# TABLE OF CONTENTS

**SECTION 1: DENTAL HYGIENE SEQUENCE OF CLINICAL PROCEDURES**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Clinic Policies</td>
<td>1</td>
</tr>
<tr>
<td>Ethics, Conduct, and Attendance</td>
<td>1</td>
</tr>
<tr>
<td>Patient Pool</td>
<td>2</td>
</tr>
<tr>
<td>Scheduling Patients/Obtaining Records</td>
<td>2</td>
</tr>
<tr>
<td>Eaglesoft Scheduling</td>
<td>4</td>
</tr>
<tr>
<td>Scheduling Appointments</td>
<td>5</td>
</tr>
<tr>
<td>Block Scheduling</td>
<td>6</td>
</tr>
<tr>
<td>Sample Scheduling with Codes</td>
<td>7</td>
</tr>
<tr>
<td>Special Guidelines for Scheduling Patients in DEN 131, DH Clinic 1</td>
<td>8</td>
</tr>
<tr>
<td>Before You See Any Patient</td>
<td>8</td>
</tr>
<tr>
<td>Procedures Before Seating Patient</td>
<td>9</td>
</tr>
<tr>
<td>Seating the Patient Before Check-In</td>
<td>10</td>
</tr>
<tr>
<td>Cancelled or Failed Appointments</td>
<td>10</td>
</tr>
<tr>
<td>Changing a Scheduled Appointment</td>
<td>11</td>
</tr>
<tr>
<td>Significance of Flags</td>
<td>11</td>
</tr>
<tr>
<td>Review of the Health Questionnaire (Medical History) - Blue</td>
<td>12</td>
</tr>
<tr>
<td>Dental Consent/Interview - Blue</td>
<td>14</td>
</tr>
<tr>
<td>Patient Privacy Act (HIPAA) - White</td>
<td>14</td>
</tr>
<tr>
<td>Extraoral/Intraoral Inspection - Yellow</td>
<td>15</td>
</tr>
<tr>
<td>Restorative Charting - Yellow</td>
<td>15</td>
</tr>
<tr>
<td>Periodontal Charting - Green</td>
<td>15</td>
</tr>
<tr>
<td>The Treatment Plan Worksheet - Green</td>
<td>16</td>
</tr>
<tr>
<td>The Dental Hygiene Care Plan and Diagnosis - Green</td>
<td>16</td>
</tr>
<tr>
<td>Record of Treatment</td>
<td>17</td>
</tr>
<tr>
<td>Check-In</td>
<td>17</td>
</tr>
<tr>
<td>Classification of Patients</td>
<td>19</td>
</tr>
<tr>
<td>Oral Prophylaxis</td>
<td>21</td>
</tr>
<tr>
<td>Patient Education</td>
<td>22</td>
</tr>
<tr>
<td>Check-Out</td>
<td>22</td>
</tr>
<tr>
<td>Dismissal of Patient</td>
<td>26</td>
</tr>
<tr>
<td>Filing the Dental Record</td>
<td>27</td>
</tr>
<tr>
<td>Completion of Dental Appointment</td>
<td>27</td>
</tr>
<tr>
<td>Cancellation and Failed Appointments</td>
<td>28</td>
</tr>
</tbody>
</table>

**SECTION 2: EVALUATION CRITERIA, TUTORIAL, & PROFICIENCIES**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Clinic/Clinic Evaluation Definitions</td>
<td>29</td>
</tr>
<tr>
<td>Evaluation of Medical History &amp; Health Questionnaire</td>
<td>31</td>
</tr>
<tr>
<td>Required Evaluation</td>
<td>33</td>
</tr>
<tr>
<td>End-Product Evaluation Formula</td>
<td>33</td>
</tr>
<tr>
<td>Evaluation of Intraoral/Extraoral Inspection</td>
<td>34</td>
</tr>
<tr>
<td>Sequence of Procedure</td>
<td>34</td>
</tr>
<tr>
<td>Required Evaluation</td>
<td>35</td>
</tr>
<tr>
<td>End-Product Evaluation Formula</td>
<td>35</td>
</tr>
<tr>
<td>Evaluation of Restorative Charting (CF 4)</td>
<td>35</td>
</tr>
<tr>
<td>Sequence of Procedure</td>
<td>35</td>
</tr>
</tbody>
</table>
# TABLE OF CONTENTS

- **Required Evaluation** .................................................. 36
- **End-Product Evaluation Formula** .................................. 36
- **Evaluation of Periodontal Charting** .............................. 37
  - **Sequence of Procedure** ........................................ 37
  - **Required Evaluation** ........................................... 37
  - **End-Product Evaluation Formula** .............................. 38
- **Evaluation of Dental Hygiene Plan** .............................. 38
  - **Sequence of Procedure** ........................................ 38
  - **Required Evaluation** ........................................... 39
  - **End-Product Evaluation Formula** .............................. 39
- **Evaluation of Calculus Removal** ................................. 40
  - **Sequence of Procedure** ........................................ 40
  - **Required Evaluation** ........................................... 40
  - **End-Product Evaluation Formula** .............................. 40
  - **Patient Classification Values for Oral Prophylaxes** ....... 41
- **Evaluation of Stain and Soft Deposit Removal** ............... 41
  - **Sequence of Procedure** ........................................ 41
  - **Required Evaluation** ........................................... 43
  - **End-Product Evaluation Formula** .............................. 43
  - **Stain/Soft Deposit Values for Oral Prophylaxes** .......... 43
- **Process Evaluation Points (Points Below the Line)** .......... 43
  - **Sequence of Procedure** ........................................ 44
  - **Instrument Exchange: Hu-Friedy** ............................. 45
- **Evaluation of Desensitization** .................................. 47
  - **Sequence of Procedure** ........................................ 47
  - **Required Evaluation** ........................................... 48
- **Evaluation of Root Planing** ...................................... 48
  - **Sequence of Procedure** ........................................ 48
  - **Required Evaluation** ........................................... 49
- **Evaluation of Sealants** .......................................... 49
  - **Sequence of Procedure** ........................................ 49
  - **Required Evaluation** ........................................... 51
- **Evaluation of Prophy Jet (Air Polisher)** ...................... 51
  - **Sequence of Procedure** ........................................ 51
  - **Required Evaluation** ........................................... 53
- **Evaluation of Ultrasonic Scaler** ................................ 54
  - **Sequence of Procedure** ........................................ 54
  - **Required Evaluation** ........................................... 55
- **Evaluation of Fluoride Treatment** ............................. 55
  - **Sequence of Procedure** ........................................ 55
  - **Tray Technique** ................................................ 56
  - **Varnish Technique** ............................................. 57
  - **Required Evaluation** ........................................... 57
- **Evaluation of Subgingival Medicaments** ...................... 57
  - **Sequence of Procedure** ........................................ 57
- **Request for Anesthesia** .......................................... 58
  - **Sequence of Procedure** ........................................ 58
# TABLE OF CONTENTS

- **REQUIRED EVALUATION** ................................................................. 59  
- **PERIODONTAL RE-EVALUATION** ................................................... 59

**SECTION 3: CLINICAL EVALUATION OF STUDENT PERFORMANCE** 63  
- **HOW TO COMPLETE A GRADE SHEET IN CLINIC (CF 007).** ............... 63  
- **ENTERING A GRADE SHEET INTO DENTAL SCORING.** ....................... 64  
- **GRADE SHEET EXAMPLE** ............................................................. 67

**SECTION 4: CHARTS** 68  
- **RECORD LOCATIONS** ................................................................. 68  
- **OBTAINING RECORDS** ............................................................... 68  
- **ORDER OF FORMS** ................................................................. 68  
- **INABILITY TO FIND A RECORD** ................................................... 69

**SECTION 5: REFERRALS** 70  
- **DENTAL REFERRALS** ................................................................. 70  
- **MEDICAL REFERRALS** ............................................................... 70  
- **PREMEDICATION PROCEDURES** ............................................... 71  
- **HOW TO PRINT A PRESCRIPTION** ............................................ 71

**SECTION 6: SCREENER, CLINIC ASSISTANT, & INFECTION CONTROL** 72  
- **SCREENING APPOINTMENTS** ..................................................... 72  
- **SCREENER/INFECTION CONTROL RESPONSIBILITIES** ....................... 73  
- **INFECTION CONTROL RESPONSIBILITIES** .................................... 74  
- **AFTER CLINIC DUTIES** ............................................................. 75  
- **CLINIC ASSISTANT RESPONSIBILITIES** ....................................... 75  
- **DURING CLINIC DUTIES** ........................................................... 76  
- **WEEKLY DUTIES- CHECK INFECTION CONTROL CALENDAR** ............ 76  
- **MONTHLY DUTIES- CHECK INFECTION CONTROL CALENDAR** ........... 77  
- **AFTER CLINIC DUTIES** ............................................................. 77  
- **ASSIGNED STUDENT DUTIES** .................................................. 77

**SECTION 7: SUPPLIES** 78  
- **CUBICLE ORGANIZATION** ........................................................... 78  
- **STORAGE ROOM AND INVENTORY** ............................................. 79  
- **LAUNDRY** ................................................................................... 80

**SECTION 8: DENTAL RADIOLOGY POLICIES & PROCEDURES** 81

**SECTION 9: RADIOLOGY FORMS** 102

**SECTION 10: DENTAL MATERIALS LAB** 103  
- **WORKING IN THE LABORATORY** .................................................. 103  
- **MODEL TRIMMERS** ................................................................. 103  
  - **OPERATION INSTRUCTIONS FOR MODEL TRIMMERS** ................ 103  
  - **MAINTENANCE OF MODEL TRIMMER** ...................................... 103  
- **STUDENT RESPONSIBILITIES** ..................................................... 104  
- **EMERGENCY GAS SHUT-OFF** ................................................... 104
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section/Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUPPLIES</td>
<td>104</td>
</tr>
<tr>
<td>LAB BENCH REQUIREMENTS</td>
<td>105</td>
</tr>
<tr>
<td>STUDENT SUPPLIES PURCHASED BY STUDENTS</td>
<td>105</td>
</tr>
<tr>
<td>SECTION 11: BASE CLINICAL ROTATIONS</td>
<td>106</td>
</tr>
<tr>
<td>DENTAL TREATMENT BASE FORM</td>
<td>108</td>
</tr>
<tr>
<td>DENTAL HEALTH QUESTIONNAIRE FORM</td>
<td>109</td>
</tr>
<tr>
<td>DENTAL HEALTH EXAM FORM</td>
<td>110</td>
</tr>
<tr>
<td>DENTAL TREATMENT SHEET</td>
<td>111</td>
</tr>
<tr>
<td>DENTAL HYGIENE DAILY WORKLOAD FORM (DIRS)</td>
<td>112</td>
</tr>
<tr>
<td>CCC HYGIENE CABINET STOCK SUPPLY LIST</td>
<td>113</td>
</tr>
<tr>
<td>APPENDIX A: AMERICAN DENTAL HYGIENIST’S ASSOCIATION CODE OF ETHICS</td>
<td>114</td>
</tr>
<tr>
<td>PREAMBLE</td>
<td>114</td>
</tr>
<tr>
<td>PURPOSE</td>
<td>114</td>
</tr>
<tr>
<td>KEY CONCEPTS</td>
<td>114</td>
</tr>
<tr>
<td>BASIC BELIEFS</td>
<td>115</td>
</tr>
<tr>
<td>FUNDAMENTAL PRINCIPLES</td>
<td>115</td>
</tr>
<tr>
<td>CORE VALUES</td>
<td>116</td>
</tr>
<tr>
<td>STANDARDS OF PROFESSIONAL RESPONSIBILITY</td>
<td>116</td>
</tr>
<tr>
<td>STANDARDS FOR CLINICAL DENTAL HYGIENE PRACTICE</td>
<td>120</td>
</tr>
<tr>
<td>APPENDIX B: STANDARDS OF CARE</td>
<td>121</td>
</tr>
<tr>
<td>STANDARD 1: ASSESSMENT</td>
<td>121</td>
</tr>
<tr>
<td>STANDARD 2: DENTAL HYGIENE DIAGNOSIS</td>
<td>123</td>
</tr>
<tr>
<td>STANDARD 3: PLANNING</td>
<td>123</td>
</tr>
<tr>
<td>STANDARD 4: IMPLEMENTATION</td>
<td>123</td>
</tr>
<tr>
<td>STANDARD 5: EVALUATION</td>
<td>124</td>
</tr>
<tr>
<td>STANDARD 6: DOCUMENTATION</td>
<td>124</td>
</tr>
<tr>
<td>APPENDIX C: DENTAL CLINIC QUALITY ASSURANCE PLAN</td>
<td>125</td>
</tr>
</tbody>
</table>
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.


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, 20 professional responsibility points will be assessed.
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.

Remember you can refer your patients to the Dental home page on the CCCC website: www.coastalcarolina.edu/degree_programs/dental/dental_hygiene/dental_hygiene_home.htm

Scheduling Patients/Obtaining Records

It is the student’s responsibility to schedule his/her own appointments. It is not the secretary'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:** The file cabinet located in the clinic contains the student’s hanging files. A blue box located on top of this file cabinet contains the yellow screening cards of patients who have been screened in our clinic but have not had their teeth cleaned. To obtain a screened patient’s record, look up the patient number in the computer and fill out a “Record Request Card” in pencil. Place the card (Record Request Card and the yellow screening card) in a sleeve and place it in the Hanging files next to the secretary’s window. The record will be put in your hanging file.

2. **Re-care patients:** To obtain a patient's record, fill out a “Record Request Card” with the date needed, patient’s number from EagleSoft, put it in a sleeve and place it in the basket next to the secretary’s window. The record will be put in your hanging file.

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! **You may only request ten records at one time. The front desk has 48 hours to place the chart in your hanging file.**

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 “Autonotes” and then choose the heading “Phone Call to Patient.” 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 secretary 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) write in big letters "INACTIVE" across the front of the record in pencil; 2) make a note in the paper Record of Treatment indicating why the patient is being inactivated; and, 3) make a note in EagleSoft in Notes section stating the reason for inactivation. Place the record in the Hanging files record holder near secretary’s window. 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 COST FOR SERVICES:** Cleanings cost is $5.00 and is paid before treatment is rendered. There is no charge for immediate family members or CCCC employees. **You must indicate that the patient is not to be charged** in the Notes section of EagleSoft. Radiographs are free and sealants are $5.00 per tooth.

3. **THE LOCATION OF THE DENTAL CLINIC:** Whenever you give your patient a parking pass, put the patient’s name on it. Patients are only allowed to park in Visitor’s parking. Please refer to the CCCC Web Site Dental Home Page: [www.coastalcarolina.edu/degree_programs/dental/dental_hygiene/dental_hygiene_home.htm](http://www.coastalcarolina.edu/degree_programs/dental/dental_hygiene/dental_hygiene_home.htm) Remember each month the passes are a different color. Make sure your patient has the correct parking pass and it is displayed in the windshield.
4. **THE LENGTH OF THEIR APPOINTMENT:** Many hours are wasted in clinic because the patient schedules with you at 8:00 AM but has a class at 9:00!

5. **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.

6. **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/quota may suffer.

7. 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 booklet 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.  o = today
ii.  << = back 7 days (1 week)
iii. <  = back 1 day
iv.  >  = forward 1 day
v.  >>  = forward 7 days (1 week)

c. Find your chair number.
d. Click on 8:00am to get a blue bar {or the appropriate appointment time}.
e. Double click on the blue bar and the “Find” box will appear.
f. In the “Find” box, type your patient’s last name. The box below will show all
   patients with that last name.

g. If there are several patients with the same last name, you may have to scroll to find
   your patient. After you find your patient, double click on your patient’s name.

3. If the patient has alerts, a yellow box will appear. Check the alerts and click “OK”. This
   box will appear at various stages of the appointment process. Just click “OK” to close the
   box each time.

4. An appointment block window will appear.

5. At the appointment block window:
   a. Verify that this is the correct patient.
      i. Choose appointment type. Use the ADA codes provided to you.
      ii. Adult prophy
      iii. Child prophy
      iv. Follow Up
      v. Revisit
      vi. Screening
      vii. Sealants
      viii. X-rays
      ix. Root planning
      x. OHI
   
   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. The
          clinical secretary will print a re-care list for each student 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).
      i. Click on the circle by ADA Code.
Section 1

Dental Hygiene Sequence of Clinical Procedures

**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 Dr. Hewitt and he will advise you, after he reviews your patient’s medical history, whether or not a prescription is required. If Dr. Hewitt tells you that your patient does require premedication, click “Prescribe Now.”

**i.** Ensure that prescription information is correct.

**ii.** Click on “Print/Save”.

**iii.** The prescription will print to the printer in front of the office window.

**iv.** Information will be saved in the patient’s record of treatment.

**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.

**Block Scheduling**

(This is utilized for patients not yet in EagleSoft, last minute appointments, base days, CA, Infection Control days, or active duty Marines coming from H1.) Failure to schedule in EagleSoft is 20 Professional Responsibility Points.

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, Base, CA, 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 20 professional responsibility points 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 give the clinic secretary a green card with all of the patient’s information so that when she has time she can enter your patient in EagleSoft. You will only use Block Scheduling if your patient is not in EagleSoft.

10. If any of the above information is not properly recorded, 20 professional responsibility points will be assessed.

11. After scheduling the patient, place record in your hanging file. Hanging files are located in the gray file cabinet labeled "1st yr. or 2nd yr." located in the clinic area. Each student has a hanging file with his/her name on it. The only records in your hanging file, maximum of 10, should be of patients in progress.

12. 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

**EXAMPLE:**

**Re-care Pedo patient (under 14)**
D0120-(Periodic oral evaluation)
D1120-(Prophylaxis-child)
D9450-(Case presentation-treatment planning)
D0274-(Bitewings-four films)
D1330-(Oral hygiene instructions)
D1206-(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)
D9450-(Case presentation-treatment planning)
D1330-(Oral hygiene instructions)
D1204-(Topical application of fluoride)

**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, DH Clinic I

1. Only appoint Class I and Class II screened patients with A or B calculus.
2. Only appoint Class I and Class II re-care patients with A or B calculus.
3. If you schedule a patient who turns out to be more difficult than a Class IIB, 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. Once the patient is seated, do a thorough medical history, vitals and consent form and check in with an instructor. Then use an explorer and probe to determine the classification of patient; after you determine the classification an instructor will do a quick screen on this 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 says you may proceed with this patient, make sure you walk the patient up to the front desk and have them pay before the cleaning begins. 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 losing professional responsibility points.

Three to 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 **two days** in advance of the appointment. Get 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 fees, length of appointment, parking, premedication, know your full name & phone number etc. If you are scheduled to be “Screener,” confirm with the secretary 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 7:29 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 20 professional responsibility points.
5. Request anesthesia (see Section II, p. 54) or premedication (see Section V, p. 68) as outlined in the Clinic Manual.
6. Check with an instructor concerning special situations that might alter your plan to treat the patient.
7. If patient has not been in the clinic within three years, the record is in the warehouse. You should request the old Record of Treatment from the secretary. The same patient number will be used.
Procedures Before Seating Patient

Before your patient can be seated, many procedures must be followed. Remember that at 8:00 there are many patients waiting to be checked in, phones ringing, money being collected, 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.**


2. Find your patient's record. The record should be:
   a. Behind your name in the student file cabinet.
   b. In an instructor's Hanging files wall pocket located next to phone in clinic if you turned x-rays in for grading.
   c. Hanging files record holders next to secretary’s window.
   d. In the secretary's office if you did not request patient's record. (You must request it.)
   e. In an instructor's office if the instructor is grading the patient x-rays. Check with individual faculty.
   f. **Under no circumstance should you just make up another record.** See "Lost Record" section in the Clinic Manual.

3. Place the Health Questionnaire (CF 1), HIPAA information and HIPAA signature page on your clipboard and place your clipboard in the stand before 8:00 AM. Turn the clipboard over so the patient’s name is not visible. Make sure your name is on your clipboard and clearly visible both front and back. With twenty plus clipboards on the wall, it is very important for both your first and last name to be on it.

4. 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.

5. The clinic assistant (CA) will check in your patient in the following manner:
   a. At 7:45, 9:45 or 12:45 (Mondays) the clinic assistant is at the front desk assisting the secretary.
   b. Once the patient checks in, the secretary places his/her name on the arrival list and the CA 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 secretary will explain why he/she cannot be seen and will ask them to reschedule.
   d. The CA acknowledges the patient is here and the Health Questionnaire & HIPAA forms are given to patient to complete or update.
   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 40 professional responsibility points.

g. If your clipboard is not on the wall when your patient arrives, your patient will be instructed to have a seat. After all other patients have been checked in; the clinic assistant will again look for your clipboard and process your patient. YOU MAY NOT PROCESS YOUR OWN PATIENT.

h. Student clinicians may not leave the clinic floor without permission from an instructor.

Seating the Patient – Before Check-In

Once your patient has paid, filled out/updated the Health Questionnaire & HIPAA, the clinic assistant will bring you your clipboard. Under no circumstance are you to escort your patient into the clinic until the clinic assistant has checked him/her in. You may NOT process your own patient.

1. 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. The coat rack may not block the fire extinguisher. Make sure to have patients turn their cell phones off upon entering the clinic.
   a. Please do not walk patients down the center aisle of the clinic.

2. Seat patient and adjust chair and head rest for maximum comfort of patient and operator.

3. Have patient rinse for 30 seconds with chlorhexidine mouth rinse, or Listerine and use saliva ejector.

4. 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.

5. 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. 20 professional responsibility points will be assessed if you fail to do this.

Changing a Scheduled Appointment

1. Open “OnSchedule” 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. Blue- student is ready to have their Health Questionnaire and Drug Summary checked. A blue flag is also used to request X-Rays.
2. Yellow- student is ready to have their Intraoral/Extraoral Exam, and Dental Charting checked.
3. Green- student is ready to have their periodontal charting, Treatment Consent Form, and Treatment Plan checked.
4. White- student is ready to have their cleaning assignment checked on an A or B calculus patient.
5. Red- student is ready to have their cleaning assignment checked on a C or D calculus patient. Red also is used to request the help of a RDH.
6. Black- student requests the help of Dr. Hewitt for anesthesia, to check for decay, to evaluate X-Rays, to evaluate Heath History, to request sealants, and/or to request prescription.
7. Red or Blue flags indicate you are ready to have a proficiency graded.- see your course syllabus for other directions as needed.

8. A plastic patient cup placed on top of your cabinet indicates you need help from the CA-screener.

Review of the Health Questionnaire (Medical History) - Blue

The Health Questionnaire is completed at the screening appointment. This form is signed by the patient, screener 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. Staple the old Health Questionnaire to the forms at the back of the chart.

1. 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. A Drug Summary Form should be completed on a patient taking prescription drugs. This must include all prescription medications that the patient is taking.

2. Take blood pressure, pulse, and respiration on every ADULT patient during your first appointment with them and every subsequent re-care appointment. *

   a. If your patient has high blood pressure or is being treated for high BP or any heart condition, you must take blood pressure at each appointment. It is permissible to treat a patient with a systolic pressure < 160 and/or a diastolic < 95. Blood pressures above this may preclude treatment until after a physician's consultation. (Do Medical Referral) Consult the clinic instructor as questions arise. Follow the AHA guidelines for blood pressure education and referral.

   • AHA Hypertension Stage 1 140/90 – any patient with reading that are 140/90 and higher should receive a medical referral.

   • Reminder: Blood pressure and pulse must be recorded on Health Questionnaire and on the “GENERAL” tab of EagleSoft.

3. 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.

   a. If a minor is not accompanied by his/her parent, a CCCC notarized letter template 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.
b. The template is located in the form cubby in the clinic and must have a notarized seal/stamp.

4. Note any allergies or precautions as discussed in pre-clinic. Highlight patient’s name on the front of the folder in pink.

5. When the Health Questionnaire and the Drug Summary are completed, put up a blue flag to have an instructor check and initial for permission to proceed.

6. If radiographs are indicated to be taken, you should have radiology consent and necessary paperwork ready at this time.

Medical History Considerations

Items that get circled in RED and get put in the MEDICAL ALERT BOX:

1. Any condition that could cause a **MEDICAL EMERGENCY** (SEIZURES, ASTHMA, ANGINIA, STOKE, CARDIO CONDITIONS, DIABETES, HBP, LBP, FAINTING,)

2. **ALLERGIES**

3. **RX BLOOD THINNERS** *(See below for special instructions regarding blood thinners and Dr’s notes)*
   
   a. **COUMADIN/WARFRIN**
      
      i. Coumadin Patients req. “INR” report from MD, if 3 or less no Dr’s note required
   
   b. Pradaxa
   
   c. Xarelto
   
   d. Eliquis
   
   e. **CHANGES:**
      
      i. Plavix alone or with aspirin is no longer a concern- no Drs note needed.
      ii. any patient taking a prescription blood thinner listed in #3 must have:
          1. CCCC Medical referral
          2. A note on from the MD ON OFFICE LETTERHEAD stating specific instructions:
             a. discontinue the blood thinner prior to tx and for how long
             b. remain on the medication and allowed to proceed with dental tx

4. **PRE-MED CONDITIONS**

5. **INFECTIOUS DISEASES**

*Do NOT circle aspirin, pregnancy, seasonal allergies, and antibiotic drugs in RED

**DO circle insulin, HBP meds, NITRO in RED*
Things to Remember

1. Take BP on any patient receiving local anesthesia, EVERY apt.
   a. NEW ADA GUIDELINES FOR PRE_MED as of Dec 2012: no pre-med needed for patients with joint replacement HOWEVER at CCCC we will require the following documentation prior to seeing the patient:
      i. Joint replacements, pins, screws, plates- we will require a written and signed doctor’s note on office letterhead or a completed and signed CCCC Dental Department medical referral stating whether pre-med is indicated.

Pre-Med Conditions

1. Joint replacements, pins, screws, plates- we will require a doctor’s note on office letterhead or a completed and signed CCCC Dental Department medical referral.
2. Prosthetic cardiac valve
3. Previous infective endocarditis
4. Cardiac transplant with valvular problems
5. Congenital heart defects
6. Immuno-compromised pts (HIV/AIDS, Systemic Lupus, Leukemia)
7. Hemodialysis
8. Chemotherapy

Dental Consent/Interview – Blue

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 HABITS, GENERAL and HISTORY tabs are asked. (However this will be evaluated at the green flag.) The patient must sign and date the blue consent 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 consent form. A new dental interview is done at each re-care appointment.

IN EAGLESOFT: on the patient information screen, a check mark should be placed in the Consent Box and the date matches the most current consent form.

Base Patients- The Dental Interview and Consent Form are on the same blue sheet and will be checked by an instructor when the medical history is checked.

Patient Privacy Act (HIPAA) – White

1. 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 Coastal Carolina Community College. (Once this form is completed and entered in EagelSoft- you do not need to update it.)
2. A copy of the Privacy Practice at CCCC should be placed on your clipboard and available to your patient.
**IN EAGLESOFT:** a check mark should be placed in the Notice of Privacy Practice and the Privacy Authorization in the patient information page to indicate the form is in the chart. The dates must match.

**Extraoral/Intraoral Inspection - Yellow**

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. On base, use the yellow forms 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.

**Restorative Charting – Yellow**

1. 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 base, you will use the yellow form to chart existing restorations in blue and decay/pathology in red.

2. On re-care patients, students must **update** existing restorative charts in EagleSoft. Put a yellow flag up to have your Oral Inspection and Restorative Charting checked by an instructor. Each clinician will be graded on the data presented to the instructor. Check carefully to assure that the dental chart is accurate and changes have been updated. Use radiographs.

**Periodontal Charting – Green**

1. 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: 3CL. Click on the “circle” in front of the Perio Case Type to indicate Type I, II, III, IV.

2. 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 1\textsuperscript{st} appointment of the re-care appointment. A new Periodontal Exam must be performed and new chart used.

3. For patients under 14 years old, you must probe permanent upper and lower incisors and permanent first molars. Circle all bleeding points as with adults. Also, as with adults, record probing depths over 3mm.

4. For all patients 14 years and older, probe all permanent teeth. Record all probing depths over 3mm, bleeding, suppuration, and recession. In Den 221 and 231 you will record probing depths, recession, furcations, mobility, BOP, and suppuration. The mucogingival line will be recorded for your treatment plan patients.
The Treatment Plan Worksheet- 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 green flag signals for an instructor to check the students work and assist with the completion of the treatment plan worksheet, Dental Hygiene Diagnosis and Care Plan. An instructor’s signature is required on completion of this document to show it’s accurate and then the student will verbally inform the patient of the proposed care plan.

In Den 231 and 233 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 C or D. 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 – 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.

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, in pencil, 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 treatment plan form (green), 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. Discuss all aspects of the care plan with the instructor prior to presentation to the patient.

5. 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.

6. 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 green flag up when you are ready for your Dental Interview, Periodontal Charting, Treatment Plan Worksheet and Care Plan and to be checked. The instructor will give you a cleaning assignment after this is completed.
Record of Treatment

**Remember to use the patient's full legal name on all clinic forms:** (last name, first name.)
If a patient’s record has been inactivated, and he/she comes in for a cleaning, request the old Record of Treatment.

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 7:45 or 12:45 (Mondays).**
   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 (form found in form cubby) 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 secretary.
      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 forms.
      iv. If the parent requests the minor be dropped off, or the supervising adult must leave the college campus, the PARENT OR GUARDIAN must have a CCCC Dental Department form signed and notarized as well as all necessary paperwork signed by the parent/guardian before they leave and must provide a cell phone # where they can be reached at all times.

2. **Forms and EagleSoft templates to be completed and checked by an instructor before you begin scaling:**
   a. Health Questionnaire
   b. Drug Summary
   c. Blue Consent
   d. HIPAA
   e. Extraoral/intraoral inspection/restorative charting {TMJ, OCCLUSION, HEAD}
   f. Periodontal charting/Dental interview {HABITS, HISTORY, GENERAL}, Consent Form, and Treatment Plan.
   g. Full mouth probing on patient’s first visit and each subsequent re-care appointment.
   h. Record of Treatment - patient's full legal name, last name, first name
   i. Name on grade sheet
   j. Patient folder (highlight patient’s name if necessary)
   k. Calculus/stain charting - DEN 131 only.
   l. Calculus charting of the first quadrant to be scaled on all C or D calculus patients in Den 221 & 231. Staple the calculus chart to your grade sheet.
   m. Mount the most recent radiographs x-rays in the patient record and place on viewbox or bring up in EagleSoft. Make sure the patient's name and the date the radiographs were taken is recorded on the mount.
n. You MUST have the periodontal chart open to consult during scaling and the most recent set of radiographs pulled up on your computer

o. 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 getting your Health Questionnaire/Drug Summary, Intraoral/Extraoral Inspection/Restorative charting, Dental Interview/Periodontal Charting/Treatment Plan Worksheet and Care Plan checked by an instructor, meet the instructor at the center isle to discuss the forms.
   c. Once you have completed the Health Questionnaire, Drug Summary and vital signs, put up a Blue 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 Blue flag.
   e. If you need to “request x-rays” complete your Health Questionnaire, Drug Summary, and necessary forms for x-rays, and then put up your Blue flag.
   f. When you have completed your Intraoral/Extraoral Inspection and Restorative charting, put up your Yellow flag to have an instructor check. {TMJ, OCCLUSION, HEAD}
   g. When you have completed your Periodontal Charting and Treatment Plan, put up a Green flag for an instructor to check. {HABITS, HISTORY, GENERAL}
   h. To have your scaling checked on an “A” or “B” patient, put up a White flag.
   i. To have your scaling checked on a “C” or “D” patient, put a Red flag for a Dental Hygiene instructor only.
   j. If you need help with scaling, root planing, Cavitron, or Prophy Jet, put up your Red flag for a Dental Hygiene instructor only.
   k. 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 Black 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 cubicle.
   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, Miss Carroll."
   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 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. The instructor will circle scaling and polishing assignments on grade sheet. 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. (1-4) judgment points will be taken away in the event a student works beyond their assignment.
Classification of Patients

Remember that a patient’s periodontal condition is always changing. If your patient was a 3BM four months ago they may be classified as a 2AL 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 Coastal 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 (1-4)

<table>
<thead>
<tr>
<th>Type</th>
<th>Gingivitis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1</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>Type 2</td>
<td>Slight Chronic Periodontitis</td>
</tr>
<tr>
<td>Type 3</td>
<td>Moderate Chronic Periodontitis</td>
</tr>
<tr>
<td>Type 4</td>
<td>Chronic Periodontitis</td>
</tr>
</tbody>
</table>

- Type 2: Progression of gingival inflammation into the deeper periodontal structures and slight alveolar crestal bone loss. There is usually a slight loss of connective tissue attachment. Findings may include: three or more areas of probing depths of 4-5mm or CAL of 4-5 mm, recession of 1-2mm, or bone loss up to 20%.

- Type 3: A more advanced stage of periodontitis, with increased destruction of the periodontal structures and noticeable loss of bone support (20-50%), possible accompanied by increased tooth mobility. There may be furcation involvement in multirooted teeth. Findings may include: three or more areas of probing depths of 6-7mm or CAL of 6-7 mm, recession of 3-4mm, bone loss from 20-50%.

- Type 4: Further progress of periodontitis with major loss of alveolar bone support (50% or greater), usually accompanied by increased tooth mobility. Furcation involvement in multirooted teeth is likely. Findings may include: Three or more areas with probing depths of 8 or > or CAL of 8 mm or >, recession of 5mm or >, bone loss of 50% or >.
Calculus Classifications (A-D)

<table>
<thead>
<tr>
<th>Class</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class A</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>Class B</td>
<td>Moderate supragingival calculus limited to the cervical third, AND/OR 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>Class C</td>
<td>Moderate to heavy supragingival AND/OR 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>Class D</td>
<td>Very heavy, hard, tenacious subgingival calculus generalized throughout the mouth. Accessibility may be difficult due to pockets or tooth alignment.</td>
</tr>
</tbody>
</table>

Stain Classifications (L, M, H, X)

<table>
<thead>
<tr>
<th>Class</th>
<th>Stain</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class L</td>
<td>Light Stain</td>
<td>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.)</td>
</tr>
<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>

Patient Conditions (Characteristic Points 1+, 2+, 3+)

1+ One characteristic point will be given:

The patient may be resistant to care, disinterested, apprehensive or uncooperative. Oral hygiene is generally poor. Restorations may be extremely rough or deteriorated. General hypersensitivity or low pain threshold. Difficult treatment conditions may exist with profuse salivation, inability to open wide or long enough, missing or malpositioned dentition. The characteristic points will be determined by the instructor based on the following criteria.

- If the student applies subgingival medicaments to assist the patient’s healing.
- If the patient is so apprehensive that routine procedures (e.g. approaching the mouth with a mouth mirror, etc. - not necessarily scaling procedures) makes the patient very jumpy.
• If the patient's pain threshold is such that probing is very difficult because the patient jumps and moves back with each probing.
• If the patient has two or more areas in a quadrant that make scaling extremely difficult. These areas could include defective restorations, malposed teeth, occlusal relationships that make scaling difficult or generalized decalcification.
• If the patient's physical characteristics are such that he/she is not able to tolerate procedures well (e.g. inability to open wide or long enough) or make performing procedures extremely difficult (e.g. excessive salivation).
• The patient is extremely disinterested, uncooperative or loquacious.
• For patients requiring anesthesia.
• For patients requiring premedication.
• For standing during the prophylaxis.
• For placement of sub gingival medicaments.

2+ Two characteristic points will be given:

• If the patient displays two of the above characteristics or an extreme of any of the above characteristics.
• If the patient displays severe characteristics of cerebral palsy, Parkinson's etc. that cannot control continuous movement.

3+ Three characteristic points will be given:

• If the patient displays three or more of the above characteristics or if any of the characteristics are uncontrollable and extreme.

Oral Prophylaxis

1. Procedures - Perform patient education, scaling, polishing, and flossing as outlined in your dental hygiene lectures. Also refer to Tutorial/Proficiency section of this manual.
2. Assistance - If you need help from a hygienist, put up your Red flag. If you need assistance from the clinic dentist, put up your Black flag. When an instructor comes to your cubicle explain your reasons for requesting assistance and what you desire of the instructor. Feel free at all times to call instructors for advice, consultation, or assistance. The instructors are here to aid and assist in the student's training and development.
3. Clinic evaluation of the oral prophylaxis:

   a. Dental radiographs and the most recent periodontal chart should be available throughout scaling.
   b. Tutorials and proficiencies are required throughout pre-clinic and clinic courses.
   c. End product evaluation is done on every dental patient.

      i. 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 if present after initial instructor evaluation and still present upon re-inspection by an instructor.
ii. DEN 221, DEN 231 - surface errors (supra and subcalculus and plaque) are counted after initial instructor evaluation and after re-evaluation. For example, if upon initial exam the instructor finds three errors and upon rechecks one of those errors remains, that error will count an additional point. Thus, the student will be charged with four errors, not three.

iii. Student - Self-evaluation will be done in all clinics. See grade sheet for further explanation.

Patient Education

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 index is calculated at each appointment before scaling is started. The student will review essential oral hygiene education with the patient to lower the plaque index 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.

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 White flag up to get scaling checked on an “A” or “B” patient. Put up a Red flag to get scaling checked on a “C” or “D” patient. 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 make the record available to the supervising faculty to check the document for all prescriptions, procedure authorizations, and forms for documentation. It is the student's responsibility to make notes in the Record of Treatment 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 White or Red flag up by designated checkout time.**

Before requesting a checkout, make sure you are ready!
1. **Print approved prescriptions** using the following procedure:
   a. Go to patient’s restorative (dental) charting
   b. On the tool bar located on the bottom of the page, click on the drop down box located beside the picture of the pill
   c. Click “Prescribe”
   d. Click on the drop down arrow located to the right of “Rx Template”
   e. Select the drug you desire to prescribe
   f. Click on “Print/Save”
   g. Your prescription will print out on the printer located outside the reception room window. Dr. Hewitt will then need to sign the prescription. It also must be documented in the patient’s Record of Treatment.

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. Fill out your Record of Treatment in the appropriate EagleSoft template.

4. The written Record of Treatment (CF6) (on BASE) should include the following: All notes must be very neat and legible. See sample chart entry with base signatures (See Base Section)
   a. Date and patient care for each visit
   b. Review medical history (rev. med. hx.)
   c. 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)
   d. If all readings 3mm or below summarize your findings). For Example: All PD are 3mm or less, with no BOP.
   e. 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.”
   f. Record findings of plaque index. Example: PI-25%
   g. 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 floss and Oral B toothbrush. The patient demonstrated good dexterity with toothbrush, but had difficulty flossing.

**h.** Exactly what you did (scale, root plane, polish). We will use the Palmer Method of recording the quadrants you scaled and polished on BASE. Example:

i. scaled (means you scaled maxillary and mandibular left quadrants)

[ ]

[ ]

**ii.** root planed (means you root planed the mandibular right quadrant)

[ ]

**iii.** complete scale & polish (means you scaled and polished the entire mouth)

[ ]

[ ]

[ ]

[ ]

i. If you use the cavitron or prophy-jet, make sure you record that information.

j. If fluoride is given - APF or NaF1. (Acidulated Phosphate Fluoride or Sodium Fluoride) or fluoride varnish.

k. Special patient instructions. Example: Salt water rinse for 7 days

l. If patient was referred to a physician, periodontist, oral surgeon, etc., make sure you note this information and why a referral is being made.

m. If anesthesia was given record type of anesthetic, number of carpules used, and area anesthetized. Ex: Septocaine 1:100,000, 2 carpules, UR quadrant

n. Next visit (N.V. - what you plan to do next visit). Example:

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

[ ]

o. Re-care (note only on final visit) - 3 mo., 6 mo., 12 mo. EagleSoft’s default interval is 6 mo. If your patient requires something other than 6 mo put a note on the outside of the chart when you turn the chart in to the department secretary. Example: R-4.
p. Note anything you want to check on next visit. Example: Ck. lesion on max. rt. buccal mucosa.

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

r. *Classification” of patient is under "Class.”

s. Review patient education (rev. pt. ed.) - do this at each appointment after initial appointment. Calculate a PI 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).

w. *Please write BASE PATIENT in the top right corner of the form; this aids in chart filing for base dental patients.

*Indicates Base charts only

**IMPORTANT:** The Record of Treatment must be written and signed by the student before checkout is requested. It is the student's responsibility to make sure the information is complete and an instructor signs the Record of Treatment before leaving the cubicle. Process evaluation points will be deducted for not having the Record of Treatment completed before asking for a checkout.

Twenty Professional Responsibility points will be assessed for a record of treatment without an instructor’s signature if discovered after patient’s appointment.

5. Place your forms in the order that the instructor will check them.

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

7. Put up a Red or White flag. Complete check-out procedure - your instructor will come to your cubicle and check the following:

   a. Scaling (what was completed that day).

   b. Polishing (what was completed that day).

   c. Record of Treatment.

   d. Patient education - be specific as to what instructions you gave your patient – type of aids dispensed.

   e. Whether a medical or dental referral is being done.

8. Be ready to record any areas you have missed in scaling or polishing on the grade sheet.
9. If areas are missed, you will be asked to remove them and be rechecked. An instructor will recheck the areas missed.

10. An instructor will complete your grade sheet. They will also review your Record of Treatment and sign it after determining that all documents are placed in the correct order within the patient’s chart.

11. Apply fluoride if indicated.

**Incomplete Check-out Procedure** - The instructor will come to your cubicle 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. **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 dismissing your patient and that all documents inside the chart are in the correct order.

3. Schedule the patient's next visit.

**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.

**Arrange the paper records as follows:**

1. Most recent X-Rays mounted in front of chart
2. Record of Treatment - latest on top stapled to old ones
3. Recent Health Questionnaire (Blue) and Drug Summary
4. HIPAA Form
5. Welcome letter (keep white copy in chart)
6. Consent Form
7. Dental Chart (if applicable)
8. Periodontal Chart (if applicable)
9. DH Care Plan
10. Plaque Index
11. Dental Referral
12. Medical Referral
13. X Ray Consent Form
14. Sealant Referral Form
15. Staple all old forms together.
16. All old X-Rays in a well labeled coin envelope.
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 placed by the patient in the Patient Evaluation Form box located in the clinic. Student must place his/her name on the form prior to giving the patient this form for completion.

Filing the Dental Record

Completed patients:

1. **Freshmen (DEN 131)**: Place completed records in the hanging file folder of your Den 131 instructor. Instructor will check paperwork and the order of the contents of the record. Twenty professional responsibility points will be assessed for any errors found by instructor.
2. **Second year (DEN 141, 221, 231)**: Place records in the secretary’s white bin in the window to be filed.

Incomplete patients:

1. **Freshmen (DEN 131)**: Place record, facing front, in your hanging file.
2. **Second year (DEN 141, 221, 231)**: Place record, facing front, in your hanging file in file.

Patients with radiographs to be graded:

1. Place record and x-rays, facing front, in the hanging file of the radiology instructor who will grade the files.

Completion of Dental Appointment

Follow steps outlined in the Infection Control Manual 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, cavitation 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.

Place the computer mouse on the charger. 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 (CF 30) located with the other clinical forms. After completing this form, give to the instructor to sign and then to secretary. You must acquire a full time faculty’s signature on this form before turning it in to the secretary.
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 Infection Control 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 20 professional responsibility points.

Clinical Evaluation forms must be entered within 48 hours of the patient’s appointment time. Failure to do so results in 20 Professional Responsibility Points.

**Cancellations and Failed Appointments**

Students should call to confirm all patients two days before their appointment. If the patient says they cannot come, note this in their record of treatment with the reason given and have an instructor 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 the CA or Infection Control person what you can 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.
SECTION 2 Evaluation Criteria, Tutorial, and Proficiencies

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 Tutorial, Proficiency and the Adjunctive service evaluations.

1. **Tutorial** is a "practice" process evaluation. Students perform a process evaluation/proficiency without being formally evaluated. No grade is recorded for a tutorial. During the tutorial the instructor can offer appropriate coaching at each step, if necessary and desirable.
   Tutorials provide both students and faculty with additional opportunities for one-on-one instruction. The use of tutorials is encouraged prior to proficiencies and adjunctive service 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 red flags up to request an instructor to evaluate your tutorial.

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 a Blue flag up to request an instructor evaluation.

3. **Adjunctive Service**- after the proficiency evaluation, adjunctive services are completed at the stated mastery level. The student performs an adjunctive service evaluation during each subsequent delivery of the service until program requirements are met. The adjunctive service evaluation is intended to ensure that the student maintains the competence originally achieved with the proficiency evaluation and consistently performs the procedure at mastery level. The instructor must give permission prior to the adjunctive service. The faculty member is not required to observe each detailed step of the criteria but must attempt to be present during most of the procedure. Once program requirements are met, the student is not observed and the procedure is evaluated within the end product evaluation. All adjunctive service requirements must be met by the end of the final spring semester. The student will not graduate unless these are completed.
**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 penalty point is given for "instrumentation" on the grade sheet and figures into the total end product grade at the end of the semester.

**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 competency points will be deducted for any critical errors. If you do not enter your critical error on the computer, you will not get credit for your patient.

**Case Points**

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

**Example:**
- A patient with 11 or more positive responses on their health questionnaire will be assigned 3 case points.

**Competency Points**

These are the points a student receives based on his/her management of the patient.

**Example:**
- The patient is assigned 3 case points. The student has 4 incorrect items in managing the health questionnaire but makes no critical errors. The student is given 2 competency points.

Competency points are calculated by the computer according to the end-product evaluation formula at the end of each procedure in this section.
Mastery Level
The percentage grade that students must achieve on proficiencies in order to receive credit is the mastery level. The mastery level changes each semester. See Tutorial/Proficiency form to obtain mastery grade levels.

Medical History and Health Questionnaire Evaluation

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
   a. Review dental interview and ask all necessary questions making sure that it is completed by the patient in ink, signed, dated and understood by the patient.
   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. Give the patient/parent the health questionnaire for review.
   b. Ask if there have been any changes in the patient's health since the last visit.
   c. Write any significant changes on the health questionnaire form; have patient sign and date.
   d. Have patient sign and date health questionnaire form at every appointment and when changes are indicated. (ie: medication, illness, etc.)

4. Evaluation of Health Questionnaire
   a. After patient has completed the health questionnaire form, circle significant "yes" answers in red. Not all "yes" circles are marked in red. Refer to your pre-clinic notes. Note significant “yes” answers in Medical Alert box on the Health Questionnaire.
   b. Ask appropriate follow-up questions to "yes" responses.
   c. Record responses on health questionnaire in blue or black ink.
   d. Have patient initial anything recorded by clinician on questionnaire or any changes made since last appointment.
   e. Any condition which may warrant precaution prior to dental treatment is noted by highlighting the patient’s name on the front of the folder in pink. Refer to your pre-clinic notes.
f. Record that the questionnaire has been reviewed on the Record of Treatment sheet. Include any additional information that is deemed necessary.

Example: Pt. took premed.

g. Note pertinent information in a concise, scientific, legible manner in black or blue ink.

h. Blood pressure should be taken and recorded for the following:
   i. Each new adult patient
   ii. At each re-care appointment
   iii. At every appointment for patients with a history of high blood pressure or heart disease. **Reminder:** Record the vital signs on the medical history, record of treatment and the “GENERAL” tab of EagleSoft.

5. **Significant Health Questionnaire Findings.** See medical referral section of this manual for further information.

6. **Procedures for Obtaining Physician's Approval by Telephone**

   a. The student involved must request the physician’s approval for treatment via fax.

   b. Note on Record of Treatment that written consent has been received from the physician via a fax bearing MD signature. (910-455-4989)

   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.

7. **Procedures for Additional Medical Concerns**

   a. **Patient Medications**

      i. Be sure patient has taken medications prescribed for medical conditions.

      ii. Use an appropriate drug reference or call pharmacist for any information about unfamiliar medications. Note all pertinent information and/or precautions on Drug Sheet.

      iii. Take appropriate precautions for medications which may affect dental treatment.

   b. **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.
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.
   iii. 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.

Required Evaluation
1. Each student is required to complete health questionnaire proficiency during DEN 121.
2. End-product evaluation of health questionnaire is done at every re-care and screening appointment.
3. Student should complete the medical history, consent and HIPAA information on EagleSoft and have both chart ready for instructor at check in.

End-Product Evaluation Formula
Case points will be determined by the complexity of the medical and dental questionnaire.
- 1 point = Patient with 0-5 positive responses on the health questionnaire
- 2 points = Patient with 6-10 positive responses on the health questionnaire
- 3 points = Patient with 11 or more positive responses on the health questionnaire

1. Competency points will be determined by the student's ability to evaluate and review the patient's health/dental questionnaire, measure and record vital signs, and obtain proper documentation.

<table>
<thead>
<tr>
<th>Points</th>
<th># Incorrect</th>
<th>Case Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0-1 no critical errors</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>2+ or 1 critical error</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>0-2 no critical errors</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>3-4 no critical errors</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>5+ or 1 critical error</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>0-3 no critical errors</td>
<td>3</td>
</tr>
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<td>3</td>
<td>4-6 no critical errors</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>7-9 no critical errors</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>10+ or 1 critical error</td>
<td>0</td>
</tr>
</tbody>
</table>
Evaluation of Extraoral/Intraoral Inspection

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 the Record of Treatment 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 (CF-21 & 22), sign it and have patient and instructor sign. Note in Record of Treatment that referral was made and a copy was given to the patient.
**Required Evaluation**

A tutorial and 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.

**End-Product Evaluation Formula**

1. Case points will be determined by the complexity of the extraoral and intraoral examination.
   - 1 point = Patient with 0-5 observations other than within normal limits (WNL).
   - 2 points = Patient with 5-10 observations other than within normal limits (WNL).
   - 3 points = Patient with 10 or more observations other than within normal limits (WNL).

2. Competency points will be determined by the student's ability to perform the examination, differentiate abnormal from normal, and describe abnormalities accurately.

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<td>3-4 no critical errors</td>
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<td>0</td>
</tr>
<tr>
<td>3</td>
<td>0-2 no critical errors</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>3-4 no critical errors</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>5-6 no critical errors</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>7+ or 1 critical error</td>
<td>0</td>
</tr>
</tbody>
</table>

**Evaluation of Restorative Charting (CF 4)**

**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 using proper symbols, notations and correct pencil color. Follow the EagleSoft instructions you received in Den 131.
5. Review recorded findings aloud, when asked, using appropriate dental terminology for verification by the clinical instructor.

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 Den 131. 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.

**End-Product Evaluation Formula**

**Case points will be determined by the number of items to be charted**

- 1 point = 0 – 10 chartable items
- 2 points = 11 – 20 chartable items
- 3 points = 21 – 29 chartable items
- 4 points = 30+ chartable items

1. Competency points will be determined by the number of items charted correctly according to the case points awarded.

<table>
<thead>
<tr>
<th>Points</th>
<th># Incorrect</th>
<th>Case Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>1+</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>0-2</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>3-4</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>4+</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>0-3</td>
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<tr>
<td>3</td>
<td>9+</td>
<td>0</td>
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<td>4</td>
<td>0-4</td>
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<td>4</td>
<td>5-8</td>
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<td>4</td>
<td>9-12</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>13-16</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>16+</td>
<td>0</td>
</tr>
</tbody>
</table>
Evaluation of Periodontal Charting

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 1 mm 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. **BASE FORMS:** If you are using the paper form, record all probing depths greater than 3 mm in pencil, and if bleeding is present in a pocket depth greater than 3 mm – circle the pocket depth in red pencil. Record a red + for bleeding if there are no pocket depths > 3 mm. Suppuration is indicated by placing a blue line under the probing depth. Indicate furcations in red on the desired surface, and mobility in pencil on the facial surface of the crown of the tooth.
8. **Den 131 & 141:** Assess probing depths, recession, bleeding, and suppuration, involvement as determined by clinical and/or radiographic examination (when radiographs are available.) Den 221 & 231: Assess probing depths, recession, bleeding, suppuration, mobility, migration, and furcation involvement as determined by clinical and/or radiographic examination (when radiographs are available.) Record significant findings. Record all findings in EagleSoft. You will document the mucogingival junction for your treatment plan patient in Den 221 and 231.
9. Review the patient's periodontal condition with the instructor prior to presentation to the patient.
10. Review the patient's periodontal condition with the patient.
11. Patients under 14 should be probed selectively; probe 1st molars and incisors. Only make notations of the measurements that are 4 mm or greater. These measurements should be noted on the periodontal charting form. Do not probe partially erupted teeth.

Required Evaluation

1. Each student is required to complete a periodontal charting tutorial and proficiency at mastery level during DEN 131, DEN 141, 221 and 231.
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.
b. Performance percentile formulas vary by year due to changes in the periodontal classification values.

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.

End Product Evaluation Formula
The formulas the computer uses to calculate your grade for periodontal charting are listed below.

1. **Case points** = # teeth probed x periodontal classification values.

   **DEN 131 and 141 Performance Percentile** = \[(# Teeth Evaluated x 6.5) - # Errors\] \(÷\) (# of Teeth Evaluated x 6.5)

   **DEN 221 and 231 Performance Percentile** = \[(Teeth Evaluated x 13) - # of Errors\] \(÷\) (# Teeth Evaluated x 13)

2. **Competency Points** = Case Points x Performance Percentile.

<table>
<thead>
<tr>
<th>Periodontal Classification Values</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Perio Class</strong></td>
</tr>
<tr>
<td>Class 1</td>
</tr>
<tr>
<td>Class 2</td>
</tr>
<tr>
<td>Class 3</td>
</tr>
<tr>
<td>Class 4</td>
</tr>
</tbody>
</table>

Evaluation of Dental Hygiene Care Plan

Sequence of Procedure
A new Dental Hygiene Care Plan is developed at each appointment and is to be checked at the green flag.

1. Develop a care plan based on patient conditions
   a. Health Questionnaire, Drug Summary and Dental Interviews
   b. Patients chief complaint, if any
   c. Oral Inspection and Restorative Charting
   d. Periodontal charting
   e. Plaque index
   f. Radiographic findings
   g. Caries Risk Assessment

2. Based on these findings, list in PENCIL, the sequence of the procedures and services to be performed at each visit. List both the educational and clinical plans of treatment.

3. Present the care plan to instructor, modify with the instructor and have the instructor sign the care plan form.
4. Discuss the plan with the patient.
5. Assess and modify plan as needed.
6. 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.

**Required Evaluation**

1. During Den 131, faculty shall assist students in developing a care plan.
2. DH care plans are evaluated when the periodontal chart (green flag is checked in by an instructor.

**End-Product Evaluation Formula**

The Dental Scoring Software Grading System will be used for end product evaluation and determine point values as follows: Case points will be determined by patient classification, patient characteristics, and any other significant factors. (ex. dental IQ, medical considerations, etc.)

<table>
<thead>
<tr>
<th>Points</th>
<th># Incorrect</th>
<th>Case Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 point</td>
<td>Class 1 patient with NO significant characteristics or factors</td>
<td></td>
</tr>
</tbody>
</table>
| 2 points | Class 1 patient with significant characteristics or factors  
Class 2 patient with NO significant characteristics or factors |
| 3 points | Class 2 patient with significant characteristics or factors  
Class 3 patient with NO significant characteristics or factors |
| 4 points | Class 3 patient with significant characteristics or factors  
Class 4 patient with NO significant characteristics or factors |
| 5 points | Class 4 patient with significant characteristics or factors |

2. Competency points will be determined by the student's ability to develop a care plan and record, modify the plan appropriately and explain the plan to the patient.
Evaluation of 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 altered cementum by instrumentation, creating a surface which is smooth and hard 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 plaque) 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 a blue dot inside the appropriate box on the grade sheet.

End Product Evaluation Formula

1. Calculus Removal Evaluation will be determined by:

   a. **Total Case Points** = (# Teeth in Dentition x Patient Classification Values) + (Characteristic points x 4)
   
   b. **Daily Case Points** = (Total Case Points - Total # of Teeth) x # Teeth Evaluated
   
   c. **Performance Percentile** =[(# Teeth Evaluated x Deposit Factor) - # Surface Errors] - (# Teeth Evaluated x Deposit Factor)

2. **Competency Points** = Daily Case Points x Performance Percentile
3. Deposit Factors
   a. DEN 131 and 141  All Deposit Levels x 4
   b. DEN 221  Deposit Level A x 2.5
                Deposit Level B x 3
                Deposit Level C x 3.5
                Deposit Level D x 4
   c. DEN 231  Deposit Level A x 2
                Deposit Level B x 2.5
                Deposit Level C x 3
                Deposit Level D x 3.5

Patient Classification Values for Oral Prophylaxes

<table>
<thead>
<tr>
<th>Periodontal Classification</th>
<th>Deposit Rating</th>
<th>Points per Tooth</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>A or B</td>
<td>.25</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>.50</td>
</tr>
<tr>
<td></td>
<td>D</td>
<td>.75</td>
</tr>
<tr>
<td>II</td>
<td>A or B</td>
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<tr>
<td></td>
<td>C</td>
<td>.75</td>
</tr>
<tr>
<td></td>
<td>D</td>
<td>1.00</td>
</tr>
<tr>
<td>III</td>
<td>A or B</td>
<td>.75</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>D</td>
<td>1.25</td>
</tr>
<tr>
<td>IV</td>
<td>A or B</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>1.25</td>
</tr>
<tr>
<td></td>
<td>D</td>
<td>1.50</td>
</tr>
</tbody>
</table>

Evaluation of 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.

5. Determine the appropriate polishing agent, fine, medium, course or a specialty paste that is available in our clinic.

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. As a self-evaluation measure, the student should disclose the patient's teeth after polishing and flossing.

9. Call the instructor to evaluate the effectiveness of polishing and flossing procedures only when all plaque and extrinsic stain have been removed.

10. 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 but what type or cosmetic or therapeutic results are expected.

   d. Explain to the patient the objectives of selective polishing 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 do not receive any polishing points and 1-4 process evaluation points are deducted for Quality of Care

   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.
Required Evaluations

1. The student must complete tutorial/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 131, 141, 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. As the instructor dictates located errors the student will record an “s” or “p” for stain and plaque, or “c” for calculus outside the appropriate box on the grade sheet.

End Product Evaluation Formula

1. Case Points
   a. Total Case Points = # Teeth in Dentition x Patient Classification Values
   b. Daily Case Points = (Total Case Points - Total # of Teeth) x # of teeth evaluated
   c. Performance Percentile = [( # Teeth Evaluated x 5) - Surface Errors] ÷ ( # Teeth Evaluated x 5)

2. Competency Points
   a. Competency Points = Daily Case Points x Performance Percentile.

Stain/Soft Deposit Values For Oral Prophylaxes

<table>
<thead>
<tr>
<th>Periodontal classification</th>
<th>Stain</th>
<th>Points per Tooth</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALL</td>
<td>L</td>
<td>.1</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>.2</td>
</tr>
<tr>
<td></td>
<td>H</td>
<td>.3</td>
</tr>
<tr>
<td></td>
<td>X</td>
<td>.4</td>
</tr>
</tbody>
</table>

Process Evaluation Points (Points Below the Line)

One (1) point deducted for each infraction in DEN 131, two (2) Points for each infraction in DEN 141, three (3) points for each infraction in DEN 221, four (4) points for each infraction in DEN 231.

EVALUATION: Each of the following are evaluated each clinic session, per patient.
Sequence of Procedure

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.

Instrument Exchange
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.
   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 tutorial and proficiency for a universal curette, sickle scaler and Gracey 1/2.
   b. During Den 221, only a proficiency at mastery level will be required. The student must demonstrate mastery on all instruments.

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 Index 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. **Professional 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 chart forms in appropriate order.

All **base charts** should contain the patient's information in the following order from front to back. WRITE “BASE PATIENT” on the top right corner of the form.

These charts are filed in your Base Chart hanging file:  
1. Record of Treatment  
2. HIPAA  
3. Consent form  
4. Intraoral/Extraoral Exam/Restorative Charting – Yellow  
5. Periodontal Probing- Green  
6. DH Care Plan/Treatment Plan worksheet- Green

### Evaluation of Desensitization

#### Sequence of Procedure

1. Assemble the necessary armamentarium.
2. Teeth must be free of all hard and soft deposits. It may be necessary to remove deposits with a porte polisher if the teeth are extremely sensitive.
3. Rinse the teeth to be treated with warm water.
4. Dry the teeth carefully using sterile gauze or short, light blasts of air.
5. Use aseptic technique to apply the desensitizing agent according to manufacturer's recommendations. Be careful not to allow the desensitizing agent to come in contact with other tooth surfaces.
6. Inform the patient as to the importance of good oral hygiene in reducing dentinal sensitivity. Give patient post product placement Information Sheet.

**Required Evaluation**

Each student must demonstrate mastery after instruction in class (DEN 220). Adjunctive service in DEN 221 or DEN 231 must be completed on twenty four teeth to meet program requirements.

**Evaluation of Root Planing**

**Sequence of Procedure**

1. **Armamentarium:**
   a. Anesthetic agents (if needed)
   b. Appropriate instruments
   c. Cotton sponges

2. **Procedure:**
   a. Recognize the indications/ contraindications for root planing.
   b. Explain the need for the procedure to the patient.
   c. Have available the patient periodontal examination form and radiographs.
   d. Obtain instructor approval and have instructor indicate specific teeth to be root planed on your grade sheet before scaling.
   e. Prepare appropriate anesthetic agents.

3. **Employ proper instrumentation techniques:**
   a. Select appropriate instruments
   b. Maintain SHARP instruments
   c. Establish proper fulcrum
   d. Use proper insertion, adaptation, angulations, and stroke
   e. Use proper pressure and grasp
   f. Evaluate the completeness of instrumentation.

4. **Adapt the tissue:**
   a. Press the area with a damp sterile sponge to adapt the tissue closely and stop the bleeding.
   b. Press to reduce the size of the blood clot. A thin clot is beneficial during healing.
Required Evaluation

1. Each student must complete a tutorial and proficiency at mastery level after instruction in DEN 221.

2. Adjunctive service evaluation at mastery level must be completed for 6 patients with a minimum of 4 teeth each which need root planing. A total of 24 teeth needed to meet minimum program requirements. When the proficiency is completed at mastery level, those teeth will count toward program requirements.

Evaluation of Sealants

Sequence of Procedure

1. Sealants will only be placed on patients that have a Sealant Referral form (CF 23) signed by their dentist within the past three months or signed by Dr. Hewitt within the past three months.

2. Make sure the patient is aware of the following:
   a. Sealants cost $5.00 per tooth and must be paid for before the student is given credit for the sealant.
   b. It is considered highly unprofessional and a display of poor judgment to share patients in order to meet your clinical requirements. When you are seeing a patient, that patient is your total responsibility. Professional judgment is an essential part of patient management; therefore, sharing patients will result in the assessment of (20) professional responsibility points for exhibiting unprofessional behavior.

3. If you see a patient that you feel is a good candidate for a sealant, give them a Sealant Referral Form (CL23) to take to their dentist. The Sealant Referral form is good for only 3 months after it is completed by the dentist. Be sure and make arrangements to get the patient back in the clinic within the three month period. Do not give a Sealant Referral form to anyone you do not intend to see yourself. If Dr. Hewitt is in clinic and you have recent radiographs on the patient, you may ask him to do the exam for sealants. Make sure he signs a Sealant Referral form. No sealants will be done without a Sealant Referral form.

4. Armamentarium
   - Explorer
   - Mirror
   - Glass Dappen Dish
   - Quick Tip
   - Saliva Ejector/Hygoformic
   - Prophy Angle with Occlusal Brush
   - Air/Water Syringe
   - Handpiece
   - Pumice
   - Cotton Rolls, 2 X 2
   - Dri-Angle
   - Cotton Roll Holder
   - Sealant Kit
   - Curing Light Unit
   - Articulating Paper
   - Floss
5. Procedure for Light-Cured Sealants
   a. Examine the tooth with an explorer to determine if any caries exist. Radiographs should be examined first. There should be no tissue impinging upon the surfaces selected for sealing.
   b. Recognize the indications/ contraindications for sealants.
   c. ONLY THE DENTIST CAN PRESCRIBE SEALANTS.
   d. Obtain the sealant referral form for sealants (CF23).
   e. Explain the purpose of applying sealants to the patient and/or parent. Include it as part of a total preventive program rather than an isolated procedure. (The patient will have this explained to them prior to the appointment, but will be reinforced at the appointment.)
   f. Teeth will be sealed a quadrant at a time if possible.
   g. Properly isolate teeth.
      i. Isolation may be done with cotton rolls and Dri-Angles.
      ii. The quadrant to be treated should be comfortably positioned for visibility and accessibility.
      iii. The patient's head should be slightly tilted away so that saliva can flow to opposite side.
      iv. Keep tooth clean and dry for optimal action of the material. This will eliminate possible contamination of the material and keep the materials from contacting the oral tissues, being swallowed accidentally, or being unpleasant to the patient because of taste.
   h. Clean the occlusal surfaces with fine grain pumice slurry with a tapered polishing brush. Do not use oil base or fluoride prophy pastes. This interferes with conditioning.
   i. Thoroughly rinse and dry selected surfaces.
   j. Using a sharp explorer, gently remove any visible debris from pits and fissures.
   k. Thoroughly rinse for 20-30 seconds. Isolate the teeth with cotton rolls. Complete one quadrant at a time. Insert saliva ejector. The etching solution (usually 37% phosphoric acid) is placed to permit greater penetration and bonding of the sealant to the enamel. The area must be kept dry.
   l. Thoroughly dry tooth with air syringe for approximately 30 seconds.
   m. Place gel etchant on to tooth for 20-30 seconds, using a dabbing motion.
   n. Rinse teeth for 20-30 seconds with water and evacuate with suction. Do not let patient expectorate. Saliva on the etched surface will reduce the bonding strength of the sealant by depositing salivary constituents on the surface.
   o. A properly etched tooth surface will appear dry and chalky. Re-etch the tooth if necessary. Dry teeth thoroughly for 30 seconds. Apply new cotton rolls if necessary.
p. Flow sealant into grooves.
q. Cure sealant with light.
r. With a cotton roll, remove the sealant residue from the sealed tooth surface.
s. Examine with explorer for any voids around margins.
t. Remove cotton rolls.
u. Floss interproximally
v. Check the bite with articulating paper.
w. Have the instructor examine the sealant.

Required Evaluation
Each student will complete a laboratory proficiency in class. Adjunctive services must be completed) to meet program requirements and graduate in DEN 221 or DEN 231- see class syllabi.

Evaluation of Prophy Jet (Air Polisher)

Sequence of Procedure

1. Armamentarium:
   a. Appropriate instruments
   b. Air polisher unit & insert
   c. Powder abrasive
   d. Barriers for unit
   e. High volume suction tip
   f. Saliva ejector
   g. Antimicrobial rinse
   h. Patient drape
   i. High filtration mask, gown, face shield, safety glasses
   j. Safety glasses with side shield for patient

2. Review the patient's health questionnaire.
3. Assess the indications/contraindications for the use of an air polisher.
4. Indications:
   a. Heavy stain that would require extensive instrumentation
   b. Orthodontia
   c. Hypersensitivity
5. **Contraindications:**
   a. Patients with sodium restricted diets.
   b. Patients with any respiratory disease.
   c. Specific oral conditions:
      i. Soft spongy tissues
      ii. Exposed cementum

6. **Obtain instructor approval.**

7. **Assemble the air polisher unit.**
   a. Plug the unit into the electrical, water, and air supply.
   b. Insert the nozzle tip into handpiece.
   c. Remove the powder cap. Turn unit on/off 3 times to clean lines.
   d. Fluff powder in jar. Fill chamber with powder. Do not cover the center tube with powder. Screw the lid on tightly.
   e. Turn on the unit.
   f. Adjust the air polisher to the lowest possible setting. Explain the significance of the 6:00 or 12:00 setting.

8. **Explain the procedure to the patient.**
   a. Rationale for use
   b. Sensitivity during instrumentation
   c. Water spray

9. **Have patient rinse with antimicrobial rinse.**

10. **Prepare the patient properly.**
    a. Use patient drape and safety lens with side shields.
    b. Lubricate lips if dry or cracked.

11. **Prepare the operator correctly.**
    a. Wear safety glasses, face shield, high filtration mask, gown, and gloves.

12. **Correct patient/operator positioning.**

13. **Instrumentation:**
    a. Use a pen grasp, resting the weight of the device in the "v" of your hand.
    b. Wrap the cord around your arm for support
    c. Fulcrum on adjacent tooth surface.
    d. Bring the tip to tooth surface before activating spray.
    e. Start the procedure on buccal surfaces. Keep the tip 3-4 mm from tooth surface.
    f. Direct the spray at the middle third of the tooth.
g. Use appropriate angulation.
   i. 80 degrees for posterior teeth
   ii. 60 degrees for anterior teeth
   iii. 90 degrees for occlusal surfaces

h. Maintain small, circular, and moving strokes.
i. Periodically stop, rinse, and evaluate.

14. Use appropriate suction.

15. Provide post-operative instructions.
   a. Possible sensitivity of newly exposed tooth surfaces. Possible sensitivity of soft tissues.
   b. Use of fluoride dentifrices.

16. Perform proper disassembly and disinfection of unit.
   a. Remove tip. Clean tip with wire cleaning tool!!!
   b. Turn off unit
   c. Open chamber
   d. Remove powder
   e. Turn unit on/off 3 times to clean chamber. If needed use HVE to remove all powder from the chamber. Be careful not to break the center stem in the chamber.
   f. Place powder in jar and tighten cap
   g. Replace cap on chamber
   h. Turn off unit.
   i. Remove barriers and disinfect.

Required Evaluation

Each student must complete an adjunctive service evaluation tutorial and proficiency after instruction in DEN 221. Adjunctive service evaluation must be completed for six utilizations to meet program requirements before graduation.
Evaluation of Ultrasonic Scaler

Sequence of Procedure

1. Assemble the ultrasonic scaler properly:
   a. Ultrasonic
      i. Plug the unit into the electrical and water supply.
      ii. Flush the tubing for 2 minutes.
      iii. Select appropriate tip. Hold the handpiece upright and fill with water. Insert tip.
      iv. Place barriers.
   b. Tune the ultrasonic scaler to the proper power and water flow.
      i. Tune the unit to the lowest possible setting.
      ii. Adjust the water setting to a constant drip about the tip.
   c. Explain the procedure to the patient.
      i. Rationale for use.
      ii. Sensitivity during instrumentation.
      iii. Water spray.
   d. Correct patient/operator positioning.
      i. Patient should be fully supine.
   e. Prepares the patient properly.
      i. Use patient drape and safety glasses with side shield.
   f. Prepare the operator correctly.
      i. Wear safety glasses, high filtration mask, face shield, gloves and gown.
   g. Instrumentation
      i. Wrap the cord around your arm for support.
      ii. Use a modified pen grasp and fulcrum on adjacent tooth surface.
      iii. Bring the tip to tooth surface before activating spray.
      iv. Keep tip parallel to the long axis of the tooth. (Should be no greater than a 15 degree angle.)
      v. Use last 2 mm of the working tip.
      vi. Maintain light continuously moving strokes.
      vii. Stop periodically to evaluate tooth surface with mirror and explorer.
      viii. Avoid use of the point
      ix. Flag lips and cheek to catch overspray
h. Use high volume suction and saliva ejector when possible.
i. Provide post-operative instructions.
   i. Possible sensitivity of newly exposed tooth surfaces. Possible sensitivity of soft tissues. Use of fluoride dentifrices.
   
j. Perform proper disassembly and disinfection of unit.
   i. Remove tip, wash to remove debris and place in ultrasonic cassette for sterilization. The cassettes may go into the ultrasonic bath.
   ii. Turn off unit.
   iii. Remove barriers and wipe unit with disinfectant. Do NOT spray unit or handle with disinfectant.
   iv. Do not put the black handle in the ultrasonic bath; it is autoclavable.

**Required Evaluation**

1. Each student must complete an adjunctive service evaluation tutorial and proficiency after instruction in class (DEN 220). Adjunctive service evaluation at mastery level must be completed for six utilisations in DEN 221 and DEN 231 to meet program requirements.

2. Students should not use the ultrasonic scalers on patients with a deposit classification A or B unless an instructor has given permission due to extenuating circumstance. After the first three teeth are hand scaled, the ultrasonic scalers may be used on patients with a deposit classification of C or D with an instructor’s permission.

3. Ultrasonic instrumentation is always followed by hand scaling.

**Evaluation of Fluoride Treatment**

**Sequence of Procedure**

1. **Armamentarium**

   **Tray Technique**
   - Fluoride trays
   - Saliva ejector
   - Fluoride gel
   - Air water tip
   - Compressed air
   - Cotton sponges
   - Timer/clock/watch

2. Fluoride treatments will be administered, when indicated, to the patient:
   a. Under 18 years of age (parent or guardian must give permission)
   b. With a moderate or high caries rate according to the Caries Risk Assessment
c. With gingival recession. **Reminder:** The condition of the gingival tissue must be evaluated. This information should be used to determine the need for a fluoride treatment at this time.

3. Explain the procedure to the patient and instruct them the use of the saliva ejector.

4. Select the appropriate fluoride product.
   a. APF has a low pH that etches porcelain and dissolves resin matrix if used repeatedly. (no longer available in our clinic)
   b. Neutral NaF is recommended for patients with porcelain and/or resin restorations.
   c. Fluoride varnish (NaFl 5%) is used on all children and adults with sensitivity or root exposure; also patients that are moderate to high risk on the Caries Risk Assessment.

5. Assemble all the necessary armamentarium, including the appropriate fluoride product, trays, saliva ejector, etc.

6. Patient should be seated in an upright position. When applying fluoride varnish follow all patient positioning and ergonomics as you would when you are instrumenting.

**Tray Technique**

1. Select tray of the appropriate size.
   a. The tray should be long enough to cover all erupted teeth but not extend beyond the most distal tooth's surfaces. General rule: small tray for primary dentition, medium tray for mixed dentition and large tray for patients with permanent dentition.
   b. The width and depth of the tray should provide effective isolation and coverage.
   c. The tray should be made of a material that does not interfere with the fluoride.

2. Fill trays with enough fluoride to cover all tooth surfaces but not enough that it overflows (a narrow strip of fluoride, covering the bottom of tray).
   a. Use overgloves when handling the fluoride bottle to prevent contamination.
   b. Do not touch the tray with any portion of the fluoride bottle.

3. Dry the teeth thoroughly and slowly.
   a. Dry the mandibular teeth starting with the buccal surfaces, then the occlusal surfaces and finally the lingual surfaces.
   b. Place tray and saliva ejector.
   c. Dry the maxillary teeth starting with the palatal surfaces, then the occlusal surfaces and finally the buccal surfaces.
   d. Place tray.
   e. Ask the patient to bite gently on the trays.

4. Time the procedure starting from the time the last surface is exposed to the fluoride.

5. Do NOT leave the patient. Monitor the patient during the entire procedure. This means stay in the cubicle with your patient.

6. Remove the trays.

7. Immediately remove any excess fluoride using a cotton sponge. Continue this process with the saliva ejector.

8. Instruct patient not to rinse, eat, drink, or brush the teeth for at least 30 minutes, preferably longer.
Varnish Technique

2. Discuss procedure and benefits with the patient.
3. Assemble complete armamentarium.
5. Dry teeth by quad. (either with gauze or compressed air)
6. Mix varnish in tray until it reaches uniform consistency
7. Apply thin uniform coat to all desired tooth surfaces
8. Informs pt. varnish hardens on contact with saliva
9. Give appropriate post treatment instructions and post instruction card (in form cubby).
   i. Allow varnish to remain on teeth for 4-6 hours or ideally overnight. Resume normal brushing the following morning. Instruct pt. to eat soft foods, cool liquids for at least 4-6 hours.

Required Evaluation

1. Each student is required to complete a fluoride tutorial and proficiency (both tray and varnish) during DEN 131. Adjunctive service evaluation at mastery level must be performed on 10 patients to meet program requirements.
2. Once the proficiency has been completed; the student must have the next 10 fluoride applications observed to meet the adjunctive services quota met.

Evaluation of Subgingival Medicaments

ARESTIN/BETADINE

After subgingival debridement, deep periodontal pockets with inflammation may require additional treatment. Placement of Arestin or subgingival irrigation with betadine solution is performed in our clinic upon approval of the instructor.

Sequence of Procedure

1. Inform the patient of the procedure and the need for a re-evaluation appointment.
2. Select product.
3. Assemble armamentarium.
4. Debridement of selected teeth must be completed.
5. Place applicator syringe in periodontal pocket and dispense medication. (DO NOT use Arestin in anterior teeth due to side effect of gingival pigmentation.)
6. Inform the patient as to the importance of good oral hygiene. Give patient post product placement Information Sheet.
7. Place patient data in the Adjunctive Service Notebook, which is found in the radiology grading area of the clinic.
8. Schedule the patient for a re-evaluation of the area in four-six weeks.
9. At the re-evaluation appointment, record patient date in the Adjunctive Service Notebook.

10. If you fail to follow protocol, NO patient credit will be given and you will be assessed Professional Judgment penalty points.


12. Schedule appropriate follow up visit and record in Arestin book.

**Oraqix**

Subgingival anesthesia: Lidocaine and prilocaine periodontal gel 2.5%

1. Obtain instructor approval
2. Assemble armamentarium
3. Apply gel subgingivally with Oraqix dispenser to applicable areas
4. Allow 30 second onset and procedure with debridement.
5. Document the location of Oraquix placement in the record of treatment (ie UR, lower anterior etc)

**Note:** Maximum recommended dose is 5 cartridges per session.

Instructors will monitor placement of selected medicaments. Student will receive one characteristic point for that appointment as well as an adjunctive service requirement for each medicament placed.

**Request for Anesthesia**

**Sequence of Procedure**

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

Prior to appointment:

1. Show Dr. Hewitt the patient’s chart and if possible, let him 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 Dr. Hewitt 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 end of your cubicle under a paper towel.
3. Once Dr. Hewitt gives you permission, dry the tissue and isolate the area to be anesthetized. Place a small amount of “Profound” topical anesthetic at each injection site! The “Profound” topical is kept in Dr. Hewitt’s office. The topical needs approximately 4 minutes for best results.

4. Assist Dr. Hewitt and rinse the patient’s mouth after the injection.

5. Document on the treatment record:
   a. Type of topical anesthesia placed (profound, benzocaine)
   b. Type of anesthesia used - including % (4% Septocaine, 2% Lidocaine)
   c. Amount of epinephrine (1:100,000)
   d. how much anesthetic was used, (x2  or 2 cartridges)
   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 2 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.”

7. Patients may be anesthetized on:
   - Fall semester – Monday thru Friday after 8:00 AM.
   - Spring semester – Mondays and Fridays after 10:00 AM and Wednesdays after 8:00 AM.

**Required Evaluation**

Local anesthesia proficiency is part of DEN 231 and must be completed. Twenty professional responsibility points will be assessed if proficiency is not completed by required date.

**Periodontal Re-evaluation**

1. **Who?**
   A. Active duty military patients needing re-evaluation appointment will be referred to the periodontist on base.
   B. 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
   C. Patients demonstrating severe gingivitis
      1. Perio Case Type I or II
      2. C-D calculus rating {CCCC classification in clinic manual}
D. 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
E. 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. A-B-C-D 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. Patient classified as 3AL
         2. Receiving hygiene care every 3-4 months
         3. Probing depths unchanged for 24+ months
         4. Excellent self-care
         5. 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 & get points for steps 5-1
      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 2CM may be reclassified as a 2AL

C. Receive points 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 initials the box “below
         the line” on the grade sheet

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
   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. Fурcations
      f. Mobility
      g. Measure mucogingival line ONLY if area has inadequate attached
         gingiva.
      h. RECLASSIFY this patient.
   7. Self-care evaluation:
      a. PI %
   8. All clinical care delivered.
   9. What next:
      a. Continue perio maintenance re-care
b. Refer to dentist of record for perio referral

4. Complications
   A. This patient may show up on your incomplete patient list.

If this happens, follow the directions you will receive in Den 230 Spring Semester for the incomplete patient report.
SECTION 3 Clinical Evaluation of Student Performance

How to Complete a Grade Sheet in Clinic

1. Use black ink pen.
2. Print Student Name, last name, first name.
3. Print Patient Name (no nicknames) last name, first.
4. Complete the Date.
5. Age of patient.
6. Is this a New patient (first time for re-care or screened), CC (continued care) or CMPL (completed) You will check New or CC and an instructor will initial CMPL at the final check out when the patient is completed.
   a. If “complete” is not checked and initialed by an instructor, this will result in loss of quota.
7. 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.
8. PTP (Permission to Proceed) is initialed by an instructor after the medical history is checked.
9. Right before an instructor checks your periodontal charting circle the classification of Perio, Deposits and Stain. If an instructor does not agree with your classification it will be changed and an Assignment made.
10. Characteristic points are given by an instructor on certain occasions. See Clinic Manual for further information.
11. Health History case points are entered by an instructor as well as errors or critical errors.
12. Extra/Intraoral Inspection-case points counted and entered by a student. An instructor will assign the errors or critical errors. (TMJ, HEAD, OCCLUSION tabs are reviewed in EagleSoft.)
13. Dental Charting-case points counted and entered by a student. One case point for each tooth that has something to chart. Only 1 point per tooth, even if there are several things to chart. (Note: Attrition and full dentures count as one point per arch, not each individual tooth.) An instructor will enter the errors.
14. Perio charting-enter the number of teeth that were probed. An instructor will enter the errors or critical errors.
15. Dental Hygiene Care Plan-An instructor will assign a 0 for no errors and assign a number 1-3 depending on the number of errors made when doing the treatment plan.
16. An instructor may make Comments and then must initial each area (Instr).
17. By check out the student must have put the # teeth Evaluated for Calculus and Stain/Soft Deposit.
18. The student will do a Student Assessment for both calculus (blue dot) and stain/soft (red dot) deposit “inside the box” before an instructor gives a final grade.
19. When an instructor grades calculus and stain/soft deposit the student will put a **P** (plaque), **S** (stain), or **C** (calculus) outside the boxes on the grade sheet.

20. 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.

21. **Process Evaluation**- points are assessed throughout the clinic appointment. The points assessed are penalty points and will be deducted from the total points earned on this patient on this date.

22. **Adjunctive Services**- an instructor must indicate the number of utilizations/# of teeth that met mastery level and initial.

23. **Total Case Pts.**-the total number of points you COULD have earned on this patient.

24. **Total Competency Pts.**-the total number of points you DID earn on this patient.

25. **Total Penalty Pts.**- number of process evaluation points assessed during this appointment.

26. Check this box if the patient is ethnically diverse, medically compromised or considered special needs.

27. Student initials and dates this line after entering grade sheet into DSS.

28. Circle patient recare interval.

**Entering a Grade Sheet Into Dental Scoring**

Clinical evaluation forms must be entered within 48 hours of the patient’s appointment time. Failure to do so results in 20 Professional Responsibility Points.

1. Click on the Icon “**Dental Scoring System.**”

2. Click on “**Clinic Evaluation**” at the top of the screen.

3. Enter your student ID number (number on student ID card).

4. Click “**Input New For.**”

5. Click either “**New Patient**”, “**Continued Care**” or “**Adjunctive Services**”(IMPORTANT: *If for any reason a verified form has been deleted by an instructor, when re-entering the form select “Continued Care”.*)

6. If “**New Patient**” enter patient information. The patient’s name will be in all caps. This is the default value, so you cannot change it. Use the patient’s given name and spell it correctly. The name in the computer MUST match your grade sheet exactly.

7. If the patient has any Medical Alerts check the “**Medically Compromised**” box.

8. If the patient is ethnically diverse, check the “**Ethnically Diverse**” box.

9. If the patient requires any deviation from “normal” treatment, check the “**Special Needs**” box. Special needs is defined as any person with any physical, emotional, social or medical condition where routine treatment needs to be altered.

10. Click on “**Clinic Evaluation**” at the top of the page. A grade sheet will appear.
11. Enter the information from your paper grade sheet. Be VERY careful as the computer should match your paper grade sheet exactly. The scroll wheel on the computer mouse is very sensitive and you may accidentally change some of the information if you aren’t extremely careful. If you have been checked in and have a classification for your patient, when selecting Continued Care you have to re-enter the classification and then go to “Oral Prophylaxis.”

12. Select “Classification” of patient from the drop down boxes. Select 0 for classification if you have not been checked on perio and the classification has not been verified by an instructor.

13. Enter Characteristic points if an instructor gives you a point or points

14. Enter # of points and errors for Health History, Extra/Intraoral Inspection, Dental Charting, and Perio Charting (this will be the number of teeth you probed)

15. Click the “Care Plan” box if you wrote a DH care plan. If there were errors enter the # in the box.

16. Oral Prophylaxis - enter the # of teeth evaluated and # of surface errors for calculus and stain. Do not enter any information if an instructor has not initialed your grade sheet.

*if the total teeth number and the teeth #’s scaled and polished at the final grade sheet to do not match, loss of quota WILL result.

17. If the patient is Complete check the box for completed patients in DSS.

   a. FAILURE to check “complete” in the Dental Scoring Software, will result in the grading system NOT recognizing the patient is completed and consequently this patient will NOT COUNT AS QUOTA. You will be responsible for seeing another patient to make up for your error.

18. Process Evaluation - enter the number of errors from your grade sheet. Instructor indicates any errors in the listed functions (using the numbers in parenthesis) by entering the appropriate number of points in the blanks and then initialing the box next to those particular functions. Number of points deducted will be determined by the semester

   DEN 131: 1 point; DEN 141: 2 points; DEN 221: 3 points; DEN 231: 4 points.

   a. Aseptic technique- ability of student to manage infection control procedures.
   b. Area/Post Appointment- cleanliness/order of cubicle during and after dental appointment.
   c. Instrumentation- ability of student to instrument correctly in the areas of adaptation, condition, fulcrum, grasp, selection and stroke.
   d. Patient data integration- ability of student to use all patient data to individualize patient care (radiographs, perio chart).
   e. Patient education - ability of student to instruct patient in correct OHI.
      i. instruction must be individualized and completed each appointment for that particular patient.
   f. Patient/operator position- ability of student to follow positioning standards taught in preclinic lecture to maximize optimum patient care.
g. Professional demeanor/appearance- ability of student to conduct herself/himself professionally and dress according to the standards established by the faculty.

h. Professional judgment- ability of student to use the highest standards in all decisions.

i. Record management- ability of students to accurately manage paperwork and records.

j. Time management- ability of student to plan ahead and manage clinic time.

k. Tissue management- ability of student to instrument without tissue trauma.

l. Quality of care- ability of student to deliver the highest level of care.
   i. For example: missing too many areas on polishing could result in a loss of points in this area, not performing OHI.

19. Adjunctive Service - Instructor enters the appropriate number, based on the information in parenthesis next to the adjunctive service. The instructor indicates whether the service was performed below mastery level and initials on the line.
   a. Please note medical/dental referrals and re-evaluations are tracked here and entered into DSS

20. Note: If you receive ten or more plaque errors for polishing on patient for that appointment, you will receive ZERO polishing points and appropriate process evaluation points for Quality of Care.
   a. For the system to zero out points- enter the same # of errors as the total # of teeth polished.

Click on “Update” at the top left of the screen and record your Case Points, Competency Points and Penalty Points on your paper grade sheet.

Place your initials in the upper left hand corner of the evaluation sheet after you submit the grade sheet in DSS and prior to placing the sheet in instructor’s hanging file.
# Clinical Evaluation of Student Performance

## C.C.C.C. Dental Hygiene Program

### CLINIC EVALUATION FORM

<table>
<thead>
<tr>
<th>STUDENT NAME</th>
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<td>CMPL</td>
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### CLASSIFICATION:
- Perio: 1 2 3 4
- Deposits: A B C D
- Stain: L M H X
- Characteristic: +

### ASSIGNMENT:

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### NUMBER OF TEETH: 6

### Critical Errors
- Com: 15
- Instr: 

### ORAL PROPHYLAXIS

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<tr>
<th>Calculus</th>
<th># Teeth Evaluated</th>
<th># Surface Errors</th>
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### Instructors
- S = Stain
- P = Soft Deposit
- C = Calculus (outside box)

### Student
- Blue Dot = Calculus
- Red Dot = Stain or Plaque (inside box)

### PROCESS EVALUATION: 20

<table>
<thead>
<tr>
<th>Name</th>
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<tr>
<td>Aseptic Technique (1-4)</td>
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<td>Desensitization (# of Teeth)</td>
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<td>Area/Post Appointment (1-4)</td>
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<td>Program Requirement – 24 teeth</td>
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<td>Instrumentation (1-4)</td>
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<td>Patient Data Integration (1-4)</td>
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<td>Air Polisher (# of Utilizations)</td>
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<td>Record Management (1-4)</td>
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<td>Time Management (1-4)</td>
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<td>Tissue Management (1-4)</td>
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<td>Recare Interval</td>
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<td>Subgingival Medicaments</td>
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### Recare: R3 R4 R6 (circle one) 27

### Instructor comments:

| TOTAL CASE PTS. | 22 |
| TOTAL COMPETENCY PTS. | 23 |
| TOTAL PENALTY PTS. | 24 |

CF007 2009  6/12x

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67
SECTION 4 Charts

Record Locations

Patient records are important legal records and under no circumstance should be taken out of the health building. They are of no value if lost, destroyed or misplaced. There are only six "legal" places a record could be.

a. Filing cabinet in secretary's office or file cabinets in Op 2 or back of clinic for inactive records.

b. Filed behind your name in the file cabinet.

c. Hanging files record holders.

d. Instructor’s Hanging files.

e. Instructor’s offices while your radiographs or paperwork is being graded.

f. Secretary’s office waiting for a patient number.

NOT RETURNING A RECORD TO THE PROPER PLACE WILL RESULT IN THE ASSESSMENT OF 40 PROFESSIONAL RESPONSIBILITY POINTS.

Obtaining Records

Only a dental instructor, secretary or the work-study student is allowed to go into the files where the patient's records are kept. If you need a record (screener patients too), look on the computer to obtain record number, fill out a Record Request card (CF 24) and place it in a plastic sleeve. Put it in the Hanging files file pocket next to the phone.

As the secretary has time, she will pull your record and place it in your hanging file behind your name. After the patient comes in, you erase the card and put it where forms are kept to be reused. If the patient does not come, place the card back in the blue box.

Record Order

1. X-Rays- The most recent X-Rays should be mounted with patient's name, date the X-Rays were taken, and the student's name who took the X-Rays. All old X-Rays should be placed in a coin envelope and properly labeled with the patient's name and the date the X-Rays were taken. The old X-Rays will be the very last item at the back of the chart.

2. Record of Treatment – White

3. Recent Health Questionnaire - Blue

4. Drug Summary- Blue

5. HIPAA Form-White
6. Welcome Letter (white copy in chart, yellow to patient)
7. Consent Form – Blue
8. Dental Chart – yellow, if applicable
9. Periodontal Chart- green, if applicable
10. DH care plan/ TX plan worksheet- Green
11. Plaque Index
12. Dental Referral
13. Medical Referral
14. X-Ray Consent Form
15. Sealant Referral Form
16. All old forms stapled together
17. Old X-Rays in coin envelope

**Inability to Find a Record**

If you filled out a Record Request card and the dental secretary cannot find your record, they will respond by writing "RECORD NOT FOUND" on the card and placing it in your hanging file. It is now your responsibility to check the following areas:

1. In your hanging file in the student file cabinet.
2. Behind instructor's name in Hanging files holder.
3. In an instructor's office being graded – consult with your instructor.
4. Located in another student’s hanging file in the student file cabinet
5. With another student - ask them!
6. If you have thoroughly searched each area above, go to your clinic instructor for further directions.

**7. Location of Files:** Ask secretary for assistance:
   a. 2010-present: In secretary’s office.
   c. 2007-2008: filing cabinets in radiography area in back of clinic
   d. 2006 and previous: Record of Treatment only.
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, immediately generate a Dental Referral Form and have it ready for your instructor to sign at the completion of dental charting and/or attached to your x-rays when you turn them in to be graded. If your instructor agrees that the patient should be referred:

Prior to seeing Dr. Hewitt for evaluation of radiographs, make sure you have the dental referral form generated AND the dental charting is accurate in EagleSoft.

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 sign the form.
5. Record on patient's Record of Treatment that a dental referral was made and WHY.
6. Mail the white copy of the dental referral with radiographs to the dentist of record
7. Give the patient the pink copy
8. Keep the yellow copy in patient's record.

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 (CF 21) and have an instructor sign, you sign and have the patient sign. Give the original to the patient and place the yellow copy in the patient's record. 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. Staple the white copy of the Medical Referral form signed by the physician to the yellow copy in the patient’s chart. 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.
**Premedication Procedures**

In your Pharmacology course, you were given information on when to premedicate patients before dental treatment.

If your patient has a documented need for premedication, you will need to give them a prescription before their appointment. To receive the prescription, please follow these guidelines:

1. Make sure the patient is not allergic to the drug before you write the prescription. 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. Bring prescription to Dr. Hewitt. He will check and sign it. Have patient’s record with you!

3. Record the data and the fact that the prescription was given in the patient’s record of treatment. Give the patient the top half of the prescription and warnings. File the bottom half of the prescription in the patient’s record.

4. 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.

5. Always allow 48 hours or more for this process. Many times Dr. Hewitt is scheduled in class, meetings, etc. If he is not available, tape a note to his door informing him that you need his assistance.

**How to Print a Prescription**

Print approved prescriptions using the following procedure:

1. Go to patient’s restorative (dental) charting.

2. On the tool bar located on the bottom of the page, click on the drop down box located beside the picture of the pill.

3. Click “Prescribe.”

4. Click on the drop down arrow located to the right of “Rx Template.”

5. Select the drug you desire to prescribe.

6. Click on “Print/Save.”

7. Your prescription will print out on the printer located outside the reception room window. Dr. Hewitt will then need to sign the prescription. It also must be documented in the patient’s Record of Treatment.
SECTION 6  Screener, Clinic Assistant, and Infection Control Duties

Screening Appointments

**These responsibilities are duly shared between the Clinic Assistant (CA) and Infection Control/Screener as a team effort**

All adult patients (18 years or older) must be screened before they can be appointed for a cleaning. The secretary will confirm screening appointments 24 hours prior to the appointment. The dental secretary 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 for CCCC. See medical consult (CF 21) 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.

5. Has the patient had a joint replacement (ie: knee, hip, finger, etc)? If the patient responds "yes" to this question, ask the patient when the joint replacement occurred and notify patient that our clinic must receive written permission from their medical doctor whether to proceed with/without an antibiotic prior to being seen in the clinic.

   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. However, Please inform the patient there will be a $5.00 charge for the cleaning appointment.

      iii. The appointment will last about 30 minutes. Arrive 15 minutes early to fill out necessary paperwork and bring list of current medications.

      iv. Patients will only be allowed to park in parking spaces labeled “V” for visitor. They may move the orange cones to park in blocked off visitor spaces.

      v. Patients will receive a Parking Pass, Welcome Letter, and a Patient Information Brochure which explains our procedures. Parking pass colors change each month.
Screener Responsibilities

Complete green screener/duty sheet during clinic, have an instructor initial it and enter your duty in DSS under adjunctive services.

For each clinic period, one student will be assigned to be the Infection Control/Screener. This student will be screening patients every half hour and performing the following duties:


2. The Dental Secretary will enter the patient into EagleSoft and make a file folder with the chart # when the patient arrives.

3. Seat the patient, verify that the HIPAA and consent forms have been signed and review the health questionnaire.

4. Have patient read and sign welcome letter, answer any questions the patient may have about the clinic policies.

5. 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.

6. 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 <95 (159/94). 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 94, 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.

7. *Review the medical history with an instructor before proceeding.

8. Perform a cursory intraoral examination to make sure there are no active lesions.

9. Use the clinic screening cassettes and appropriate PSR probe to perform the PSR.

10. Record sextant score in the PSR Chart in EagleSoft and the yellow card.

11. Inspect for hard and soft deposits.
12. Fill out Record of Treatment SCREENING template indicating services rendered at the screening appointment. Remember to include the classification of the patient on the Record of Treatment and that a pamphlet was given. Do not place any blank clinic forms in folder to be used at following appointments.

13. When you have determined the patient’s classification put up your white flag for an instructor check.

14. Explain to the patient that his/her name will be placed in the screening box 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.

15. In Den 221 & 231 the appointments are at 8 & 10:00. One patient should not be scheduled for a entire morning clinic. Make sure the patient is aware that they will be expected to pay $5.00 at the time of the first visit.

16. Give the patient a monthly colored parking pass and the Patient Information Brochure, which describes procedures and policies of our program.

17. Turn in the chart to be filed. Do NOT keep the patient’s chart.

18. Fill out, in pencil, a yellow “Screening Card” 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.

   a. Place the yellow card in the screening box (DO NOT place in any hanging files! Do NOT place the screening card in the patient chart.) This is our “patient pool.”

19. Once a screened patient begins treatment, remove the yellow card from the screening box, erase the yellow card and place the BLANK card in the form cubby to be reused.

20. Have instructor sign Record of Treatment in the presence of the patient being screened before patient is dismissed.

**Infection Control Responsibilities**

Complete a green infection control/screener grade sheet during clinic, have an instructor initial it and enter your duty in DSS under adjunctive services.

For each clinic period, a student will be assigned to be Infection Control/Screener. This person will report no later than 7:15 and 12:15 (Monday) for clinic, in the proper clinic uniform, and will be responsible for the following:

1. Retrieve holding solution containers, fill with Enzymax and warm water and place in sterilization area.

2. Fill ultrasonic with hot water and Enzymax solution (make sure valve on back of ultrasonic is closed so water will not drain)

3. Pass out sterilization bag to students, for their handpieces, with their name and date on it.

4. When the holding solution containers are full, run instruments through ultrasonic for 15 minutes. DO NOT CUT THIS TIME.
5. Check instruments to make sure they are free from debris. If debris remains, run the instruments in the ultrasonic again.

6. Rinse instruments in tap water and then dip in deionized water and let drain for 5 minutes.

7. Insert biological indicator strip and 3-2x2 gauze.

8. Wrap cassettes for sterilization & label the side of the cassette with the students’ last name, first initial and the #1(first year) or #2(second year) for your appropriate class and appropriate sterilizer letter.

9. Sterilize instruments. In Den 221 & 231 instruments will be sterilized at 10 and 12:00.

10. Mix Enzymax to be used as evacuation cleaner, place on center isle for students to run their unit suction lines.

11. Repeat steps 6-12 at: 9:30 and 11:20 in DEN 221 and 231; 10:30 and 3:30 in DEN 131; and 11:20 in DEN 141.

12. Refer to the Infection Control calendar posted in the sterilization area for additional daily duties.

13. Set up both X-ray processors in the dark room, run cleaning film and test film prior to 8am, and have an instructor sign off on the test films and record in the QA book.

**After Clinic Duties**

1. Drain ultrasonic and rinse out.

2. Spray with disinfectant.

3. Clean and disinfect center aisle tabletops. (Ex. put away disinfectant, barriers, glove and mask boxes.)

4. Sterilize instruments.

5. Run Autoclaves - Make sure you do not leave campus before the autoclaves have been turned off. One point will be deducted from your final clinic grade if the autoclave is left on.

6. Enter your name in the computer and select adjunctive services column for I (Infection Control).

**Clinic Assistant Responsibilities**

Complete a grade sheet during clinic, have an instructor initial it and enter your duty in DSS under adjunctive services.

For each clinic period, a student will be assigned to be clinic assistant (CA).

1. The clinic assistant will report no later than 7:15 and 12:15 (Monday) for clinic, in the proper clinic uniform, and will be responsible for the following:

2. Follow the PINK CA grade sheet for clinic duties.

3. Open the clinic, turn on all lights, equipment etc. and make sure to restart all clinic computers including the back grading area and all X-ray rooms.

4. From 7:45 and 12:45 (Monday), the clinic assistant will stand at the patient check-in window to process patients in the following manner:
a. Look for patient’s name on “Patient Check-In Form” which the secretary will place on the counter by the window in clinic.
b. Acknowledge the patient is here.
c. Give health questionnaire forms on clipboard for patient to fill out or update. Instruct patient where to sign.
   i. Once this is done, the patient will be asked to return the clipboard to the clinic assistant and have a seat until their student comes to get them.
   ii. The clinic assistant will bring your clipboard to each clinician.
   iii. 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 waiting area and are not to be seated in the clinic until after 8:00 and proper procedures are completed.
   iv. If your clipboard is not in the stand when your patient arrives, your patient will be instructed to have a seat. After all other patients have been checked in, the clinic assistant will again look for your clipboard and process your patient.

During Clinic Duties
1. Keep clinic, central sterilization room, and reception area neat and clean.
2. Sterilize any instruments ready to run (first year, second year or dental assisting).
5. Maintain supply of ALL items in center aisle and rotate supplies and dispose of expired goods.
7. Maintain paper towels in dispensers in clinic and sterilization room; stock 2 x 2’s and fill soap dispensers in each cubicle.
8. Sweep outer isles of clinic and hallways.
9. Clean sinks and under cabinets in central sterilization room.
10. Use initiative to assist students and instructors during clinic session.
11. Exhibit appropriate attitude.
12. Clean removable appliances of patients when the need arises.
13. Dust, sweep and clean any area that may need attention.
14. Check that all disinfecting solution containers are full and have not expired.

Weekly Duties-Check Infection Control Calendar

Monday
1. Run a monitoring vial through each sterilizer following directions in the Infection Control Manual.
2. After cracking the vials, place the 2 vials from the sterilizers and 1 control vial in the incubator. Follow directions in the infection control notebook.
Tuesday

1. Record results of each indicator vial in the small notebook and large black IC notebook on counter in sterilization area and initial IC calendar.

2. Report color change to an instructor immediately.

Monthly Duties—Check Infection Control Calendar
See infection control calendar in sterilization room for each semester. Monthly dates vary depending on holidays and other clinical assignments. Check the calendar, complete the duties, and initial the calendar to verify that all of your duties are completed. Failure to do so will result in the loss of 20 professional responsibility points for both the CA and Infection Control. These two students should work as a team and are responsible for each other’s activities.

After Clinic Duties

1. Leave sterilization room clean, orderly, and everything put away!

2. Check sterilization area, reception area, clinic storage room for neatness and cleanliness.

3. Reposition lights and units if necessary.

4. Make sure all units; computers, wireless keyboards, mice and x-ray units are off.

5. Turn off suction and vacuum system.

6. Remain on duty until all your classmates are out or until you at least ask if you can help them finish up.

7. Leave the clinic as you would like to see it when your parents, the Commanding Officer or a pop-in visitor come for a tour!

8. Enter your name in the computer and select adjunctive services column for CA (clinic assistant).

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. Failure to complete your assigned duty results in 20 professional responsibly points.
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 lockers.
3. Do not tape anything to walls or place personal items in drawers! Anything you buy should be put in your locker at the end of clinic.
4. See location of items as listed below in order to properly organize your cubicle- see the diagram in the bottom of the middle drawer in your unit. All units should be identical.

Top Drawer
- Stethoscope and Blood Pressure cuff (labeled for each unit)

Middle Drawer
- Prophy angle and brush
- Floss
- Prophy paste
- Disclosing solution
- Gauze
- Cotton tip applicators
- Saliva ejector tips
- Floss threaders
- Lubricoat
- Kleenex

Bottom Drawer
- 1 bag over gloves
- Sample TB
- Patient education guide
- Pink Sterilex card

**No personal items in drawers
**No extra barriers are to be kept in the drawers

Please use plastic file holders mounted about view boxes in units to store loose papers, patient charts and other extra item you may not need close by. A neat, clean work environment is both important and productive.
Storage Room and Inventory

*No student is authorized in the storage room without permission from either a faculty member or the dental secretary.*

To request inventory items 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 Secretary and notify secretary that you are requesting items to be pulled. The secretary will then accompany you to pull the items indicated from the Storage Room.

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: ________________________________

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<th>QUANTITY NEEDED</th>
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79
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 (CSR) **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 CSR.
4. Once the Dental Department has 2 full bags of soiled towels, the Dental Division Secretary is to be notified so that arrangements can be made for the soiled laundry to be picked up and cleaned. (# of soiled bags will be modified, if needed to support clinical needs, as necessary.)
5. Notify Dental Division Secretary to contact 455-1474 (Coastal Dry Cleaners) for pick up.
6. Laundry basket to be placed outside Dental Department waiting room doors for pick up.
7. Label the outside of the bag **DENTAL PO #________** (check with dental secretary re: PO # as it frequently changes)
SECTION 8 Dental Radiology Policies and Procedures

Operation of Radiographic Operatory I, II and V

Type: Progeny JB-70

1. Operatory I and II: The on/off button is located on top of the control panel. The control panel with keypad is on the wall in the operatory. For film radiographs, use the lightning bolt setting and change the tooth symbols for each exposure. For digital radiographs, use the computer monitor and keep the exposure setting on 0.050. The exposure button stands alone outside the door.

2. Operatory V: The on/off button is located on top of the panel on the wall behind the patient chair. The control panel keypad is located on the wall outside the operatory door. For film radiographs, use the lightning bolt setting and change the tooth symbols for each exposure. For digital radiographs, use the computer monitor and keep the exposure setting on 0.050. The exposure button is on the control panel key pad outside the operatory door.

Operation of Radiographic Operatory III, IV and VI

Type: ProStyle, Planmeca: preset kVp and preset mA

The on/off button is located under the panel that is on the wall behind the patient chair. The control panel keypad is located on the wall outside the operatory door. 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. The same settings are used for both digital and film radiographs.

Operation of All Radiographic Operatories

The door should be closed for all exposures. The exposure button should be held down long enough to make the exposure complete. An audible signal can be heard when an exposure is being made.

Digital Radiographs

1. Turn on control panel.
2. Only in Operatories I and II, V. Select digital on control panel keypad (computer monitor symbol).
3. Choose adult or child.
4. Log on to computer.
5. Student password = password.
6. Log on to EagleSoft, opens to clinical screen.
7. Click on x-ray tube head.
8. Type in patient’s name.
9. Select “USE”
10. Connect sensor.
11. Place an appropriate barrier over the sensor.
12. Attach stabe/tab/XCP appropriate for the area of the mouth for each projection.
13. Place a cushion on the sensor in areas needed.
14. Click on FMX 18 on left side of computer screen.
15. Eighteen area of projections will show up blank.
16. The left side of the screen is the patient’s right side and vice versa.
17. Assure that the correct projection is flashing blue/yellow before exposing patient.
18. Place sensor in mouth for the projection needed, being careful not to crimp the wire.
19. After placing sensor, exit room, pull door closed, press and hold exposure button.
20. Immediately remove sensor from patient’s mouth and proceed to next projection.

**Film Radiographs**

1. Turn on control panel.
2. Only in Operatories I and II, V. Select film on control panel keypad (film with lightning bolt symbol).
3. Choose adult or child.
4. Select specific projections.
5. Place unexposed films in lead lined box.
6. Use proper film holders (Styrofoam stabes, paper bitetabs, etc) for appropriate areas of the mouth for each projection.
7. Place a cushion on the film in areas needed.
8. Place film in mouth for the projection needed.
9. After placing film, exit room, pull door closed, press and hold exposure button.
10. Immediately remove film from patient’s mouth and proceed to next projection.

**Operation of Panorex: Operatory I**

Type: Shick, CDR Pan X

1. Log in to computer (in far right corner of room).
2. Student password = **password**.
3. Log on to EagleSoft.
4. Click on clinical portion of the screen.
5. Click on x-ray tube head.
6. Type in the patient’s name.
7. Select “use” at bottom of screen.
8. Choose **new exam** and select panoramic.
9. The on/off button is located under the section that lifts up and down.
10. Control panel is located on the machine.
11. Select the kVp and mA according to the size of the patient.
13. Once the patient is positioned, click **acquire new image** in the upper left corner in EagleSoft (yellow radiation sign).
14. When ready to acquire image appears, step outside the door to press button. **Hold button in the entire time.** Important because there is a little lag time between pressing the button and movement of the tube head.
15. When the exposure is complete, push button again to move the tube head so the patient can exit. Press exposure button again to move tube head to the ready position.
16. Follow all infection control procedures previously learned in radiology lab.

**Operation of Panorex, Operatory II**

**Type: Proline EC, Planmeca**

1. The on/off button is located underneath.
2. Be sure film cassette is loaded correctly.
3. Control panel is located on the machine.
4. Select the kVp and mA according to the size of the patient.
5. Place lead apron on patient and align patient correctly in focal trough.
6. When ready to acquire image, step outside the door to press button. **Hold button in the entire time.** Important because there is a little lag time between pressing the button and movement of the tube head.
7. Take cassette to darkroom to process and reload two new pieces of film.

**Darkroom Protocol**

1. CA and Infection Control are responsible for setting up and breaking down processor(s) daily. They are also responsible for keeping the darkroom neat and orderly.
2. The processor needs to be up and running by the start of clinic.
3. To set up the processor, check developer and fixer levels.
   a. If levels are low, add more solution by pouring more solution directly into existing solution. Also, check to make sure the bottles below the sink are not empty. They are considered empty if they have about an inch remaining. Pour out remaining solution and rinse out the bottle and place it in the hallway.
   b. Attach new bottles of developer and fixer located under the sink.
4. Let the clinical radiography instructor know if the fluids are dirty. (They will look dark or there will be debris that has settled in the bottom of the tanks). The clinical instructor will remove, clean and refill the fixer, developer, and water tanks.
5. Place the rollers back into the fixer, developer, and water tanks and lock each in place.
6. Close the processor and turn it on to warm up.
7. Make sure lid is closed properly so light will not leak in.
8. Students should not develop their film(s) until the current day’s paper towel with the test film(s) including the instructor’s signature is taped on the darkroom door.
   a. Run test film in the processor.
      • To create a test film, take dental aluminum stepwedge and place on double packet film. Align x-ray tube head and take the image on the Bitewing setting. Make multiple test films. Run a test film through processor #1 and a separate test film through processor #2. Image will be several shades of gray and will reveal if the fixer and developer solutions need to be replaced or the rollers need to be cleaned.
   b. Tape the test films onto a paper towel and label the film from Processor #1 and Processor #2.
   c. Take the test films to an instructor to see if the films are developed correctly.
   d. Put today’s date on the paper towel and have the instructor initial.

9. The result of the day’s test film(s) will be written in the black book in the x-ray viewing area called “Quality Control.”
   a. The student will write the date and whether or not the test film(s) passed or failed.
   b. Then, the student will place their initials in the proper column.
   c. The first film of each month from Processor #1 and Processor #2 should go in front of the “Quality Control” book.

10. The Clinic Assistant is responsible for checking the Darkroom Calendar located in the darkroom to complete and initial all assigned tasks after clinic.

Guidelines for Prescribing Dental Radiographs

It is the Dental Department’s practice to keep patient radiographic exposure to a minimum. The initial step to keeping exposure low is the proper prescribing (ordering) of radiographs. Guidelines developed by an expert panel of dentists convened by the Public Health Service and adopted by the American Dental Association will be used when deciding when, what type and how many radiographs should be taken. These recommendations are subject to clinical judgment and are used only after reviewing the patient’s health history and completing a clinical exam (oral inspection), and discussing the possible need for radiographs with a clinical instructor and/or dentist. These guidelines do not need to be altered because of pregnancy according to the literature; but in our dental clinic we will not take radiographs on a pregnant patient. Please refer to the written guidelines from radiography lecture.

Before coming to an instructor for permission to proceed with radiographs, the student should:

1. Review Medical Questionnaire.
2. Perform brief oral inspection. Count the number of teeth and write on analysis form. Determine if digital or film x-rays are appropriate for the patient.
3. Refer to Department of Health and Human Services Guidelines for Prescribing Dental Radiographs to determine if radiographs are recommended at this time.
4. Determine if the patient’s dentist will evaluate the radiographs. If the patient does not have a dentist of record, the patient must be encouraged to make an appointment with a dentist for an examination and diagnosis of the radiographs. The student may use the dentist’s name on the consent form as a temporary measure until the patient sees a dentist. If the student feels that radiographs are indicated, seek a clinical instructor to obtain permission to proceed with radiographs. Be prepared to explain why radiographs are indicated for the best care of your patient.

Note: Any attempt by a student to alter records in any way to keep from taking a set of radiographs or to be allowed to take a set of radiographs, will be regarded as cheating. Disciplinary action for cheating/academic dishonesty is detailed in the College Catalog.

Taking Post Operative Bite Wings – You must take post operative bitewings on all C and D patients with radiographic calculus. Make sure you have the post-op bitewing survey entered into the Radiography Notebook. Post-op BWX will count toward quota if all analysis and technique forms are completed to CCCC standards. A new consent form must be completed for all post-op BWX.

No radiographs will be taken aboard Camp Lejeune.

Procedure for Patient Radiographs

1. Paperwork to complete before requesting to proceed with radiographs:

   Prepare a record and place the forms in the order listed. If the patient has been seen in the dental clinic previously, request the record at least 48 hours prior to the scheduled appointment. Established patients may not require ALL new paperwork.

   I. Radiology Consent Form (white/yellow carbon copied)

      a. Every patient will need a new Radiology Consent Form for each visit requiring radiographs (even post-op BW).
      b. Complete patient’s full name (last name, first) and demographics.
      c. Determine if there is a dentist that the patient wants the radiographs to be sent to.
      d. If they DO, complete the information for that dentist using the dentists’ full name.
      e. If the patient does NOT have a dentist of record, TEMPORARILY use:

         Dr. Joseph Hewitt, 444 Western Boulevard, Jacksonville, NC  28546
         Email Address:  N/A

         **Please stress to the patient the importance of finding a general dentist. We will temporarily store their radiographs at Coastal but once a general dentist is found, request that we forward the radiographs to that dental office.**
f. The patient will sign (18 and older are adults, if 17 and under, a parent or legal
guardian)
g. Student to sign LEGIBLY (this pertains to all forms)
h. Fill in the date of the appointment
i. The Instructor and Dentist Signatures will be done by the instructor
j. Check which type of x-ray you will be performing
k. **Complete the Radiography History**
l. You will need to contact their dental office to determine the dates of their last
dental x-rays.
m. Record the date, phone number and person you spoke with.
n. If they **do not** have a dentist of record, then the patient will need to recall the best
they can when they had their last x-rays (i.e. month/year or season/year, Fall 1998)
and place N/A in the date, phone number and name of person that was contacted.
o. If they cannot determine dates of their last dental x-rays, then place N/A in the
spaces.
p. If they have never had a particular dental x-ray, place “NEVER” in the space.
q. **Leave none of the blanks empty.**
r. List and date any radiographs in the last 12 months (chest, left hand, etc).
s. If there are no radiographs to record, place “NONE” in the space.
t. The last portion of the form will be completed after the dentist has viewed the
radiographs.

**II. Medical History and Drug Summary** (Blue)

a. Complete form in pen.
b. If using a previous Medical History Form, have patient review form and make any
changes, then initial and date the Update Boxes on the bottom of the back side of
the form.
c. Any medical concerns that may affect dental treatment are to be circled in red and
notated in the Alert Box in pen.
d. Take patient’s BP and pulse if patient is 18 years or older.

**NOTE:** See Pre-Clinical Notes to assist with form.

**III. Record of Treatment**

a. Print Legibly in Pen.
b. If there is a Record of Treatment in an established chart then just make sure that the
last notation is “See EagleSoft for any further notes.”
c. If there is not a similar notation then write the current date and make that notation
and under student write: your first initial and last name.
d. If this is a new chart then fill out a paper Record of Treatment:
e. Patient name—last name first and date of birth.
f. Date of appointment.
g. Under type of treatment write: “see EagleSoft for any further notes.”

**IV. Chart Envelopes**

a. Write in pencil.
b. Patients name – last name first.
c. Complete additional information.
d. If a dental concern is indicated in the alert box on medical history, highlight the patient’s name (in pink, with highlighter provided in the cubby).

V. Radiographic Analysis Form

a. In pen, complete top half of form and the number of teeth on the lower portion of form.
b. For type of survey taken, look in patient’s mouth and observe any abnormalities. This step is important for digital radiographs because the patient may have maxillary or mandibular tori that may prohibit digital sensors from going in the mouth. They may also have a mouth that is too small to accommodate the digital sensor or a variety of other reasons. Have patient take out any prosthetic removable appliances at this time. Place appliance in labeled plastic bag and give to CA to be cleaned. If the patient cannot tolerate the digital sensor then immediately switch to film.

VI. Panoramic Radiology Form

a. In pen, complete top half of one form and obtain a second blank form.
b. Ensure that all forms are filled out completely, correctly dated and signed by both the student and patient. **One point will be deducted from the x-ray grade for EVERY paperwork error!**
c. Extend your blue flag at your cubicle to have instructor check necessary forms and log you into the radiology notebook.
d. After receiving permission to proceed, the student will place barriers in the x-ray operatory. Students will not set up the operatory before the instructor has completed the paperwork. The student will escort their patient to the x-ray room. Bring both forms in the radiology operatory in case a retake is needed.
e. If after taking the pano a retake is needed, the instructor will initial the first panoramic form at the top portion where it states **RETAKE**. On the second panoramic form the instructor will initial **Retake Exp**. Both Panoramic x-rays must be submitted for a grade but neither will count for quota.
f. If a retake is needed, open a new exam and take a new exposure.
g. CA is not responsible for setting up or cleaning up the radiography rooms.

2. Procedure for exposing radiographs using **DIGITAL**: Expose and Critique

a. Be sure to use lead apron on all patients (Failure to use lead apron will result in the loss of 60 Professional Responsibility Points).
b. Use acceptable aseptic technique.
c. Use good patient management techniques.
d. Have patient remove eyeglasses, oral piercings and removable appliances, etc. For Panorex: have patient remove hairpins, necklaces, piercings, etc.
e. Perform brief oral inspection. Record in the lower right of the Analysis Form
any findings that might hinder correct placement of image receptor or viewing areas of interest. Count the patient’s number of teeth.

f. Use proper machine settings.
g. Remove and discard gloves, alcohol hand rub, then place mask on paper towel.

h. Determine if you need retakes and record an “R” on the Analysis Form under student error in the correct projection, if not leave blank.
i. Have full-time instructor verify if retakes are/are not needed. (Failure to do so is loss of 20 Professional Responsibility Points).
j. If NO retake is necessary, have instructor initial the form, close EagleSoft.
   • Flip STOP sign (Failure to do so is loss of Professional Responsibility Points).
   • Escort your patient to the cubicle
   • Return to your x-ray operatory to clean it BEFORE proceeding with patient care. When cleaning the op be sure to wear your PPE. (Failure to clean the op first is the loss of 20 Professional Responsibility Points).
k. If retakes ARE necessary, have instructor initial and circle retakes.
   • Place mask back on, use alcohol hand rub and re-glove.
   • Instructor will monitor your sensor and tubehead placement, then you will expose the retake. (Failure to have an instructor approve a retake and initial the form will result in the loss of 20 Professional Responsibility Points and the errors on the image will count against your grade as well).
   • If a retake is still undiagnostic, then one more attempt will be made. If the third attempt is undiagnostic, we will not take any further retakes for that projection.
   • Remove and discard both gloves and mask.
   • Close EagleSoft.
   • Flip STOP sign (Failure to do so is loss of 20 Professional Responsibility Points).
   • Escort your patient to the cubicle.
   • Return to your x-ray operatory to clean it BEFORE proceeding with patient care. When cleaning the op be sure to wear your PPE. (Failure to clean the op first is the loss of 20 Professional Responsibility Points).

3. Procedure when exposing radiographs using FILM: Expose, Process, Mount and Critique

Follow 2. a. – 2. g. as stated above.

a. After exposing x-rays, flip STOP sign (Failure to do so is loss of 20 Professional Responsibility Points), escort the patient to the cubicle and advise them that you will return soon.
b. Return to your x-ray operatory to clean it BEFORE going to the darkroom to process your films. When cleaning your room be sure to wear your PPE. (Failure to clean the op first is the loss of 20 Professional Responsibility Points).
c. Use good darkroom etiquette as you learned in DEN 112.
d. Separate the double packet film before placing it in the automatic processor.
e. Take care not to load the films into the processor too quickly. **Stay in the darkroom** while films are processing.
f. Mount films correctly (**Failure to do so is loss of 60 Professional Responsibility Points**).

g. Record the patient’s name, student’s name and date on the mount in pencil. (**Failure to do so is loss of 20 Professional Responsibility Points**).

h. Do not critique the films at this time. Determine if you need retakes and record an “R” on the Analysis Form under student error in the correct projection, if not leave blank.

i. Have full-time instructor verify if retakes are/are not needed (**Failure to do so is loss of 20 Professional Responsibility Points**).

j. If **NO** retakes are necessary, have instructor initial Analysis Form then proceed with patient care.

k. If retakes **ARE** necessary:
   - Film(s) will be given by instructor.
   - Set up an x-ray operatory with new barriers.
   - Escort patient to x-ray operatory.
   - Place mask back on, use alcohol hand rub and re-glove.
   - Instructor will monitor your film and tubehead placement, and then you will expose the retake. (**Failure to have an instructor approve a retake and initial the form will result in the loss of 20 Professional Responsibility Points and the errors on the image will count against your grade as well**).
   - If a retake is still undiagnostic, then one more attempt will be made. If the third attempt is undiagnostic, we will not take any further retakes for that projection.
   - Remove and discard both gloves and mask.
   - Flip STOP sign (**Failure to do so is loss of 20 PRPS**).
   - Escort your patient to the cubicle.
   - Return to your x-ray operatory to clean it **BEFORE** proceeding with patient care. When cleaning the op be sure to wear your PPE.
   - (**Failure to clean the op first is the loss of 20 Professional Responsibility Points**).

l. Process and mount retakes in place of undiagnostic films.

**Critiquing Radiographs will take place after patient care.**

**Note:** Do not forget! If a patient has special circumstances, i.e., large tori, narrow arches, natural overlapping, gag reflex, etc.; the student must make a note on the analysis form before turning in the set to be graded. Your instructors will not always remember your special case unless reminded!
Make a note.

**No charts or radiographs are to be removed from the health building for any reason. All critiquing must be done in the dental area.*

Critiquing Radiographic Surveys

The abbreviations below can be used to critique the Radiographic Analysis Form:

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>Density</td>
</tr>
<tr>
<td>Vf</td>
<td>Vertical Foreshortening</td>
</tr>
<tr>
<td>Ve</td>
<td>Vertical Elongation</td>
</tr>
<tr>
<td>H</td>
<td>Horizontal</td>
</tr>
<tr>
<td>M</td>
<td>Movement</td>
</tr>
<tr>
<td>U</td>
<td>Unequal Distribution</td>
</tr>
<tr>
<td>B</td>
<td>Backward Film</td>
</tr>
<tr>
<td>Pr</td>
<td>Processing Error</td>
</tr>
<tr>
<td>C</td>
<td>Cone Cut</td>
</tr>
<tr>
<td>Mt</td>
<td>Mounting Error</td>
</tr>
<tr>
<td>MA</td>
<td>Missing Apices</td>
</tr>
<tr>
<td>MC</td>
<td>Missing Crowns</td>
</tr>
<tr>
<td>O</td>
<td>Other (specify)</td>
</tr>
<tr>
<td>P</td>
<td>Packet Placement (see radiology class notes)</td>
</tr>
<tr>
<td>OK</td>
<td>No Errors</td>
</tr>
<tr>
<td>A</td>
<td>Absent (missing film)</td>
</tr>
</tbody>
</table>

1. **Interproximal Survey (Bitewing)**
   a. Each projection is worth five points: four points for technique, one point for critiquing.
   b. One point will be deducted for each technique error and one point will be deducted for each film critiqued incorrectly.
   c. One to five points will be deducted for errors in paperwork with the exact penalty left to the discretion of the instructor.
   d. **60 professional responsibility points** will be deducted for incorrect mounting.
   e. One point will be deducted for one retake; each retake over one will result in the loss of 4 points per additional retake. This is different from radiography lab.

2. **Full Mouth Survey/Modified Full Mouth Survey**

A modified full mouth survey will consist of at least 9 projections. (MFMS)

   a. Each projection is worth five points; four points for technique, one point for critiquing.
   b. One point will be deducted for each technique error and one point will be deducted for each film critiqued incorrectly.
c. One to five points will be deducted for errors in paperwork with the exact penalty left to the discretion of the instructor.

d. **60 professional responsibility points** will be deducted for incorrect mounting.

e. One point will be deducted per retake up to three. After three retakes, four points will be deducted per additional retake. This is different from radiography lab. (Differs slightly for MFMS)

3. Penalty - Professional Judgment

Ten Professional Judgment points will be deducted for improper patient management. This includes and is not limited to: failure to seek an instructors help preventing multiple retakes, falsifying patient information on the radiology consent form, taking incorrect vertical or horizontal bitewing projections for each patient, and failure to identify oral anatomy that may prevent use of the digital sensor.

**Radiographic Interpretation**

An interpretation of the anomalies seen on an x-ray projection will be done on each patient survey (FMS, BW).

The patient with all primary dentition or mixed dentition will have a primary/mixed dentition interpretation form. To fill this form out correctly, show teeth present, both permanent and primary and any decay. Do not draw bone level or restorations.

1. Complete the top of form RF5, Radiographic Interpretation: Adult FMS/MFMS
   a. Student name – last name first.
   b. Patient name – last name first.
   c. Date – date radiographs were exposed.

2. Chart missing teeth:
   a. Circle impacted/unerupted teeth in **blue**
   b. Cross out missing teeth in **blue**.
   c. If you can’t see a tooth on the radiograph, circle it in blue (i.e., 3rd molars, unerupted permanent teeth).

3. Chart calculus in **blue** exactly how it appears radiographically

4. Chart caries in **red** exactly how it appears radiographically

5. Chart periodontal condition:
   a. Draw bone level in **blue**.
   b. Draw bone level from the proximal of one tooth to the proximal of the adjacent tooth – carry the line through the tooth.
   c. Use bitewings to draw bone level, when possible.
   d. Draw furcation involvement in **red** – triangle in furcal area.
6. Draw conditions that should be brought to the attention of the dentist in **red**.
   a. Retain root tips
      - When tooth has been extracted and root tips remain – X crown out in **blue**, circle root(s) in **red**.
      - If decayed to the gumline – circle crown in **red**.
   b. Foreign bodies – draw exactly as it appears.
   c. Fractures – draw exactly as it appears.
   d. Defective restorations – draw restoration in blue, circle in red the defective area.
   e. Internal resorption.
   f. Root resorption.
   g. Periapical pathology (abscess, cyst, granuloma).
   h. Other pathosis.

7. Draw other conditions in **blue**.
   a. Pulp stones
   b. Overhangs – draw straight line beside tooth
   c. Dilaceration
   d. Supernumerary
   e. Tori

8. Draw and label normal anatomy in **PENCIL**.
   a. Draw only anatomy that is visualized radiographically.
      - If you can’t see it, don’t draw it.
      - Draw anatomy exactly as it appears.
      - Label each structure using abbreviations when necessary.
      - Draw the structure bilaterally if it appears bilaterally.
   b. **Anatomy commonly seen in maxillary radiographs:**
      - Maxillary sinus
      - Incisive foramen
      - Midpalatine suture
      - Nasal fossa
      - Nasal septum
      - Anterior nasal spine
      - Zygoma- malar bone
      - Maxillary tuberosity
      - Lip/nose lines
      - Pterygoid hamulus
      - Condyle
   c. **Anatomy commonly seen in mandibular radiographs:**
      - Inferior border of the mandible
      - Angle of the mandible
- Mandibular canal
- Mental foramen
- Lingual foramen
- Symphysis
- Genial tubercles
- Mylohyoid ridge
- External oblique ridge
- Mental ridge
- Ascending ramus

9. Do NOT draw existing restorations.

10. The interpretation will be graded by deducting three points for each error in DEN 131, 141, and 221. In DEN 231, six points will be deducted for each error. If a student misses a large area of decay on a tooth, (MODFL) in DEN 131, 141, and 221, this would result in the loss of 15 points. In DEN 231, a MODFL would result in the loss of 30 points.

11. An interpretation of anatomy seen on a Panoramic projection will be done on ONE patient survey in DEN 141, DEN 221, and DEN 231.
   - Expose the Pano
   - Print ONE copy of the Pano
   - Using tracing paper, trace the dentition, and all anatomy present in the Pano
   - Draw and label normal anatomy in PENCIL.
   - Draw only anatomy that is visualized radiographically.
   - If you can’t see it, don’t draw it.
   - Draw anatomy exactly as it appears.
   - Label each structure using abbreviations when necessary.
   - Draw the structure bilaterally if it appears bilaterally.

12. **Anatomy commonly seen on a panoramic radiograph:**
   - Coronoid Process
   - Sigmoid Notch
   - Mandibular Condyle
   - Condylar Neck
   - Mandibular Ramus
   - Angle of Mandible
   - Inferior Border of Mandible
   - Lingula
   - Mandibular Canal
   - Mastoid Process
- External Auditory Meatus
- Glenoid Fossa
- Articular Eminence
- Zygomatic Arch
- Pterygoid Plates
- Pterygomaxillary Fissure
- Orbit
- Inferior Orbital Rim
- Infraorbital Canal
- Nasal Septum
- Inferior Turbinate
- Medial Wall of Max. Sinus
- Inferior Border of Max. Sinus
- Posterolateral Wall of Max. Sinus
- Malar Process
- Hyoid Bone
- Cervical Vertebrae 1-4
- Epiglottis
- Soft Tissues of Neck (Look
- Auricle
- Styloid Process
- Oropharyngeal Air Space
- Nasal Air Space
- Mental Foramen

Preparing Patient Radiographs for Clinic Grade

1. Dr. Hewitt will need to view the radiographs.
   a. Dr. Hewitt’s office hours (posted on his door).
   b. Have on hand: Patient’s entire chart, Dental Referral, Radiology Consent Form, completed radiology analysis form, completed student radiology evaluation form, and a pen.

If patient DOES need referral:
   - Record all of your findings as verified by the dentist (so have pen with you).
   - Complete the patient demographics.
   - The dentist needs to sign the form.
   - Sign your name (legibly).
   - For patient signature: Have patient sign or write patient is no longer present.
   - Update EagleSoft charting with current findings
• Document in EagleSoft that the referral was sent to Dr. XXXXX

• If patient does not have a general dentist, document in EagleSoft that the referral was kept at CCCC until the patient finds a general dentist.

If patient does NOT need a referral:
• The dentist will need to initial your consent form verifying there is no dental referral needed.
• Return the blank referral to paper cubby in clinic.

2. Place in this order and paperclip together in upper left corner:
   a. Interpretation form.
   b. Student Radiology Evaluation form.
   c. Radiographic Analysis form.
   d. Radiographic Consent form.
   e. Signed dental referral (unless the patient does not need a referral).
   f. Place paper clipped forms in front of patient’s chart and put it in the clinical radiography instructor’s x-ray file in clinic.
   g. If FILM radiographs were used:
      • If intraoral films were used, place envelope with undiagnostic film(s) and mounted radiographs on top of forms listed above and paperclip together.
      • If panoramic film was used, place label on lower left hand corner and write patient name, your name and date. Fill out a panorex evaluation form and place film and evaluation form in the patient’s chart as listed above.
      • When turning in bitewing and panoramic films together, place panoramic film and evaluation behind all other x-ray papers.
   h. Radiographs will be graded within 48 hours and be placed in the student’s hanging file in the clinic.

**Do not forget radiographs are due one week after exposure! (Failure to do so will result in the loss of 20 Professional Responsibility Points)**

• Five points will be deducted from the radiology technique grade for each clinic day the survey is held over the one week period.

• Exceptions must be approved in advance and documented on the patient’s record of treatment by the instructor who will grade the survey. If the grade ends up being less than 85% because of the 5 point per day deduction, or any error deemed “non-critical” the grade will be recorded as it stands, and the student will receive credit for quota. Interpretation grade will not be affected.

• Non-Critical Errors
  o Paperwork
  o Professional Judgment
• Critical Errors
  o Technique Errors
  o Mounting
  o Analysis Errors
• All surveys will be evaluated by the instructor, graded and recorded.
• If the technique grade is below the 85%, it will not count towards quota and the student will need to repeat the survey on another clinic patient.
• All grades must be turned in whether diagnostically acceptable or not and will be recorded.

Quota
Each student will be required to meet a radiology quota every semester. The exact number of radiographs needed will be listed in the student’s course syllabus. In the event the student does not meet the required quota of radiographs, point deductions will be factored into the final clinic grade the amount due will carry over into the next semester. However, the total required quota for Radiology must be completed by the last day of clinic for DEN 231.

Entering a Radiology Grade Form Step By Step

The student has 48 hours from the time the survey was graded to put the grade in the computer. (Failure to put the survey grade on the computer within 48 hours will result in a loss of 20 Professional Responsibility Points).

1. Click on the Icon Dental Scoring System.
2. Click on Radiography at the top of the screen (a drop down box will appear).
3. Click on Panoramic or Analysis depending on type of x-ray.
4. Enter your student ID number (number on student ID card).
5. Click on Input New Form.
6. Select type of x-ray taken (the analysis form will appear).
7. Enter date exposed (the date you took the x-ray).
8. Enter the patient’s first and last name.
9. Enter the patient’s age.
10. Enter the room number you were in when you exposed the radiograph.
11. Enter analysis errors (errors made when you critiqued the projection).
12. Enter technique errors (errors made when you exposed the projection).
13. Enter the number of shots you took for each projection(s) (for ex., if you took one shot, put one, if you took the shot and took a retake, put two).
14. Enter the letter symbol for each error made in the far right column.
15. Enter the interpretation grade. (Note: if this is a set of post-op bitewings you will enter the interpretation grade as 100).

17. Click on update in the upper left corner of the screen.

18. Record total “films/projections” taken, case points, penalty point, competency points and performance percentile on your paper grade sheet.

19. Case points = 1 projection x 5, competency points = 1 point for each error. Computer will generate a percentage.

**Note: In the event the student receives a “zero” for a set of x-rays, the following numbers will be entered into the computer**

- -99 for FMS
- -29 for BW

20. Record grade at bottom of the form and initial and date the upper right hand corner. Staple the white copy of the interpretation form behind the white copy of the Radiology Analysis Form and place it in the clinical radiography instructor’s file.

21. Check the information carefully and hit either Save or Submit. If a form is saved it cannot be verified by an instructor. Do not turn in a grade sheet for verification until you have submitted the form. If you save the form you can go back and make changes. **Once a form is verified you cannot make any changes. You have 48 hours to submit your grade form. If you save your form and forget to submit it, you will lose two paperwork points.**

If the student selects the wrong patient name, or wrong patient series, the radiographic form will be deleted from the computer. Ten points will then be deducted from the form and the student will be asked to re-enter the form.

**Mailing, Documentation and Filing of Patient Radiographs/Chart**

**BEFORE** mailing out Consent Form, at the bottom of the form, complete the date/manner in which you will be sending the x-rays out or check the box that the x-rays are staying at CCCC.

**BEFORE** mailing out Dental Referral Form, if used, at the bottom, check if radiographs are being enclosed (sent via email, mail or hand-carried) or kept at CCCC.

**NOTE**: Address Labels are only to be used on the large manila envelopes. DO NOT use metal clasp on manila envelope to close the envelope- seal over the metal clasp instead. Hand write the patient/DDS address on the legal size white envelopes

**NOTE for Carbon Copied Forms**:

- White Copies are for General Dentist
- Yellow Copies remain in Patient Chart
- Pink Copies are for the Patient
For Film Radiographs:
- For patients who will be treated in the dental hygiene clinic, keep the most recent films in the mount and place them in the front of the patient record.
- For patients who will NOT be treated in the dental hygiene clinic, complete a second coin envelope. Take the films out of the mount and place them in the coin envelope in the front of the record.
- Staple one coin envelope horizontally to the upper left corner of the white copy of the Consent Form.

Mailing of Patient Radiographs

No General Dentist
1. If Dr. Hewitt is recorded on the Consent Form, then do NOT separate the Consent Form. Note in EagleSoft record that the films will remain at Coastal Carolina Community College.
2. If NO Dental Referral Form was used: EagleSoft Notation
   - Obtain a Patient Radiology Letter and CCCC letter envelope from paper cubby in clinic.
   - On Patient Radiology Letter include date and patient’s name and place your signature in the space above “Dental Department” (legibly).
   - Check applicable box.
   - Address envelope to patient.
   - Place Patient Radiology Letter in envelope and.
   - Place in the outgoing wooden mailbox on the Dental Secretary’s counter in the Reception area.

3. If Dental Referral Form was used: EagleSoft Notation
   - Obtain a Patient Radiology Letter and CCCC letter envelope from paper cubby in clinic.
   - On Patient Radiology Letter include date and patient’s name and place your signature in the space above “Dental Department” (legibly).
   - Check applicable box.
   - Address envelope to patient.
   - Place Patient Radiology Letter and Dental Referral (pink) in envelope and seal.
   - Place in the outgoing wooden mailbox on the Dental Secretary’s counter in the Reception area.

**NOTE:** Consent Form/Dental Referral (yellow and white) will remain in patient chart until DDS is found

Hand Carried/Mailing Radiographs

To Print Radiographs:
- Computer in far right corner in OP 1.
- Paper should feed from BLACK TRAY NOT TRAY FEED ON TOP.
- Glossy side of paper DOWN.
- **NOTE:** IF there are computer printer issues, have faculty contact IT Department.
• Pull up patient Radiographs.
• Highlight each Radiograph (hold SHIFT and click each one).
• Select FILE.
• PRINT.
• LANDSCAPE.
• Make sure ALL images will appear on layout.
• OK.

1. Separate the yellow and white copies of the Consent Form and Dental Referral Form (if used).

2. Obtain X-Ray letter, large manila envelope and address label from the paper cubby in clinic.

3. Fill in the X-Ray letter using information from Consent Form:
   • Include date, dentist name, address and patient’s name.
   • Place your signature in the space above “Dental Department” (legibly).

4. Address the envelope to General Dentist using the information from the Consent Form.

5. Place the X-rays, X-ray letter, white copy of the Consent Form, white copy of the Dental Referral Form (if used) in the envelope addressed to the dentist.

6. Close and seal flap of envelope (with tape, do NOT open and use metal clasp).

   • On Patient Letter include date and patient’s name and place your signature in the space above “Dental Department” (legibly)
   • Check applicable box
   • Address envelope to patient
   • Place Patient Radiology Letter and Dental Referral(if used) in envelope, seal
   • Place both in the outgoing wooden mailbox on the Dental Secretary’s counter in the Reception area.

**NOTE: If patient Hand-Carried, then just hand them the envelopes.**

**Emailing Digital Radiographs**

1. **Computer in far right corner in OP 1**
   • Log into patient’s x-rays in EagleSoft.
   • Select “FILE” at the top of the page.
   • Find “EMAIL ALL” on the list and select it.
   • An email box will open to allow you to enter the email address of the dental office to receive DIGITAL RADIOGRAPHS.
   • Choose the X-ray Form Letter AutoNote and edit it.
   • Be sure the AutoNote includes: Patients Name, DOB and the date the images were taken and that the Consent Form/Dental Referral (if used)will be sent via regular mail (PLEASE IDENTIFY THE PATIENT IN THIS).
• Click the Send button.
• Make a note in the EagleSoft patient’s record that the films were emailed, date emailed, and where they were sent.

2. Separate the yellow and white copies of the Consent Form and Dental Referral Form (if used).

3. Obtain X-Ray letter and CCCC letter envelope from the paper cubby in clinic

4. Fill in the X-ray letter using information from Consent Form:
   • Include date, dentist name, address and patient’s name.
   • Place your signature in the space above “Dental Department” (legibly).

5. Address the envelope using the information from the Consent Form.
6. Place X-ray letter, white copy of the Consent Form, white copy of the Referral Form (if used) in the envelope addressed to dentist.
   • On Patient Radiology Letter include date and patient’s name and place your signature in the space above “Dental Department” (legibly).
   • Check applicable box.
   • Address envelope to patient.
   • Place Patient Radiology Letter and Dental Referral (if used) in envelope and seal.
   • Place in the outgoing wooden mailbox on the Dental Secretary’s counter in the Reception area.

Documenting
2. Open ClipBoard in patient chart.
3. Be sure to document the handling of radiographs:
   • Radiographs at CCCC until general dentist if found.
   • Radiographs were mailed, emailed or hand-carried to Dr. XXXXX.
   • Dental referral not needed.
   • Dental referral was needed and sent to patient but has not general at this time.
   • Dental Referral was sent to patient and Dr. XXXXX.

FINAL Chart Order for Audit/Filing

All Coastal Carolina Community College charts should contain the patient's information in the following order from front to back.
1. X-Rays - The most recent X-Rays should be mounted with patient's name, date the X-Rays were taken, and the student's name who took the X-Rays. All old X-Rays should be placed in a coin envelope and properly labeled with the patient's name and the date the X-Rays were taken. The old X-Rays will be the very last item at the back of the chart.
2. Record of Treatment - latest on top stapled to old ones
3. Recent Health Questionnaire (Blue) and Drug Summary
4. HIPAA Form
5. Welcome letter (keep white copy in chart)
6. Consent Form
7. Dental Chart (if applicable)
8. Periodontal chart (if applicable)
9. DH Care Plan
10. Plaque Index
11. Dental Referral
12. Medical Referral
13. X-Ray Consent Form
14. Sealant Referral Form
15. Staple all old forms together.
16. All old X-Rays in a well labeled coin envelope

**NOTE: At max, there should only be 2 groups of paperwork STAPLED (ROT/Old Forms). Ensure that there are no miscellaneous items left in the chart**

**Other Important Information:**

Coastal’s email address to RECEIVE digital radiographs: clinic@coastalcarolina.edu

To get the patient’s emailed radiographs into the patient’s EagleSoft chart:

1. Drag x-rays from the email and place on desktop
2. Open EagleSoft and open the x-ray program for your patient
3. Minimize EagleSoft so you can see the x-rays on the desktop
4. Drag x-rays into the x-ray program
5. Assure the radiographs are saved in patient chart
6. Delete radiographs off of desktop
SECTION 9  Radiology Forms

RF 1: Radiology Consent Form

RF 3: Radiographic Interpretation- Adult Bitewing

RF 5: Radiographic Interpretation- Adult FMS/MFMS

RF 9: Evaluation of Radiographs

RF 10: Radiographic Interpretation- Primary or Mixed Dentition

RF 26: Radiography Analysis Form

RF: Evaluation Panoramic Radiography
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 semester. 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 floor in lab and prep room.

**Emergency Gas Shut-Off**

In the event that a student believes there is a gas leak, notify the instructor and immediately depress the big red button located beside the door exiting Health Building, Room 143.

**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, he/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 in the drawers provided. Expendable items such as cleaners will be continuously resupplied (upon request) by a lab instructor at the completion of a lab period.

**Student Supplies Purchased By Students**

<table>
<thead>
<tr>
<th>Protective lenses</th>
<th>Lab apron</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waterproof sandpaper</td>
<td>Ink pens</td>
</tr>
<tr>
<td>Compass</td>
<td>Millimeter ruler</td>
</tr>
</tbody>
</table>

**Non-Expendable Items Furnished by Dental Department**

<table>
<thead>
<tr>
<th>Green rubber bowl</th>
<th>Alginate water/mechanical mixing bowl</th>
</tr>
</thead>
<tbody>
<tr>
<td>Powder measurer</td>
<td>Plaster spatula</td>
</tr>
<tr>
<td>Rubber molds</td>
<td>Wood-handled Spatula</td>
</tr>
<tr>
<td>Glass plates (2)</td>
<td>#7 wax spatula</td>
</tr>
<tr>
<td>Amalgam</td>
<td>Amalgam well</td>
</tr>
<tr>
<td>Glass slab</td>
<td>Small Cement Spatula</td>
</tr>
<tr>
<td>Parchment mixing pad</td>
<td>Composite mixing pad</td>
</tr>
<tr>
<td>Lab knife</td>
<td>Dappen dish</td>
</tr>
<tr>
<td>Cement spatula</td>
<td>Dentiform</td>
</tr>
<tr>
<td>Amalgam carrier</td>
<td>Lab pan</td>
</tr>
<tr>
<td>Cotton pliers</td>
<td></td>
</tr>
</tbody>
</table>

**Expendable Items Furnished by Dental Department**

<table>
<thead>
<tr>
<th>2 x 2 gauze squares</th>
<th>Paper cups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>Tongue Depressors</td>
</tr>
<tr>
<td>Solitine</td>
<td>Mixing sticks</td>
</tr>
</tbody>
</table>
SECTION 11  Base Clinical Rotations

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

- Make sure you have your pass and ID card if applicable for entrance to building on Camp Lejeune.

- Be sure to pack lunch and eat it on the way back to CCCC especially on lab days. You will not have any time to stop anywhere and pick anything up, nor allowed to be tardy due to being on base.

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

- You are to wear you CCCC lab coat when you are in your base operatory treating your patient. 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).

- Name tags should be worn on your scrubs and on the dark blue lab coats that are provided on base. The dark blue lab coats are required when walking the base clinic halls.

Paperwork Order

1. Clinic evaluation form (not attached)
2. CCCC record of treatment form
3. CCCC consent form (Blue)
4. HIPAA form (white)
5. CCCC restorative charting form (yellow)
6. CCCC perio charting form (green)
7. CCCC dental hygiene care plan (green)

At the end of your appointment, staple these forms in order and write BASE PATIENT in the upper right hand corner. (See below)

- This is all the paperwork you will need to complete on base.
- Note that there is no plaque index form completed on base, you still have to disclose and estimate a PI % and perform OH.
- No calculus detection is performed.
1\textsuperscript{st} day you see a base patient

- If you don’t finish a base pt on the first appointment, you will need to turn in their record to the front desk.
- Make sure that your Marine is available for their next appt prior to beginning. This way, if for example, they deploy to Afghanistan in 2 days, you can make arrangements to possibly change your patient out for another that will be here since it would not be beneficial to send a Marine to war with ½ of their mouths clean.

2\textsuperscript{nd} day you see a base patient

- If they need an additional appointment to be seen at CCCC, make sure that you give them your business card with their appt date on the back in addition to the appointment slip that the front desk gives them. It’s important to make sure that the front desk gives them an appt slip because that Marines command will acknowledge the base appt slip as an official one.
- Be sure to give your pt a parking decal and a map of CCCC so that they know where they need to go.
- If you do not finish your base pt, you will collect all forms and put them in the 1\textsuperscript{st} year’s filing cabinet near the x-ray operatories labeled “1\textsuperscript{st} year base patients.”

Upon completion of your patient

When you complete your base patient, you are to staple forms (See paperwork order at top of page) and place it in Ms. Carroll’s hanging file along with your evaluation form already entered. Do not staple the grade sheet with the treatment forms, grade sheet is submitted separately in the hanging file. Be sure to write BASE PT on the of the Record of TX form (these paper charts get filed separately in the clinic file cabinet in your base chart hanging file and do not get a chart folder or EagleSoft #.)
Example forms

**Dental Treatment – USN 2nd DENTAL BN - BASE form ONLY**

<table>
<thead>
<tr>
<th>Date</th>
<th>Medical alert</th>
<th>Dental class</th>
</tr>
</thead>
</table>

**Heidi H. Student**

**Heidi H. Student**

2D BN/NDC Camp Lejeune

CCCC STUDENT

E. Carroll, RDH, CCCC Faculty

---

**Reminders:**

1. **Dental Charting:** On base, you will use the yellow dental form to chart existing restorations in blue pencil and decay/pathology in red pencil in accordance to Den 120 Dental Charting.

2. **Periodontal Charting:** Using the green paper Perio chart record all probing depths greater than 3mm in pencil. If bleeding is present in a pocket depth >3mm; circle the pocket depth in red pencil. Record a red + for bleeding if pocket depths < 3mm. Suppuration is indicated by placing a blue line under the probing depth. Indicate furcations in red on the desired surface, and mobility in pencil on the facial surface of the crown of the tooth.
**DENTAL EXAM**

**S:** Reason for Examination:  
Initial / Periodic / Separation / DD2808 / Other

**Chief Complaint:** None/

**O:** Type of Exam:  
T-1 T-2

**Blood Pressure:** /  
HQ dated:  
Reviewed

**HGR:** WNL/

**Radiographs Ordered:** BWS  
Pano  
PA#

**Radiographic Findings:** (except caries)

Caries, defective restorations & fractured teeth (radiographic & clinical). None / Noted as follows:

<table>
<thead>
<tr>
<th>Inclp:</th>
<th>R</th>
<th>PSR</th>
<th>L</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**OCS/Soft Tissue:** WNL/

**Endo:** WNL/

**TMD:** WNL / Pain / Dysfunction

**Occlusion:** WNL/

**Oral Surgery:** WNL / Impacted: #  
Partial Impacted (Comm): #  
Symptomatic: #

**Other findings:**

**A:** Assessment of Chief Complaint:

Period: Healthy / Grits (Local/Gen) / Pts is (Mild/Mod/Severe) / Other

**Oral Surgery:**

Endo:

**Tobacco use:** None/

**Other:**

**P:** Treatment Plan

**Department** | **TREATMENT NEEDS** | **DATA ENTRY**
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>HYGIENE</strong></td>
<td>Sequence</td>
<td>Urgent</td>
</tr>
<tr>
<td><strong>OPER</strong></td>
<td>Regular</td>
<td>RDH(1) DT(2) DO(3)</td>
</tr>
<tr>
<td><strong>ORAL</strong></td>
<td>Simple</td>
<td>1 16 17 32</td>
</tr>
<tr>
<td><strong>PERIO</strong></td>
<td>Eval</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td><strong>PROS</strong></td>
<td>Ant.</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td><strong>TMJD/ORTHOD</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SEALANTS</strong></td>
<td></td>
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</tr>
</tbody>
</table>

**ADDITIONAL REMARKS (See reverse)**

Patient counselled regarding the health hazards associated with tobacco use and where to seek cessation assistance.

<table>
<thead>
<tr>
<th><strong>Patient's Last Name:</strong></th>
<th><strong>First Name:</strong></th>
<th><strong>MC:</strong></th>
<th><strong>PMP / SSIC:</strong></th>
</tr>
</thead>
</table>

**RECALL DATE**

**RECALL INTERVAL:** 12 Months

**DENTAL CLASS**

| 1 | 2 | 3 | 4 |

110
## DENTAL TREATMENT

<table>
<thead>
<tr>
<th>DATE</th>
<th>TOOTH NUMBER</th>
<th>MEDICAL ALERT</th>
<th>DENTAL CLASS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Patient's Last Name: __________________________ First Name: __________________________ MI: __________________________ FMP / SSN: __________________________ Date of Birth: __________________________

NAV MED 8660/14 (01-2010)
## DENTAL HYGIENE DAILY WORKLOAD SHEET CDT5

2D DENBN/NDC CAMP LEJEUNE, NC

**DATE: __________________**

### PROVIDER

<table>
<thead>
<tr>
<th>NAME/RANK SSN UNIT</th>
<th>CDT4 TREATMENT CODES</th>
<th>BENEFICIARY CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>1</td>
<td>PREVIDENT FOR MOD/HIGH RISK CARIES</td>
<td>A9634</td>
</tr>
<tr>
<td></td>
<td>PATIENT TREATED</td>
<td>A9999</td>
</tr>
<tr>
<td></td>
<td>ADULT PROPHY NO FLUORIDE</td>
<td>D1110</td>
</tr>
<tr>
<td></td>
<td>TOPICAL FLUORIDE NO PROPHY</td>
<td>D1204</td>
</tr>
<tr>
<td></td>
<td>FLUORIDE VARNISH HIGH CARES RISK (Duration)</td>
<td>D1206</td>
</tr>
<tr>
<td>2</td>
<td>NUTRITIONAL COUNSELING</td>
<td>D1310</td>
</tr>
<tr>
<td></td>
<td>TOBACCO COUNSELING</td>
<td>D1320</td>
</tr>
<tr>
<td></td>
<td>OHI</td>
<td>D1330</td>
</tr>
<tr>
<td></td>
<td>SEALANT PER TOOTH</td>
<td>D1351</td>
</tr>
<tr>
<td>3</td>
<td>SURF 4+ TEETH PER QUADRANT</td>
<td>D4341</td>
</tr>
<tr>
<td>4</td>
<td>SURF 1-3 TEETH PER QUADRANT</td>
<td>D4342</td>
</tr>
<tr>
<td></td>
<td>FULL-MOUTH DEBRIDEMENT</td>
<td>D4355</td>
</tr>
<tr>
<td></td>
<td>LOC DEL ANTIMICROBIAL (Arrestin)</td>
<td>D4381</td>
</tr>
<tr>
<td>4</td>
<td>PERIO MAINTENANCE</td>
<td>D4910</td>
</tr>
<tr>
<td>5</td>
<td>OTHER DRUGS/MEDICAMENTS (Oraqix, Peridex)</td>
<td>D9650</td>
</tr>
<tr>
<td></td>
<td>ROOT DESSENS (Protect, Guma)</td>
<td>D9910</td>
</tr>
</tbody>
</table>

Den 131 folder
### CCCC Hygiene Cabinet Stock Supply Check Off List

<table>
<thead>
<tr>
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<td>Disp Dappen Dish</td>
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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.
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  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
Appendix B

• 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 patients 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 Coastal 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
Coastal 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. Blue - student is ready to have their Health Questionnaire, Drug Summary, HIPAA, and Treatment Consent Form checked. A blue flag is also used to request X-rays.
2. Yellow - student is ready to have their Intraoral/Extraoral Exam, and Dental Charting checked.
3. Green - student is ready to have their Periodontal Charting and Treatment Plan checked.
4. White - student is ready to have their cleaning assignment checked on an A or B calculus patient.
5. Red - student is ready to have their cleaning assignment checked on a C or D calculus patient. Red also is used to request the help of a RDH.
6. Black - student requests the help of Dr. Hewitt for anesthesia, to check for decay, to evaluate X-rays, to evaluate Heath History, to request permission to place sealants, and/or to request prescription.
7. Red/Blue flags indicate you are ready to have a proficiency graded.
8. A 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. Professional Responsibility Point System

Students are graded on their professional responsibility in all laboratory and clinic courses. Points are assessed for a variety of infractions that could occur in the delivery of patient care. The Professional Responsibility Point System is designed to ensure the students abide by the program’s established standards of care. The Professional Responsibility Point System is communicated to the students in the Policy and Procedures Manual. When infractions occur, students are given a slip stating the infraction and the number of points deducted.

D. 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.

**E. 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.

**F. Monitoring the Completion of Patient Treatment**

Completion of patient treatment is an essential element of delivering quality patient care. The Dental Scoring System (DSS), utilized in the clinic, tracks completed and non-completed patients. In March of each year, a report is generated indicating all incomplete patients. 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. In April, the report is updated and the student must discuss their completion plan with the Clinic Coordinator (Mrs. Catherine Cotter). 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 reassigned to the second year student’s “little sister”, who is currently a first year student.

**Chart Audit**

The dental record serves as the primary source of information documenting the care provided to the patient. On a regular basis, charts are audited based on the departments’ standards of care. The faculty member conducts the chart audits using the Dental Chart Audit 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 returned to the student with a record repair form enclosed and the student must return the corrected chart to the instructor within 48 hours. Chart audit results and strategies are emailed to all faculty and results are reviewed with the students. The results are compared with those from previous semesters to document improvements or to identify the need for additional interventions.
Patient Satisfaction Surveys
Patient’s perceptions of quality of care are documented by the Patient Satisfaction Surveys and through daily interaction in the clinic. Patient Satisfaction Surveys are requested after each patient has been treated in the clinic. The department head and faculty appropriately handle legitimate complaints and regularly interact with patients to ensure their satisfaction with patient care services. At the end of the semester, patient satisfaction surveys are summarized and data is shared with faculty and students to facilitate the ongoing improvement of services and professionalism.

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

Film Processing and Quality Assurance

A. Basic Procedures
1. 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.
2. Process films according to the specifications that is located above the processors in the darkroom.
3. Always check expiration dates on film and the chemicals used in the processor. Do not use films or chemicals after the expiration date.
4. 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.
5. **When using an automatic processor:**
   a. The students 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.
   b. 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.

B. Quality Assurance (QA) Tests
1. 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.
2. 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.
3. Safelight/darkroom checks will be performed on the first clinic day of each semester by the RSO.
4. Records of the QA tests designated above and other services are located in the Radiology Viewing Area.
Summary

The Dental Department at Coastal 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.