tbody>
</table>

**DENTAL - Continuation**

#### Section II: Chronological Record of Dental Care

8. Restorations and Treatments (Completed during service)

9. Subsequent Diseases and Abnormalities

**Remarks**

---

**10. Services Provided**

<table>
<thead>
<tr>
<th>DATE</th>
<th>SYMPTOMS</th>
<th>DIAGNOSIS</th>
<th>TREATMENT</th>
<th>PROVIDER</th>
<th>TREATMENT FACILITY (Sign each entry)</th>
<th>CLASS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Periodic Oral Eval**

**Initial Charting** Yes/No

**BP**

**Pain Index** /10

**PSR**

**Caries Risk**

1=LOW 2=MID 3=HIGH

**Radiographs**

**BWXR:**

**PANO:**

**PER XRs:**

**Oral Cancer Screening Findings:**

**Radiographic Findings:**

**Clinical Findings:**

**Disposition:**

(Check all that apply)

**Pros Eval**

**OS Eval**

**Endo Eval**

**Fluoride at Pro**

**Perio Eval**

**Oper X**

**Other**

**Class I After Pro? Yes/No**

**Examiner Stamp/Signature**

**Assistant**

---

**Patient's Identification (Use this Space for Mechanical Implant)**

**Patient's Name** (Last, First, Middle Initial)

**Date of Birth**

**Relationship to Sponsor**

**Component/Status**

**Department**

**Sponsor's Name**

**Rank/Grade**

**SSN or Identification No**

**Organization**

**Exception to SF 603A**

**Approved by GSA/RMS 1:91**

---

**Standard Form 603A (10-75)**

**GSA/CMR**

**FRMR (41 CFR) 201-45 505**

---

145
### Section II. Chronological Record of Dental Care

#### 8. Restorations and Treatments (Completed during service)

|   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |

#### 9. Subsequent Diseases and Abnormalities

|   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |

#### 10. Services Provided

<table>
<thead>
<tr>
<th>Date</th>
<th>Symptoms, Diagnosis, Treatment, Provider, Treatment Facility (Sign each entry)</th>
<th>Class</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Patient's Name:**

**SSN:**

---

**Harnett Correctional Institute**
The following information is required before you can attend the Orientation for HCI:

<table>
<thead>
<tr>
<th>Name</th>
<th>D.O.B</th>
<th>Driver’s License #</th>
<th>Social Security #</th>
<th>Sex</th>
<th>Race</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hali Tosis</td>
<td>01/23/1974</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
DEN _____  
Extramural Site Evaluation

Name:______________________  Date:___________________

Place a check mark in the appropriate box for each criterion under “CA” for clinically acceptable performance, or under “U” for unacceptable performance.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Student Evaluation</th>
<th>CA</th>
<th>U</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Student arrived at facility on time and was prepared for site rotation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Student demonstrated adequate clinical skills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Student used proper aseptic technique and PPE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Student performed as part of the dental team</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Student showed appropriate professional behavior</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Student used correct dental terminology to present information to staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Student communicated with patients in an appropriate manner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Students overall performance was adequate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Student must complete all items to a clinically acceptable level.

Comments:

Evaluators signature:______________________________
APPENDIX

A
Appendix A: American Dental Hygienist’s 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.
Appendix A

American Dental Hygienist’s Association Code of Ethics

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 well being 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 well being 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
Appendix B  Standards of Care

Standard 1: Assessment
Assessment is the systematic collection, analysis and documentation of the oral and general health status and patient needs. The dental hygienist conducts a thorough, individualized assessment of the person with or at risk for oral disease or complications. The assessment process requires ongoing collection and interpretation of relevant data. A variety of methods may be used including radiographs, diagnostic tools, and instruments.

I. Patient History:
   a. Record personal profile information such as demographics, values and beliefs, cultural influences, knowledge, skills and attitudes.
   b. Record current and past dental and dental hygiene oral health practices.
   c. Collection of health history data includes the patient’s:
      1. Current and past health status
      2. Diversity and cultural considerations (e.g. age, gender, religion, race and ethnicity)
      3. Pharmacologic considerations (e.g. prescription, recreational, over the counter (OTC), herbal)
      4. Additional considerations (e.g. mental health, learning disabilities, phobias, economic status)
      5. Record vital signs and compare with previous readings
      6. Consultation with appropriate healthcare provider(s) as indicated.

II. Perform a comprehensive clinical evaluation which includes:
   a. A thorough examination of the head and neck and oral cavity including an oral cancer screening, evaluation of trauma and a temporomandibular joint (TMJ) assessment.
   b. Evaluation for further diagnostics including radiographs.
   c. A comprehensive periodontal evaluation that includes the documentation of:
      1. Full mouth periodontal charting:
         • Probing depths
         • Bleeding points
         • Suppuration
         • Mucogingival relationships/defects
         • Recession
         • Attachment level/attachment loss
         • Presence, degree and distribution of plaque and calculus
         • Gingival health/disease
         • Bone height/bone loss
• Mobility and fremitus
• Presence, location and extent of furcation involvement
• A comprehensive hard tissue evaluation that includes the charting of existing conditions and oral habits.
• demineralization
• caries
• defects
• sealants
• existing restorations and potential needs
• anomalies
• occlusion
• fixed and removable prostheses
• missing teeth

III. Risk Assessment:
Risk assessment is a qualitative and quantitative evaluation gathered from the assessment process to identify any risks to general and oral health. The data provides 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):
• Fluoride exposure
• Tobacco exposure including smoking, smokeless/spit tobacco and second hand smoke
• Nutrition history and dietary practices
• Systemic diseases/conditions (e.g. diabetes, cardiovascular disease, autoimmune, etc.)
• Prescriptions and over-the-counter medications, and complementary therapies and practices (e.g. fluoride, herbal, vitamin and other supplements, daily aspirin)
• Salivary function and xerostomia
• Age and gender
• Genetics and family history
• Habitual and lifestyle behaviors
• Cultural issues
• Substance abuse (recreational drugs, alcohol)
• Eating disorders
• Piercing and body modification
• Oral habits (citrus, toothpicks, lip/cheek biting)
• Sports and recreation
• Physical disability
• Psychological and social considerations
• Domestic violence
• Physical, emotional, or sexual abuse Behavioral
• Behavioral
• Psychiatric
• Special needs
• Literacy
• Economic
• Stress
• Neglect

Standard 2: Dental Hygiene Diagnosis
The dental hygiene diagnosis is a component of the overall dental diagnosis. The dental hygiene diagnosis is the identification of an existing or potential oral health problem that a dental hygienist is educationally qualified and licensed to treat. The dental hygiene diagnosis requires analysis of all available assessment data and the use of critical decision making skills in order to reach conclusions about the patient's dental hygiene treatment needs.

I. Analyze and interpret all assessment data to evaluate clinical findings and formulate the dental hygiene diagnosis.

II. Determine patient needs that can be improved through the delivery of dental hygiene care.

III. Incorporate the dental hygiene diagnosis into the overall dental treatment plan.

Standard 3: Planning
Planning is the establishment of goals and outcomes based on patient needs, expectations, values, and current scientific evidence. The dental hygiene plan of care is based on assessment findings and the dental hygiene diagnosis. The dental hygiene treatment plan is integrated into the overall dental treatment plan. Dental hygienists make clinical decisions within the context of ethical and legal principles.

I. Identify, prioritize and sequence dental hygiene intervention (e.g. education, treatment, and referral).

II. Coordinate resources to facilitate comprehensive quality care (e.g. current technologies, pain management, adequate personnel, appropriate appointment sequencing and time management).

III. Collaborate with the dentist and other health/dental care providers and community-based oral health programs.

IV. Present and document dental hygiene care plan to patient.

V. Explain treatment rationale, risks, benefits, anticipated outcomes, treatment alternatives, and prognosis.

VI. Obtain and document informed consent and/or informed refusal.

Standard 4: Implementation
Implementation is the delivery of dental hygiene services based on the dental hygiene care plan in a manner minimizing risk and optimizing oral health.

I. Review and implement the dental hygiene care plan with the patient/caregiver.

II. Modify the plan as necessary and obtain consent.

III. Communicate with patient/caregiver appropriate for age, language, culture and learning style.

IV. Confirm the plan for continuing care.
Standard 5: Evaluation
Evaluation is the process of reviewing and documenting the outcomes of dental hygiene care. Evaluation occurs throughout the process of care.

I. Use measurable assessment criteria to evaluate the 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. Collaborate to determine the need for additional diagnostics, treatment, referral, education and continuing care based on treatment outcomes and self-care behaviors.

Standard 6: Documentation
Documentation is the complete and accurate recording of all collected data, treatment planned and provided, recommendations, and other information relevant to patient care and treatment.

I. Documents all components of the dental hygiene process of care (assessment, dental hygiene diagnosis, planning, implementation, and evaluation).

II. Objectively records all information and interactions between the patient and the practice (i.e. telephone calls, emergencies, prescriptions).

III. Records legible, concise and accurate information (i.e. dates and signatures, clinical information that subsequent providers can understand, ensure all components of the patient record are accurately labeled).

IV. Recognizes ethical and legal responsibilities of record keeping including guidelines outlined in state regulations and statutes.

V. Ensures compliance with the federal Health Information Portability and Accountability Act (HIPAA).

VI. Respects and protects the confidentiality of patient information.
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.
A. **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 X-Rays.
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 X-Rays, 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.

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

B. **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.

C. **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.
D. 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.

E. 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.

F. 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.
G. 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.

H. 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 the 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 30, 2014. 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.