SANTA ROSA JUNIOR COLLEGE

Department of Health Sciences

SANTA ROSA JUNIOR COLLEGE
DENTAL HYGIENE PROGRAM

CLINICAL POLICY MANUAL
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CLINICAL POLICY MANUAL(CPM)

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Santa Rosa Junior College
Dental Hygiene Program

Policies and Procedures

INTRODUCTION

This clinical manual is intended to describe the policies and procedures of the Dental Hygiene Program. Policies and procedures for treatment of SRJC Dental Hygiene clinic patients are set forth to protect the patients, students, school and faculty. The clinical policy manual and other sources; such as syllabus and written or oral documentation are used to convey these policies to the students.

Each student is expected to be familiar with the rules and policies found in this manual. Adherence to these rules and policies will ensure the maintenance and promotion of high standards in health care delivery, education and professional growth. The understanding, valuing and adherence to policies is important to prevent exposing those involved to legal actions and additional procedures and/or work in correcting misunderstandings and mistakes.

Policies and procedures are constantly evaluated to preserve quality of care. At all times the student will be expected to maintain a current edition of the Clinic Manual during all clinic sessions. The manual may be rearranged to the student's preference and each page must be covered in plastic to allow for proper disinfection when necessary.
If policies and/or procedures are changed, faculty will distribute the appropriate changes or additions in writing. It is then the student's responsibility to adhere to the new policy. Individual syllabus should be regarded as the correct policy if it is conflict with policies stated herein.

Students are also expected to review the Santa Rosa Junior College Catalog and the Student Handbook. Questions regarding any of the information should be directed to the appropriate faculty.

DENTAL HYGIENE PROGRAM GOALS

- To provide a student-centered learning environment in which students are stimulated to learn, to grow personally, to develop decision making, ethical, and problem-solving skills, and to stimulate creative and independent thinking.
  Program Student Learning Outcome (PSLO)/ Competency - 1

- To prepare students who will achieve professional and personal growth through application of classroom knowledge in clinical, laboratory and community settings with the provision of self-directed planning, implementation, and evaluation of professional clinical services.
  Program Student Learning Outcome (PSLO)/ Competency – 3 4 5 6

- To prepare students who will be prepared to assume responsibility for continued professional growth, high professional standards, and to meet the emerging challenges of dental health care.
  Program Student Learning Outcome (PSLO)/ Competency – 2

- To prepare students to successfully pass the Dental Hygiene National Board Examination and California State or Regional clinical licensure examinations.
  Program Student Learning Outcome (PSLO)/ Competency – 1 4 5 6

ACCREDITATION INFORMATION – Commission on Dental Accreditation
Dental Program Accreditation – please refer to the Student Handbook for accreditation information.

QUALITY ASSURANCE
Please refer to the Student Handbook and appendix of this Clinical Policy Manual for SRJC Dental Programs Quality Assurance.

COMPETENCY STATEMENTS/MAPPING
Please refer to the Student Handbook and appendix of this Clinical Policy Manual for SRJC Dental Programs Competency Statements, mapping and evaluations.

PROFESSIONALISM
Please refer to the Student Handbook for SRJC Dental Programs Professionalism Policy and the individual clinical course syllabus for specific criteria evaluation.

STATE OF CALIFORNIA DENTAL PRACTICE ACT
A very important policy begins with the State of California Dental Practice Act. The functions of a dental hygienist may be performed in an educational setting under the supervision of licensed faculty. An educational program for registered dental hygienists is one which has as its primary purpose providing college level programs leading to an associate or higher degree, which is either affiliated with or conducted by an approved dental school, or which is accredited to offer college level or college parallel programs by the American Dental Association Commission on Dental Accreditation or an equivalent body.
The list of functions that may be legally delegated to dental hygiene students while they are practicing in assigned clinics may be found in Article 5 of the California Dental Practice Act. Functions of the dental hygienist may not be performed outside of the SRJC assigned clinics.

ILLEGAL PRACTICE OF DENTAL HYGIENE
Any student who practices any dental hygiene procedure without a license is engaged in the illegal practice of dental hygiene. In such cases, the student's name will be submitted to the Dental Hygiene Committee of California and the student will be dismissed from the SRJC Dental Hygiene Program.

TEACHING METHODS AND LEARNING ENVIRONMENT

The Dental Hygiene faculty at SRJC employs an active and participatory teaching methodology. Teaching facilitates learning by incorporating a variety of methods and strategies to accommodate and enhance diverse learning styles. Learning strategies include, group exercises and projects, discussion, writing, lecture, demonstrations, clinical observation, role playing, problem-solving, self-evaluation and self-learning with instructor guidance. **The student is ultimately responsible for his/her own learning**. Preparation for classes and clinic is crucial. Learning activities in the clinic and classroom are designed with the assumption that the student has come to class/clinic well prepared and that he/she has sufficient background knowledge to gain maximum benefit from class/clinic time. Students are expected to spend a minimum of 2-3 hours of preparation/study time for every hour of class/clinic.

Learning complex psychomotor skills is an important component of the curriculum. Practice on models and student patients, with students achieving minimal competence, is utilized prior to attempting procedures on "real" dental patients. Students will qualify as "safe beginners" before being expected to perform skills on patients. Instructors assist students by providing constructive feedback designed to facilitate learning. Clinical faculty assesses both the process of performing procedures and the final result of those processes. Individual students learn psychomotor skills in different ways and at different rates. It is important that students recognize individual differences and work progressively toward the accomplishment of individual goals. Sufficient time is allowed for practice and many learning experiences are evaluated at a satisfactory or unsatisfactory. Minimal competency levels and process evaluation will be part of all preclinical and clinical courses. The goal of clinical evaluations is to provide instruction and feedback to assist the student in utilizing problem solving and decision-making and in working independently will skill and confidence. As the curriculum progresses, students are expected to perform with increased proficiency and efficiency to acquire more complex clinical skills.

Students will experience diverse teaching styles in clinic. Instructional diversity provides a rich environment for learning. In order to obtain maximum learning in the clinical environment, it is important to learn to appreciate the knowledge, background, and experience of each clinical instructor. Initially psychomotor skills are taught with one basic approach describing specific task components. This encourages consistency of teaching and evaluation, minimizing student confusion and frustration. As the student skill level improves, appropriate advanced techniques will be introduced. The program expects that all students will achieve career entry-level skills by the time of graduation.

The program is dedicated to assisting members of the community to progress toward optimum oral health. Students are taught to provide comprehensive care to include assessment, planning, implementation and evaluation. General education, basic and dental science background and communication skills will be utilized to assist the community patients in achieving oral health goals. Advancement in the program will be dependent upon the attainment of competencies in all of these areas.

Professional conduct standards, student policies and responsibilities, academic standards and curriculum policies are outlined and discussed in the Clinical Manual and the Student Handbook. All students are responsible for reviewing, understanding and complying with these policies. It is the responsibility of the student to monitor his/her academic and clinical progress when necessary, to schedule meetings with the course instructors, clinical coordinators and program director.

CLINICAL PHILOSOPHY

Santa Rosa Junior College Dental Hygiene clinic is operated primarily to provide an opportunity for students to integrate and utilize knowledge and skills for the development of clinical competency and secondarily to provide dental hygiene services to the Santa Rosa community. The practice of clinical dental hygiene requires performance characterized by:

- Acceptance of responsibility for learning
- Integration of knowledge and skills into clinical setting
- Development of clinical competency
- Demonstration of ethical and professional practice
- Development of a professional attitude
- Belief in the importance of the patient as an individual
- Delivery of services based on the patient's individual oral health and treatment needs
- Ability to perform responsibilities as an integral part of the dental team
- Recognition of the dental hygienist's role in the prevention and treatment of dental disease and maintenance of oral health
- Belief in the importance of providing total oral health care

The primary intent of the clinical facilities is to provide an environment for educating the student in clinical dental hygiene practice. The clinic is also operated as a public service, contributing directly and indirectly to an increasing public awareness of the need for dental hygiene care.

TECHNICAL STANDARDS

The curriculum leading to the Associate Degree in Dental Hygiene and the Certificate of Completion in Dental Assisting requires students to engage in diverse, complex and specific experiences essential to the acquisition and practice of essential dental hygiene/assisting skills and functions. Students in the Dental Programs should possess sufficient physical, motor, intellectual, emotional and social/communication skills to provide for patient care and safety, and the utilization of equipment.

Becoming an RDH/RDA requires the completion of an educational program that is both intellectually and physically challenging. In order to be successful in completing the requirement for these programs, students must be able to fully participate in both the academic and clinical environments. Full participation in the academic and clinical environments requires that students possess certain technical standards. Examples of these are listed below.

Technical Standards for the Dental Programs (dental hygiene and dental assisting)

Issue	**Standard**	**Examples**
Critical Thinking	critical thinking sufficient for clinical judgment.	Take and interpret medical histories and radiographs, develop treatment plans, and react to medical emergencies.
Interpersonal	interpersonal abilities sufficient to interact with individuals, families, and groups from a variety of social, emotional, cultural, and intellectual backgrounds.	Provide oral hygiene/oral health care instruction to patient/parents. Explain information consent and treatment plans and establish good patient rapport.
Communication	communication abilities sufficient for interaction with others in verbal and written form.	Communication during the delivery of oral health care services, document procedures and consult with other health care providers.
Action	ability to move from room to room and retrieve items from small spaces, as well as ability to be present at a work station for several hours at a time.	Work with a patient for prolonged periods of time and seat and/or assist in the transfer of a patient. Retrieve instruments/equipment to and from sterilization. Accompany patient to X-ray and take x-rays
	abilities sufficient to provide safe and effective oral health care.	Perform expanded functions, debridement, root planning and x-rays.

abilities sufficient to monitor and assess health needs.	Assess medically compromised/medical emergencies; detect indicator tones (curing light units and x-ray units); communicate with patient/parent.
~~a~~bilities sufficient for observation and assessment necessary in oral health care.	Read, record in patient charts, evaluate tissue, write tissue descriptions, assess and evaluate the oral health needs of the patient.
abilities sufficient for physical assessment.	Palpate tissue, detect restorations, calculus and evaluate debridement.

The Dental Programs are committed to ensuring that otherwise qualified students with disabilities are given reasonable accommodations. Students with disabilities who wish to request these accommodations are encouraged to contact the Disability Resources Department (DRD) to determine eligibility for services prior to the start of the program. While the process can be initiated at any time, reasonable accommodations cannot be implemented until eligibility has been formally established with DRD.

Degrees of ability vary widely among individuals; the Dental Programs are committed to creating access to qualified individual with a disability using a case-by-case analysis. The program remains flexible with regard to the types of reasonable accommodations that can be made in the classroom and clinical settings. Student with disabilities are invited to offer suggestions for accommodation that have worked in the past. Accommodations made will specifically address the limitations associated with the student's disability.
Our belief is that accommodation should be tailored to individual situations. The process for determining the type of reasonable accommodation in the clinical setting shall be determined by the Disability Resource Department and the Dental Programs Director.

GENERAL CLINICAL POLICIES

GENERAL CLINICAL GUIDELINES

1. The clinical area is defined as: the dental hygiene clinic, restorative clinic, radiographic clinic, hallways connecting these clinics, dirty and clean area of sterilization, storage room and reception area.
2. Students must enter clinic in compliance with the dress code; stop at your locker first to drop your belongings, secure your hair and change your shoes, etc.
3. You must be in complete uniform with appropriate PPE when working on any patient.
4. When you leave the dental clinic area, you must remove your clinic gown and leave it on the hook in your operatory.
5. You may not enter the clean side of the sterilization area or the reception area with your clinic gown on.
6. If you need to enter the hygiene clinic while patients are being seen, even if you are not seeing patients, you must be in lab coat or scrubs.
7. You are not allowed in clinic areas when a clinic other than your assigned clinic is in session.
8. You are required to furnish safety glasses for your patients and monitor their use. Patients may wear their own glasses if those glasses provide adequate coverage.
9. Please keep in mind that the clinical area is a professional environment. Appropriate language, volume, tone and respect for your classmates and faculty will be expected at all times. Use a quiet voice and appropriate language and conversation whenever in clinic.
10. No food or drink (including water) is allowed in any clinical area.
11. Over gloves - you will be required to wear over gloves during patient treatment when charting, using the keyboard, handling the patient's chart or clinic manual and any item in the operatory which is not sterilized or disinfected or when exiting your unit to sign up for faculty assistance. <u>You may not wear operator gloves or over gloves outside your unit.</u>
12. You are welcome to ask the rotation assistants to help you with clinical tasks, however the clinical student is ultimately responsible for the accuracy and completion of these tasks.
13. In the process of conducting hands-on courses, the instructor may be required to have physical interaction when directing the student as part of instruction.

RECRUITMENT OF PATIENTS

Students are expected to have a patient(s) for each clinic session. Recruitment of clinical and/or radiographic patients is ultimately the student's responsibility. Failure to meet course requirements may result in failure of the course. Mechanisms to recruit patients are available. It is the student's responsibility to become familiar with these mechanisms through consultation with fellow students, program partners, mentors and faculty. The school will make every attempt to appoint patients; however, it is not the school's responsibility to supply patients for student requirements.

The program director and public information officer or designee must oversee the content and presentation of all clinic advertising and public service announcements.

PROTOCOL FOR CLINICAL/ROTATION ABSENCES

- Call your patient at the earliest possible time.
- Always call the lead instructor **and** the clinic reception phone (522-2844) one hour before start of clinic, leave a message with your name and information regarding if you have contacted your patient. Instructor's messages may not be picked up until after clinic hours.
- Please remember that your absence from clinic cannot be made up. Missing clinic has the least impact on the function of the clinic YOUR ABSENCE FROM ROTATION IMPACTS EVERYONE

CLINIC PREPARATION

1. Students assigned to all rotations must be present 30 minutes before the start of morning clinic. Students not on rotation may enter clinic 30 minutes before the start of clinic.
2. Take all belongings you will need from your locked cabinet and move them to the unlocked cabinet in your assigned operatory. (assigned operatories may change daily) You may not interrupt a student in an operatory to obtain supplies during clinic time.
3. 20 minutes before start of clinic: prepare your operatory utilizing the protocols outlined in your SOP's under **operatory preparation**, and **operatory set-up**.
4. After cleaning: Place all instruments, supplies and equipment on tray or counter of your work area. All other materials must be placed in the unlocked cabinet of your unit. You will not be allowed to store your instrument containers, purses, coats, notebooks (except plastic covered policy manual), books or book bags in the clinical area. A coat hook is available for patient coats and your clinic gown only. Patient's book bag/purse may be placed on the floor behind the assistant's chair
5. Pre-setup operatory: If you are presetting your operatory before leaving for lunch break or classes
    - Continuing patients from morning to afternoon clinic **must** have a new instrument setup.
    - You may sharpen instruments from sterilized cassettes before leaving for lunch
    - Cassettes must be closed and in sterilization bag or place a bib over the cassette and bracket tray and place your delivery system behind the patient's chair
    - Place the patient's bib over the cassette and bracket tray
6. You are responsible for keeping your assigned cubby free of sterile instruments. At the end of each clinic day, retrieve your sterile instruments and place them in your locked clinic cabinet.
7. Rotation students will meet with the lead clinic faculty. During the group huddle you will hear what all students in your group are doing. You must stay in your group huddle until **all** discussion is complete.

INSTRUMENTS/CASSETTES

- Whenever possible you should be working from cassettes, this practice helps in the recirculation of instruments as well as organizing your instrument choices.
- When individual instruments are needed, they should be bagged as part of a set, i.e.; mirror and explorer, or sets of Gracey or universal curettes.
- When organizing your cassettes keep in mind the instruments you like to use as well as giving thought to the instruments needed for Calculus Case types, i.e.; for light case types, you will probably only need your universal curettes and your anterior and posterior sickle, for moderate or heavy case types you will need more universals and your Gracey curettes.
- A sharpening stone should be in each of your cassettes, remember that instruments may dull through use and sterilization.
- Before you lock your clinic cabinet at the end of each clinic day, retrieve your sterile instruments from your cubby in the dispensary, the only instruments remaining out of your cabinet will be those in the Midmark or those being prepared for the Midmark.

ORGANIZING YOUR CASSETTES AND ASSIGNED UNITS

You have three 14-instrument cassettes and two 8-instrument cassettes. These cassettes should be organized as follows; (2nd year will be slightly different)

14 instrument, large cassettes – total 3

Item (1 each)
Mirror
2DE explorer
11/12 explorer
Probe (DH II change to UNC)
2 Universal Curettes
2 Sickle Scalers
1 Nevi Scaler
Gracey 1/2, 11/12, 13/14

11 instruments total

1 sharpening stone
1 cylindrical stone

8 instrument, small Cassettes – total 2

Mirror, 11/12 explorer, probe, 2 DE explorer, universal curettes, anterior and posterior sickle and sharpening stone

		Bag separately
Nabers Probe		1 total
Assessment group	1 each	probe, mirror, 11/12 explorer, 2DE explorer

You may decide to have one set of your instruments at home for your typodont practice, you have enough instruments for this.

Have the following items in the unit assigned to you for the day: Place these items in the unused cabinet of your assigned unit

1. Extra 8-instrument cassette and 14-instrument cassette
2. Extra bag of sterilized assessment instruments

3. Hand piece and coronal polish items for 2 patients
4. Extra saliva ejector, cotton tip applicators
5. Extra sharpening stone
6. Sterilized syringe, cotton pliers and topical anesthesia – DH II students
7. 1 bag with Nabors probe
8. Mini Gracey sets, Files – DH II students
8. Blood Pressure Cuff and wrist cuff

* For screening **scheduled through the screening book**, you will be using the clinic instruments.

CONTAMINATED, SEMI-CONTAMINATED AND NON-CONTAMINATED AREAS

Your unit areas must have clearly defined contaminated, semi-contaminated and non-contaminated areas. To provide this distinction all units will be set-up in the following manner.

- Contaminated Areas - that area where items coming in direct contact with the patient's mouth are placed. This area is designated as the bracket tray. When performing anesthesia this area may also include a second tray placed on the semi-contaminated area of the counter. Once a procedure has begun, any item on these trays must be sterilized or discarded.

- Semi-contaminated - that area where contamination is expected; however, items are not placed directly into the mouth. This area is designated as the counter directly adjacent to the operator, or for left-handed students the rolling cart. Items such as your plastic enclosed clinic manual, the patient's chart, over-gloves, pen and anything that can be appropriately, protected, covered or disinfected are placed. When you need to take off your mask, you may place it on the designated semi-contaminated counter area on a paper towel
  If you are working in unit 1 or 18 or are left handed you may use the rolling cart for this area

- Non-contaminated - that area where there is no risk of contamination. This area is designated as the counter furthest from the operator. Items such as oral health demonstration aids, bottle of disclosing solution and topical anesthesia and non-petroleum lubricant, box of gloves and masks are placed.

Extra instruments and items - these items are to be placed in the unoccupied cabinet. You are responsible for emptying this cabinet at the end of your clinic.

Patient items - these items may be placed in the unoccupied cabinet or if too large in an appropriate out of the way area, behind the assistant's chair. Please place the patient's coat on the provided hook.

REQUESTING AN INSTRUCTOR or A PATIENT CHECK-OUT

Anytime you need a faculty member, please leave your cubicle and sign-in on your faculty's sign-in sheet. It is not acceptable to call out from your cubicle, call out down the aisle or interrupt in another cubicle. It is important to maintain a professional tone in the clinic. You must only sign-in with your assigned faculty of the day unless you are directed to sign-in on another faculty member's sheet. Sign-in sheets are located in 4 areas of the clinic; determine the sheet that belongs to your assigned faculty.

Introduction of Clinical Instructor

When a clinical instructor comes to your unit for an evaluation of any of your assessments, it is your responsibility to introduce the clinical instructor to your patient.
Always introduce the patient first to the instructor - "Judy this I my Professor Smith, Professor Smith, this is my patient Judy."
Once a clinical instructor has been introduced it is not necessary to reintroduce the instructor during that clinical session.

Be Prepared and Plan Your Time!!!!

When you request an Instructor check, **be prepared**. Have **all** paperwork ready, the operator chair ready, a clean mirror, probe and explorer ready, patient's mouth should be rinsed and cleared of blood and debris; cassette should be organized – free of gauze, floss and other clutter; and patient bib should be clean.
Check-outs **mus**t be complete prior to the last half-hour of clinic. Plan your time wisely and request a checkout with plenty of time to complete any residual work. Instructor may need to assign check out times to their students in order to accommodate several requests. Patients may need to be rescheduled regardless of how little work is remaining.

Clinical Instructor Signatures

- You must have all chart notations and signatures by the close of that clinical session; All signatures are obtained with your Instructor within your unit. Do not ask for signatures outside of the unit.
- The practice of writing a correction or addendum to charting notations is strongly discouraged. If, due to unforeseen circumstances an addendum or correction is needed, you must have the chart signed by the lead clinical faculty. Please refer to the policy on Charting an addendum or correction:

PROTOCOL FOR INSTRUCTOR CONFERENCE

1. The purpose of the instructor/student conference is to gather information, assess patient care and evaluate student skills.
2. This is an opportunity for both instructor and student to ask questions and obtain clarification regarding patient care and instrumentation skills.
3. This is the time to obtain all signatures from your assigned instructor
4. Before signing up with your assigned instructor the following **MUST** be completed.
    - Corrections to all electronic assessments as noted on the Patient Completion Form (purple sheet)
    - Record of Treatment
    - Time management sheet including
        - What did you accomplish today?
        - Plan for improvement
    - Pink point tracking sheet

- Did you complete any competencies or test case today?

5. During the conference, state what you had learned that day, and what you believe requires further improvement.
6. Read over the comments made on your daily evaluation sheet and ask for clarification if needed.
7. This is the instructor's opportunity to give recommendations for how to improve deficits in instrumentation skills, patient care and patient safety issues. (The instructor will also give praise, encouragement and support).
8. Please remember, "This is an Opportunity to Do Better".

NOTE: to ensure confidentiality during this session, no student is allowed to enter an assigned unit while a conference is in session. Please wait with your instruments in your assigned unit until the completion of the conference before you enter the unit to access your cabinet or set-up the unit for the next clinic.

CLINIC BREAKDOWN

Clinic procedures **must** stop no later than 30 minutes prior to the close of clinic, no patient checks will be allowed after this time.

1. After entering your route slip, and dismissing your patient, you will **then** take your instruments/cassettes to sterilization and prepare them for the thermal disinfector utilizing the department SOP's on **instrument recirculation**. Remove all cotton and disposable products and secure instruments in cassette. Place your prophy paste holder and U-Adapter into a small instrument bag labeled with your number. Leave your properly labeled bags in the designated area.
2. You may then return to write-up your charts. **Patient records must be ready for instructor's signature before cleaning operatory. During the last 15 minutes of clinic you MUST check with your assigned instructor to review your daily progress. To allow for privacy, this will be done in your assigned unit and no students are allowed to enter your unit until after the unit is cleaned or during your instructor conference.**
3. Breakdown your room utilizing the department SOP's on **operatory reprocessing**

- **Remember you must first enter your route slip, then get your instruments to sterilization, meet with your instructor for signatures, & cleaning your room is last.**
- **Patient records must be returned to the reception faculty no later than 5 minutes before the end of clinic**

PROTOCOL FOR END OF CLINIC SESSION

1. Always ask your assigned instructor if you can dismiss your patient at each clinic session.
2. Before dismissing patient accurately fill out route slip
3. Remove the patient napkin and place in debris bag
4. Remove PPE except for gown and escort patient out of the dental hygiene clinic
5. Return to unit and put on utility gloves, place instruments back into cassette, makes sure used needles are placed in sharps container and place contaminated debris in bag
6. Take instruments to sterilization
7. Remove utility gloves, wash hands and make all entries in patient chart
8. Sign up for instructor conference and signatures
9. If you notice that you will have a long wait for your instructor conference you may begin to disinfect your unit
10. Please do not leave your unit once you have signed up for an instructor conference
11. After you have completed your instructor conference, put on utility gloves and remove all barriers and saliva ejector (place saliva ejector in debris bag) from the unit
12. Disinfect the unit and counter tops with approved disinfect
13. Remove debris bag and tape closed before disposing
14. Wash utility gloves with antibacterial soap
15. Wash hands thoroughly
16. At the end of the day empty and purge waterline, leave emptied water bottle on top of the bracket tray, turn off unit and return unit and rheostat to the chair base

CELL PHONES

Cell phones must be turned to silent prior to entering clinic. Your patient's compliance with this policy is your responsibility.

TREATMENT POLICIES

PATIENTS NOT SEEN IN THE SRJC DENTAL HYGIENE CLINIC

General

Patients who are under the age of 18, must be accompanied by their parent or legal guardian. The parent or legal guardian must be present for all appointments to provide medical history review and/or consent for treatment. Signatures are required from the legal guardian at these times.

Patient who are unable to communicate with their student operator

Every attempt will be made to accommodate patients who do not speak English (or a language in which their student operator is proficient). If the assigned student and/or faculty cannot adequately communicate medical/dental history questions or treatment needs, the patient will be informed that they must provide an appropriate interpreter for all appointments.

Medical

- Patients who have had a stroke or heart attack within 6 months
- Patients with active TB
- Patients with herpetic ulcers in the vesicle stage
- Patients with acute ANUG
- Patients with health history documentation that indicates the need for premedication either as defined by the American Heart Association guidelhttp://www.santarosa.edu/for_students/student-services/student-health-services/sonoma-county-resources/index.shtmlines, or for other health conditions (i.e. joint replacements, implants, etc.) that have failed to take their premedication as prescribed prior to the dental hygiene appointment.
- Patients who have blood pressure outside the limits of the clinic
- Patients ASA IV or V
- Patients who have uncontrolled Diabetes
- Patients who have unstable angina

Defer Treatment for patients who do not know the medications they are taking, and the clinical DDS is not able to release for treatment, for asthma patients who are at risk and do not have their inhaler and for angina patients without medication.

Dental/Periodontal

- Patients with greatly advanced periodontal conditions (untreatable)
- Patients with severe carious conditions
- Patients with Full Dentures – maxillary and mandibular
- Patients with a significant number of defective restorations

POLICY ON ELIMINATION OF TREATMENT AREAS AND PATEINTS NO LONGER ABLE TO BE SEEN IN CLINIC DUE TO IMMEDIATE CLINICAL TREATMENT NEEDS

If a patient presents with oral conditions/teeth that the instructor feel should not be treated a notation (red dot) and instructor signature will be placed on the following forms:

1. Dental Chart – Digital, under "conditions", chart tooth not treated, and it will turn the tooth red.
2. Treatment Plan – red dot on tooth not treated and faculty and patient signature.
3. Patient Completion - signature and treatment needs description. Treatment that must be completed before patient returns to clinic for their recare or reevaluation. This area of the form must be signed off by the clinical dentist and the policy clearly explained to the patient.
4. Record of Treatment – make the notation on the date that the decision is made with the rationale and clinical DDS signature. <u>This will be the last notation in the treatment record</u>. **The patient understands that they will not be allowed to return to the clinic for any recare/reevaluation appointments until the following condition(s) has/have been corrected _____**

A radiograph and/or intraoral picture may be indicated – your clinical faculty and clinical DDS should be consulted to determine what is needed

CONTRAINDICATION and MODIFICATIONS FOR TREATMENT MODALITIES

<u>Patients not seen in clinic – a medical release form is required before these patients may be treated in the SRJC clinic.</u>

Patients with medical history contraindications - these patients are not seen in the clinic

Patients needing medical clearance
Patients with blood pressure ranges of Stage III and IV and some in Stage II
Patients with active TB
Patients with active herpetic lesions

<u>Ultrasonic Scaler – Standard precautions apply, however in certain instances modifications of treatment may be necessary</u>

Ultrasonic scaler use may not be appropriate for use on a compromised patient due to:

- Active, infectious disease
- Respiratory conditions (emphysema and TB)
- Newly erupted teeth
- Dentinal surfaces exposed
- Porcelain jacket crowns
- Titanium implants – except with the use of the specialty ultrasonic tip
- Demineralized areas
- Patients with swallowing difficulties

<u>Prophy Jet – modifications of treatment may be necessary</u>

Respiratory conditions (emphysema, asthma, cystic fibrosis, and TB)
Patients with swallowing difficulties
Hypertension and/or sodium restricted diet
Recession (exposed cementum or dentin)

Soft, spongy gingiva
Nonmetallic restorations
Communicable infection
Patients with end stage renal disease

MEDICAL ALERTS

It is the student's responsibility to alert the faculty of any medical history or intraoral findings that may alter treatment. These findings may include but are not limited to: allergies, medications, abnormal vital signs, patient positioning, lesions, abscesses, etc.

RADIOGRAPHS

- The case type should not be determined without supporting x-rays when the assessments show disease indicators. The type of x-rays recommended will depend on the patients age, history and assessment information.
- Bitewings may be **required** before sealants to rule out proximal and/or occlusal caries
- A request for radiographs from another clinic or private dentist may be appropriate.
- If the patient has a dentist, a request for radiographs will be submitted to that dentist by phone, Fax or by patient delivery.
- If a patient does not currently have a dentist, the SRJC clinical dentist may request the radiographs.
- All radiographs must be evaluated within 1 week of exposure, any radiographs evaluated after 1 week will not be counted toward requirements.
- Any exceptions to these guidelines must be agreed upon with the lead clinical faculty

CARIES CHARTING PROTOCOL

Listed below is the clinic protocol for charting unsound dentition. See Appendix for Dental Charting Notations. Remember that other than periodontal disease we are not diagnosing disease, the patient is referred to their dentist for diagnosis of dental treatment need.

- Note any areas of unsound dentition in red in the dental charting box on the purple sheet.
- When the clinical DDS checks your assessment, you will read off the dental charting – include your findings by saying for example "Tooth #3, class II, MOD amalgam with obvious unsound enamel on the facial CEJ.
- The clinical DDS may agree or disagree with your detection, you will transfer this information to the electronic chart in red and have this notation checked at the end of the clinic session.
- If you have x-rays, you should transfer unsound dentition that you note on your radiographic interpretation to the dental charting form after agreement with the clinical DDS. If you take x-rays anytime during treatment, you must view the films and then update the dental charting form.
- How to communicate this with patients? You should communicate as honestly with a patient about their unsound dental conditions as you do their periodontal issues. Explain that they have obvious unsound areas, but this does not mean that they have no other areas of concern. Educate them about the condition and the role that plaque and diet play in this process; and refer them to their dentist. It is important that they understand they must go to a dentist to have a complete exam and a confirmation about the extent of their disease/condition.
- Every patient that is seen in the clinic must have a referral to a dentist, this is noted in the patient completion letter

CARE OF REMOVABLE APPLIANCES

Due to the possibility of altering an appliance during the cleaning procedure, **no appliances will be cleaned as part of clinical procedures.** This policy includes orthodontic as well as prosthetic appliances.

Ask a clinical assistant for a baggie or have one on hand if you know your patient has an appliance. Place the appliance in the baggie seal the baggie and place it on the semi-contaminated area of your counter or give it to the patient to store.

POLICY FOR SCALING OF DENTAL IMPLANTS

It is the policy of SRJC, Dental Hygiene Department to provide patients with dental implants, the highest standard of care. If the clinical instructor feels that the area is appropriate for treatment, the following guidelines will apply;

1. Use of plastic/silicon scaler and periodontal probe.
2. A periapical and/or bitewing radiograph is necessary prior to treatment.
3. Traditional ultrasonic scaler tips will not be used on the implant/crown; use only designated tips.
4. Patient will be referred back to Dentist of record for continuing care.
5. Oral Hygiene instructions reviewed for patients with implants.

PROCEDURE PRE-RINSE

Before beginning intraoral procedures, the 60 second use of an antimicrobial pre-rinse is suggested. Patients who have a history or alcohol abuse and those under age 16 are possible exemptions.

FLUORIDE

Fluoride varnish will be used on appropriate patients.

PATIENT SCREENING

- Will be conducted when deemed necessary by the clinical faculty
- Unless otherwise indicated, all screening patients are patients of the clinic and may be assigned to students as the lead instructor indicates.
- Students on rotation will be responsible to set up, seat patients, review health history and obtain vital signs before notifying a clinical instructor for screening. Do not write on the Health History form, use the screening form for notations. **NOTE:** review the medical history for contraindications to screening only, the student assigned to the patient will do the complete medical history review. New health histories are obtained every 2 years or if there is a major health change.
- All screening appointments will only occur during clinic hours.
- Patient classification from screening is guaranteed for that semester only and may be changed if sufficient patient conditions change, i.e. the patient has had their teeth cleaned in an outside facility

RECALL/PERIODONTAL MAINTENANCE(PMT)

When you have completed your patient's treatment you will need to indicate their **recommended** recall or PMT interval; 3, 4, 6-month recall.

- •6 month - healthy conditions, does not exceed non-inflammatory early periodontitis
- •3-4 month - early periodontitis to moderate periodontitis with no inflammation
- •2 month - advanced periodontitis and any early or moderate with inflammation or special needs
- • 1 year – most SRJC patients, unless determined by the student and signed off by the faculty as a teaching case.

Please record this by writing on the last line of your treatment record after the patient tolerated treatment section ("patient completion, recommended 3-month recare, the patient understands that the SRJC clinic may not be able to accommodate the recommended recall suggested by the student.

You will also enter the recommended interval into the computer and on the completion letter, (with patient and student initials).

SAFETY POLICIES

POLICY ON LATEX SENSITIVITIES/ALLERGIES

There has been an increasing incidence of sensitivity reactions to latex products reported in the scientific literature. Students **must** purchase latex free gloves. All students and faculty will wear latex-free, powder-free gloves to reduce the incidence of latex sensitivity.
True latex allergy is rare and patients who have this type of reaction are very aware of their limitations. Students are advised that the dental hygiene clinic facility cannot be rendered latex-free. Patients with true latex allergies will not be seen in the dental clinics.

POLICIES FOR THE SAFETY AND COMFORT OF STUDENTS AND PATIENTS

1. Never pass or examine instruments over the patient's head or neck area. Do not flip instruments over a patient's head, when examining instruments, they must be no closer than 6 inches from the patient's face.
2. Never adjust your light with an instrument in that hand. When not utilizing instruments, such as when you are adjusting the light or chair, place the instruments in your non-dominate hand or back on the bracket tray.
3. Clutter and blood are a concern to both the patient receiving care and the patients and visitors walking through the clinic. You are responsible for keeping your tray free of "bloody gauze". If you drop gauze, have it picked up as soon as convenient. Place all used "bloody gauze" in the paper bag that you have taped to your instrument tray.
4. Dropped instruments must be dealt with immediately, pick up the instrument with your contaminated gloves and place it in the sink of your counter, wash and re-glove before continuing. Notify the clinical assistant and ask them to process the instrument.

GUIDELINES FOR THE USE OF MAGNIFICATION (LOUPES)

- You are required to purchase loupes.
- You may begin using magnification during the summer semester.
- You remain responsible for wearing safety glasses for all patient exposures.
- You are responsible for the comfort of your patient. It is possible that magnification can focus you with such a narrow vision that you are not aware of patient nonverbal clues to discomfort.
- The purchase of the light is optional.
- You will be allowed to use the attached light only if you are considerate for the safety of others. Please be aware of the safety concerns for those around you. Light directed into the patient's eyes or in the eyes of those working around you is very uncomfortable and can be a trigger for seizures.

PROTOCOL FOR PATIENT INJURY

For a patient injury beyond normal tissue trauma, follow the procedure listed below. If it is a broken needle or instrument, follow the already established protocol; lead faculty will complete an incident report and notify the program director.
For severe lacerations of lip, cheek, gingiva, tongue or any unforeseen type of patient injury:

- Call for an instructor. Remain calm and professional.
- Render necessary first aid – i.e. pressure to punctures or lacerations; ice
- Have the clinical dentist evaluate the situation for treatment or follow-up.
- Inform the patient of the extent of injury.
- Make a notation about the incident in the treatment record of the chart. Have faculty initial.

- Lead faculty will complete an incident report and notify the program director.
- Consult with the lead faculty to establish a follow-up phone call (within 1-2 days) when appropriate.

TISSUE TRAUMA

Soft Tissue Trauma – defined as an isolated cut in the marginal tissue (not tissue tags or loose granulation tissue). Soft tissue trauma can also be an isolated laceration and/or puncture to the epithelial attachment.

Gross Tissue Trauma – defined as flagrant abuse or harm to a patient. Including a burn, deep laceration, long laceration and/or puncture to soft tissue and/or bone. A burn as a result of ultrasonic heat, which could be found intra-orally or extra-orally. A deep or long laceration is defined as a cut so large, it may require suturing, or a cut so large it extends across more than one tooth surface and/or exposing bone.

Hard Tissue Trauma – defined as a loss or irreversible damage of the tooth structure integrity (enamel and/or root) but not limited to pitting and/or gouging,

Gross Hard Tissue Trauma - multiple surfaces of hard tissue trauma constitutes gross hard tissue trauma.

Documentation - any hard or soft tissue trauma will be documented with the following:

1. location - describe in relationship to tooth or tooth bearing area
2. measurement - measured in mm
3. type – puncture, laceration
4. patient is aware of incident

Soft tissue trauma will be documented as indicated above in the patient's treatment of record and in the student's daily notes with the appropriate point deductions.

Gross and any hard tissue trauma will be documented as above, and an intraoral photograph will be taken as well as any appropriate radiograph(s) for hard tissue trauma.

A second instructor will be asked to verify gross and any hard tissue trauma. If verified by two instructors, then the clinical director and clinical dentist will be notified so that a proper referral can be made.

Any hard or gross tissue trauma will result in the termination of treatment for the session and the student will be accessed for the appropriate form of remediation.

CLINIC POLICY FOR DISPOSAL OF LOCAL ANESTHETIC CARTRIDGE AND NEEDLE

1. All needles must be disposed of into the SHARPS containers(s) in clinic.
2. All local anesthetic cartridges that contain blood must be disposed of in the SHARPS container(s) in clinic.
3. All partially used, empty, or unused local anesthetic cartridges that have been contaminated* must be disposed of in the Local Anesthetic Disposal Container in sterilization.

*contaminated cartridges are those that have come in contact with ANY contaminated item, i.e. instruments, contaminated gloves, floor, etc.

STUDENT/FACULTY SHARPS EXPOSURE INCIDENTS
All Students working in clinic/lab classes and all Faculty
These students/faculty are covered by Worker's Compensation

1. If this is a patient sharps exposure, the faculty will ask the patient if they are willing to be tested.
2. Student/Faculty/Patient should be tested ASAP
3. Fill out all paper work – PAPERWORK WILL BE FURNISHED BY YOUR LEAD FACULTY
   Form A – sent to Health Services
   Form B – for each student/faculty/patient
   Form C and D – sent to SRJC Human Resources
   Form F – in the back of our binder
4. If the student/patient/faculty are going for testing, give each individual a map with directions to Kaiser Occupational Health Department, East Building 2nd floor, Suite 260 or 270, 401 Bicentennial Way, Santa Rosa, CA 95403 Hours of operation are M-F 8:30 am – 5pm
   707 571-3000 After hours call the ER at 707-571-4800
   Please ask the student to direct the patient to Kaiser Occupational Health Department, the student or faculty MUST not drive the patient. If the patient does not have transportation, we can arrange for a cab and pay for this with clinic funds. The procedure may take as much as 1 hour to complete at Kaiser.

PROCEDURE FOR BROKEN INSTRUMENTS

If an instrument tip breaks in the patient's mouth, the following protocol must be followed:

- Reassure the patient but do not allow the patient to swallow.
- Seat the patient upright and have them spit into a cup. DO NOT USE THE SUCTION.
- Summon an instructor to help locate the tip with an explorer or dental floss.
- If the tip cannot be located easily and removed, an x-ray will need to be taken.
- When the tip is located on the x-ray, it may be removed by the student or faculty member. Magnetized instruments, perio retrievers, are in the anesthesia dispensary box on the main clinic counter to assist with tip removal.
- If the tip cannot be removed, an incident form will have to be filled out, signed by a faculty on the floor and a referral made to a periodontist or their own dentist. Some tips have to be removed by a periodontal surgical procedure.
- If the tip cannot be located, an incident form will have to be filled out and signed by the faculty. The patient may be sent to their physician for a chest x-ray.
- Note the incident in the patient's chart and have the lead instructor sign it.
- Lead faculty will inform program director of all incidents.

PROCEDURE FOR BROKEN NEEDLES

If a needle breaks during anesthesia administration, the following protocol must be followed:

- Remain calm; do not panic. Call for a faculty member.
- Instruct patient not to move. Do not remove your hand from the patient's mouth. Keep your eye on the end of the broken needle.
- If the needle is protruding, use cotton pliers or a small hemostat to remove.
- If the needle is NOT protruding and cannot be retrieved, do not proceed with probing or manipulating the tissue.
- Inform the clinical dentist.
- Calmly inform patient; note the incident in the chart (regardless of outcome) and have the lead instructor sign it.
- Lead faculty will fill out an incident report and notify the program director.

Note: It is mandatory that during any anesthesia, you must have cotton pliers or a hemostat on the instrument tray. Failure to do so will result in loss of production /professional points.

HEMATOMA FROM LOCAL ANESTHETIC INJECTION

Hematoma: leaking of blood from vessels into surrounding tissue due to inadvertent nick of blood vessels during injections.

Operator Responsibility:

- Early Recognition and Response
- Be alert to hematoma formation
- Respond to initial signs of swelling
- Discontinue treatment for the day

Chairside Management:

- Apply pressure directly to area
- Ice area

Instruct the Patient:

- Apply ice intermittently for the next 4-6 hours, no heat to area for 24 hours
- Ibuprofen for inflammation, Ibuprofen or Tylenol for discomfort if needed. Avoid aspirin for pain as this may increase bleeding.

Advise the patient:

Regarding development of bruising and discolorations – may last up to 2 weeks

To notify you immediately of any changes

Signs and symptoms of infection

POLICY ON EMERGENCY TREATMENT DURING CLINIC SESSIONS

If an incident occurs during the treatment of a patient in the Dental Hygiene clinic that requires emergency/temporary care the following must be done:

1. Inform the patient of the incident
2. Inform the clinical faculty assigned to you for the day
3. Inform the clinical dentist **and** lead faculty
4. As directed by the clinical dentist, take a radiograph or intraoral picture of the area
5. Assist the clinical dentist in providing temporary care
6. Chart the incident on a plain piece of paper and allow the clinical dentist and lead faculty to approve the charting notations before transferring them to the record of treatment.
7. Refer the patient to their dentist, if the patient does not have a dentist consult with the lead faculty.
8. Call the patient the next day to check on their condition. Make notes of your conversation and consult with the lead faculty.

PROTOCOL FOR A SWALLOWED OBJECT

Objects used in dentistry can be dropped into the patient's oral cavity or oropharynx. Precautions should be taken to avoid this from occurring. In some instances, a patient's restoration can become loose and dislodged during scaling: checking for restoration stability is an important part of initial assessments. If an object falls into a patient's oropharynx, the following protocol should be followed:

Protocol is found in the Incident Report Binder

MEDICAL EMERGENCY PROTOCOL FOR DENTAL CLINICS

The Emergency Protocol for students seeing patients in dental clinics includes responsibilities in the following positions:

Operator

- Notify the student operator in the adjacent operatory that you are having a medical emergency
- Positioned the patient properly for the emergency
- Make sure the HH is out
- Calm the patient
- Report the particulars of the incident to the faculty who come to assist in the emergency
- Assist at the directions of the faculty

Operator in the adjacent unit

- Notify the nearest instructor
- Get the Oxygen, AED and Emergency Kit – located at the East end of the dental hygiene clinic

Student asked to initiate the 911 protocol

- Location of the phone
- **Dial 1000** on the phones in the clinic/reception
- Remain on the phone with the emergency operator
- Direct another student to go outside to the parking lot area, holding the door open and direct the EMS personnel

All students and faculty

Know location of medical emergency equipment
Know location of phones and how to dial for campus police
Know basic life support procedures and medical emergency protocol.

SRJC GENERAL SAFETY TIPS

- To report an emergency occurring on campus dial (707) 527-1000 to reach the campus Police Department.
- Know your location! If you are calling from a mobile phone you must be able tell us where you are if you need help.
- Get to know the names of buildings, fields, streets, etc. around campus.
- Lock your car doors anytime you leave the car. It takes only seconds and can save you from being victimized.
- Don't leave obvious valuables in plain view in your car. Sometimes, availability is all that is needed to cause someone to break in and rob you.
- Check the back seat of your car before you get in. You may have an uninvited passenger.
- Be extra alert as you approach your vehicle to get in it. Many suspects use this as an opportunity to commit a crime.
- Walk with a friend when out after dark. Walk on designated pathways and well-lit areas. There is truly safety in numbers. Be aware of your surroundings.
- If you are alone and do not feel comfortable walking to your car, call the Police Department for an escort.
- Don't walk while staring at your phone; you may become the victim of an accident or a crime.
- Report any criminal or suspicious activities or other emergencies that occur on campus to the Santa Rosa Junior College Police Department.
- Every time a crime is reported, there is a chance to catch the criminal. When a crime goes unreported, the suspect will become more brazen and strike again.
- In most sexual assaults, the victim and suspect knew each other prior to the assault. Knowing someone does not guarantee a sexual assault will not occur.
- Limit the amount of personal information you share online. Some services archive messages indefinitely, providing key-word search capabilities to find anything that you ever posted on a public site.

"Shelter in Place" When an evacuation is not safe, or conditions are more dangerous outside

If a message is received from campus security that there is "Shelter in Place" :

- Immediately seek refuge inside the nearest building
- Move to rooms without windows if possible
- Close any open windows and doors if you cannot move
- Close window blinds
- Rooms that have little or no ventilation are preferred
- Silence cell-phones
- Only come out when you are told that it is safe by District officials or emergency personnel at the scene

"Active Shooter" Run - Hide - Defend

If a message is received from campus security that there is an "Active Shooter":

- Run - If there is a shooter and you can safely get away, do so. Get as far away as possible and take cover. What's important is you, not your stuff.
- Hide - If escape isn't possible, take cover. If possible, lock/blockade doors, turn off lights, and remain quiet. If unable to secure area, hide out-of-sight.
- Defend - If you cannot run or hide, commit to fighting, Disarm the shooter.
- Find out about more tips for surviving an active shooter event through campus security.

PATIENT POLICIES

PATIENT RIGHTS

Dental professionals are privileged to serve the public. Specific rights are provided for all patients who elect to receive treatment. Dental patients will receive consent for Treatment forms when they present to the dental hygiene clinic for their first appointment. The Consent for Treatment form outlines the dental patient's rights and the rights of the dental hygiene clinic Students have the obligation to assure the dental patient confidentiality is protected. Dental patients must be told in a language or terminology that they understand; the nature of the procedure(s), the cost of the procedures(s), the risks of the procedures(s) the prognosis of the procedure is performed or not performed.
The Patient Bill of Rights is found in the appendix.

CULTURE

Culture is defined as the totality of socially transmitted behavior pattern, arts, beliefs and all other products of human work and thought typical of a population or community. Knowledge of culture is essential in understanding how tradition affects health related beliefs and behaviors and approaches to oral health care.
Throughout your clinical practice, you will be developing cultural competency in the treatment of a variety of patients. This development will be tracked through interactions with a patient who is different from you in background, belief system, culture, norms, traditions or language.
Becoming Culturally Competent

- Approach each individual as a valued, unique person
- Be sensitive to cultural norms
- Be aware of your biases
- Learn about your patient's health care values, ask
- Display acceptance and nonjudgmental attitude
- Use the appropriate and acceptable terms when referring to the patient's culture

SRJC POLICY ON DISCRIMINATION

SRJC provides equal opportunity to all eligible patients and does not discriminate on the basis of race, color, national origin, age, sex or disability.

VISITORS

No one other than the patient is allowed in the hygiene clinic units. Exceptions include; caregivers, parent/guardian, interpreter. In addition, please do not allow minor children to remain in the waiting room unattended. This practice presents a security issue for the child, as no one is responsible for watching them.

NOTE: Children including babies and toddlers are not permitted in the clinic while their parent is receiving dental care.
The faculty have the right to ask any visitor to leave the clinic.

SECURITY AND PRIVACY POLICIES

HIPAA PROTOCOLS FOR DENTAL CLINIC

As a student at SRJC Dental Hygiene program, you have a legal and ethical responsibility to safeguard the privacy of all patients and protect confidentiality and security of all health information. Protecting the confidentiality of patient information means protecting it from unauthorized use or disclosure in any format oral, FAX, written or electronic. Patient confidentiality is a central obligation of patient care. The Dental Hygiene Clinic is in compliance with HIPAA. Any breaches in patient confidentiality or privacy may result in disciplinary action, up to and including dismissal from the program

Protected Areas; all health information that relates to the patient's past, present or future condition(s), and all patient information that is individually identifiable.

How do we Comply;

1. Notice of privacy practices are posted in a prominent location
2. Notice of privacy practices are given to each patient to read, review and sign
3. Patient's will be identified only by their first name on any document that is visible to any individual other than the student operator and their assigned faculty. This includes any document that is not stored in the patient's permanent record.

Please pay attention to any sign-in/up list, time management sheet, radiology sheet, appointment sheet, case study sheet, priority sheet and any oral or written communication with faculty.

PATIENT CONSENT FOR TREATMENT

Each patient will be required to sign the Dental Hygiene Teaching Clinic Conditions of Treatment document. This document outlines information on consent for dental procedures, photographs and dental records, financial responsibility and the importance of keeping appointments. A copy of the Consent for Treatment form is found in the appendix of this manual.

PATIENT CHARTS

Patient charts must remain filed alphabetically in the business office. Patient charts are not to leave the clinic area. Removal of patient charts is a serious breach in professionalism in patient confidentiality and in clinical operation. If chart contents are needed for class work, copies are made with permission from reception faculty. During clinic, do not remove your patient charts until they have been released by the reception students/faculty. This policy includes all electronic charts as well as hard copy charts.

Policies/regulations for Patient Charts

- Chart components/pages must be kept in proper orderly sequence
- Charts must never be kept in student cabinets, or lockers
- Chart components must not be contaminated
- Charts must be returned to reception at the completion of a clinic session
- Charts can be reviewed only during the student's assigned clinic time or with the permission and direct supervision of a faculty member

- Outside of clinic, Heath Histories must never be in the possession of the student. If a patient is given a Health History to fill out prior to the appointment, the patient must keep the form until they come to the reception desk for their first appointment.
- No portion of a patient electronic or paper chart may be copied onto any device or emailed without written permission from the lead faculty.

POSTING OF PATIENTS NAMES
Under no circumstances are patient's full names to be posted in any area including on computer screens. If a patient's name is needed for a document that is posted where it can be seen by other patients, students or staff; only the first name of the patient may be used.

INSTRUCTOR AREA
The privacy of the instructor's area is to be respected at all times. Instructors are readily available to assist students, however, there are times they are inaccessible in order to prepare for clinic/classes or consulting with students.

STUDENT SECURITY POLICIES

For reasons of personal security, student's nametags will have only the student's first name and the students designated identification number. All posted documentation will include the student's first name only (if there are students with the same first name, they will use their first name and last initial). All chart entries and documents given to the patient will include the student's first name and number only.

In addition, for personal security, students will not give their personal phone numbers or addresses to patients. If requested, SRJC will provide a voice mail system to receive messages from patients. Students may choose to arrange for their own **secure** phone numbers that do not contain identification of the student's name of other contact information other than the **secure** phone number, text number of email address.

Any business cards, flyers, advertisements or promotions associated with students must not contain the student's last name or personal phone number.

A student will not see any patient who demonstrates inappropriate behavior. Please notify the lead faculty immediately and together you will decide the best plan of action.

Students will <u>not</u> transport patients to or from the campus.

If students are recruiting patients during clinic hours, they must check-out and back in with reception faculty and check in with their assigned clinic faculty every 30 minutes for the duration of time they are out recruiting.

<u>Student Records</u>
It is our intention to protect the confidentiality of grading information. Students <u>may not</u> enter any file cabinet containing student records without direct instructions and supervision from the lead faculty. If an instructor is discussing grading information with a classmate, please allow them as much privacy as possible. You may ask your instructor of the day or the lead instructor to review your progress notes at any time during the clinic session.

Guidelines for Advertising your Clinical Services

Business cards and or flyers or any other written materials must follow these guidelines:

1. Your first name only
2. SRJC Dental Hygiene Program - must be included
3. Your contact information **does not use the clinic phone number.**
   Your contact information must be a secure contact number, and the secure phone number used must have that information indicated. (707 555-1212 is a secure phone number)

Other information that may be helpful

Address of the school – include Race building off Elliott on Emeritus Circle
Location of parking
Time and date of your appointment
Clinical fees
Clinical hours

Flyers or other written materials posted on or off campus must be regularly monitored and removed at the end of each semester.

The lead faculty must approve all business cards and/or other written materials

1. Bring a hard copy to me to review or bring your lap top or tablet to show me your proposal
2. Show me your proposal during my office hours or make an appointment to see me.

Agreement on Flyers/Advertisement of Dental Hygiene Services

The following are the guidelines for the use of flyers or other advertisement to recruit your dental hygiene patients.

- all flyers/advertisement must be approved by program director before use in **any area on or off the SRJC properties**
- all flyers/advertisement **posted on SRJC properties** may ONLY use the clinic phone number 707 522-2844
  - **NO individual phone numbers or contacts**
- all flyers/advertisement **posted on SRJC properties** must have approval for posting from the Interclub Council - they may stamp the poster as approve
- any flyers/advertisement posted in areas **outside the SRJC properties** or given directly to potential patients may contain the individual student's secure contact information
- if outside patients are appointed in clinic for screening in DH I or DH II, they will be screened for case-type classification and then assigned to the appropriate class:
  - if they are case type 1 or 2 patients they will be assigned first to a first-year student
  - if they are a case type 3 or higher to second year student

BUSINESS OFFICE POLICIES

BUSINESS OFFICE

The business office is only opened during Dental Hygiene Clinics. During non-clinic hours, you must receive permission from a faculty and request that they open the office.
The business office is limited to students assigned to reception rotation and students who have permission to review patient charts, no patients are allowed in the business office.

- Respect for business office personnel and willingness to cooperate with polices and procedure is imperative
- Congregating in the business office areas is not permitted
- The business office desks and computers are not available for student use
- Clinic gowns are not permitted in the business office
- The copy machine is not available for student use, instructors must authorize copies when special assignments are made
- The business office phones are for receiving calls or placing calls to patients. Patients may use the phone in the clinic for essential calls only
- The use of college stationary is not permitted without the signature or permission of the program director.

PATIENT APPOINTMENT LIST AND CHARTS

All patient appointments should be scheduled in the computer as soon as possible and this should be updated at the beginning of each clinic session. During the previous clinic, a patient appointment list is prepared and posted on the reception desk and all charts are pulled and placed in the chart rack. If a patient is being added to or taken off this list, it is the student's responsibility to make this change no later than 20 minutes before clinic starts. The student must then pull the chart and add necessary notes to the list "new patient" etc. Patient charts may not be taken from the reception chart rack within 20 minutes before the beginning of clinic. Plan to view chart prior to that time or at the previous clinic session.

PHONES

Students may use the phones at the front desk of the business office and in the radiology area during posted hours for brief phone calls related to that patient's only. Other phone use for students will be approved on a case-by-case basis. If a patient needs to use a phone, they should be directed to the phone located in the clinic.

COLLECTION OF FEES

Beginning in the summer semester and through your second year of dental hygiene:

- The collection of fees is completed in reception before the patient may be seen by the assigned student. To avoid disappointments, it is advisable to discuss fees with your patients before their first appointment.

There are 3 exceptions to fees: (there are **no exceptions** for radiographic fees during radiography classes)

1) Four (4) "free pass": good for free NSPT will be issued to each hygiene student at the beginning of the summer semester. You may use these passes for any hygiene patient throughout your summer and 2nd year of dental hygiene. Reception personnel will track these free passes on the computer.

2) DH students and Dental Program faculty and faculty's families will not be charged for services. A dental hygiene student's child under the age of 18 may have all clinical procedures done at no charge if the parent, who is the dental hygiene student, is the operator.

3) DH and DA grads are free within 1 year of graduation.

ASSIGNED PATIENTS-STUDENT PATIENT RESPONSIBILITY

The clinic's first priority is to patients who have been screened by clinical faculty through screening appointments or in your unit. These patients have committed at least 30 minutes of their time to come to the clinic to be evaluated for treatment. If their case type and

conditions fall within the criteria set by the faculty, they **must be appointed and completed with a reasonable time frame (6-8 weeks).** Failure to treat these patients in a timely and professional manner results in patients who are frustrated and justifiably angry and will result in removal of the student's name from further clinical patient assignments. This type of behavior also has a negative impact on the reputation of the clinic. The clinic has enjoyed a very positive reputation within the community, this reputation is a reflection of the outstanding treatment previous classes have worked hard to provide. Your class benefits from their good work, we expect that each class will continue to enhance this reputation with their continued professional and capable trea**tme**nt of patients.
Each student must respect and adhere completely to the following policies:

1. When you have been assigned a patient, either through a screening appointment or in your unit, you must appoint that patient within 7 days. Accounting for this will be tracked on the patient screening form through reception faculty. If the patient's schedule does not allow you to appoint the patient within 7 days, you must appoint the patient as soon as the patient's schedule allows. **This information must be given to the reception faculty within the first week of receiving your assigned patient.**

2. If the patient changes the appointments, these changes must be accounted for on the screening form in reception or, if the patient has begun treatment, on the treatment record. Both notations must be arranged through the reception faculty. You must convey this information to the reception faculty before the beginning of the next clinic session.

3. When you have been assigned a patient, the patient's screening sheet will be placed in the screening binder under your student number and checked by reception faculty each week.

4. Under no circumstances may you give your "clinic assigned" patient to another student. If it is determined that you cannot appoint this patient, on your communication sheet you must submit a written request to the clinic to have your name removed from the screening form. This request must include a detailed explanation of why you cannot appoint this patient and must occur within the first week after they are assigned to you. The patient may then be placed back into the screening pool and assigned to another student.

5. Patients who you know or have recruited will also be tracked for appointing and completion within a reasonable timeline.

6. Remember it is your responsibility to keep an accurate and detailed log of all conversations with any of your patients regarding appointment scheduling. These details are essential in establishing justification for removing a patient from your schedule or discontinuing a patient.

7. You may request that your name be removed from the student priority list at any time.

Failure to follow any of these policies will result in the removal of your name from the priority list.

SHARING PATIENTS BETWEEN STUDENTS
Planning for the care of each patient in the student caseload (whether assigned or personally recruited) is the responsibility of the student. Sharing of patients is only approved under unusual circumstances and requires the lead faculty's permission.

PATIENT DISCONTINUED PROCEDURE

How to enter a patient as "Discontinued"

- Before the discontinued process begins all notation of missed, failed, cancelled appointments and items of note regarding patient cooperation, etc. should be in the Record of Treatment on the day they occurred or contained within a typed document from the students record of correspondence with the patient
- Discontinuing patients occurs during end of semester Chart Audits
- The following are examples of cause for discontinuing (note that these items are also listed on the Patient Discontinued Letter)
    - Medical or dental condition that would make treatment hazardous to patient or operator
    - Failure to be on time for your appointment
    - A total of TWO cancellations without 24 hours' notice, TWO missed appointments, or repeated unsuccessful attempts to arrange for an appointment may be cause to discontinue a patient from further treatment in the Dental Hygiene Clinic. Dates _____
    - Oral conditions that are considered unacceptable for student learning.
    - Oral conditions that have been determined to be necessary before further treatment is begun.
    - Lack of interest and/or cooperation in learning preventive oral hygiene techniques
    - Inappropriate patient behavior toward students, staff or instructors.
    - The clinic supervisor reserves the right to refuse or discontinue treatment when indicated.
    - Other _____
- It is **not** appropriate for a student to discontinue patients without a consultation with the lead faculty.
- All patient discontinued for less than 24 hours' notice to cancel an appointment, failing appointments and arriving more than 15 minutes late will have documentation for these occurrences written in red in the patient's chart on the day they occur.
    - The following items must be completed by the student before a patient can formally be discontinued. (Students must have these forms completed BEFORE chart audit)
    - Completed patient discontinued letter (obtained from reception faculty) with reason(s) checked and dates recorded
    - Copy of Signed Patient Consent Form from patient chart
    - Produce an envelope with SRJC return address and complete patient's name/ address for mailing.
    - Letter is signed by the student and lead faculty
    - Yellow copy goes into the chart and white copy is mailed to the patient
    - Give completed envelope to reception faculty
    - Date, list and document the forms to be sent to the patient in the patient's chart.

Chart Management After Patient is Discontinued

- Highlight over the patient's name on the patient's chart in pink
- 2 hole punch the white copy of the discontinue letter and place on top of treatment records, so it is obvious to find
- Place chart back in appropriate alphabetic location in files

NOTE: In order for a patient to be discontinued these items must have been done

- Patient Consent for Treatment must have been reviewed and signed at the beginning of the first appointment.

- SRJC dental Clinic policies and fees must have been reviewed and signed by student and patient at the beginning of the first appointment.

GENERAL FACILITIES POLICIES

Building Maintenance

The condition of the dental facilities is vital to the success of the program. It is everyone's responsibility to help maintain the cleanliness and good condition of the facility and the equipment. The clinic, lab/classroom needs to be kept clean on a continual basis. Equipment and supplies must be returned to the appropriate storage place immediately upon finishing with them or at the end of the clinic/lab. Custodians do not move personal items or equipment in order to clean. Only approved signs are permitted on clinic walls.

Locker Room

The appearance of the locker room depends on the cooperation of each student. Personal belongings and other property, for which a student is responsible, must be kept in the locker assigned to him/her during clinic or labs sessions. Students must provide combination locks to secure their belongings. The combination must be registered with Becky. Locks must be removed, and lockers cleaned and vacated at the end of the summer semester.

FORMS

There are several forms that need to be documented on patients. You are responsible for obtaining these forms, documenting completely and obtaining all appropriate signatures during your clinical time.

- All documents must be complete before requesting a patient, or instructor signature.
- All signatures must be obtained during the clinic time in which the procedure was performed.
- No charts are to leave the clinical area in hard copy or electronic form including email.
- All charts are to be placed in reception after each clinic, do not store them in your cabinet or locker.
- All documentation must be legible, written in non-erasable blue or black ink
- Dental Charting, EOIO and PSE forms are charted in the computer's Eagle soft software as electronic charts
- At the completion of each clinic, place all paperwork in the patient's chart in the correct order.

CORRECTION or ADDENDUMS TO ENTRIES IN CLINICAL TREATMENT RECORDS

Corrections are defined as mistakes made in treatment entries

Cross out the error with a single line – hard copy forms
The student and the instructor will initial the correction
Note: if the mistake is identified during the clinical session, your assigned faculty will initial the correction. If the mistake is identified after the assigned faculty signs off the chart for the day, the lead faculty must be asked for their initials.

Addendums are defined as additions to the treatment entries – hard copy forms

Addendums will be written as followed and always require the initials of the lead faculty.

Date	Treatment Rendered
(Today's date)	addendum to (date of original entry) the following treatment was delivered
	Student initials and #
	Lead faculty initials

All corrections to Electronic Forms must be completed during **that clinic session**. The assigned faculty will cross off any correction notation to EOIO, Dental Charting, PSE assessments which have been indicated on the purple sheet after they have re-checked your electronic chart.

TREATMENT NOTATIONS FOR PATIENT COMMUNICATIONS OUTSIDE OF CLINICAL TREATMENT INCLUDING APPOINTMENT COMPLIANCE

Occasionally a notation will be necessary regarding communications outside of clinical treatment. These occasions may include communications such as; appointment compliance, inappropriate behavior, after hours' emergencies, etc.

In the cases of inappropriate behavior or after hours' emergencies, the student may not make any notations in the patient's chart without prior approval of the lead faculty. It is the student's responsibility to make notations on a separate paper to be reviewed by the lead faculty. After this review, the student will be asked to transfer the notations into the patient's chart.

In the cases of appointment compliance, if the patient fails a confirmed appointment or cancels the appointment within 24 hours, or is more than 15 minutes late; a notation in **red** is made on the Record of Treatment.

- Here are some examples of this documentation:
    - date the entry, then write: Called patient on 9-12-19, confirmed 4-hour AM appointment on 9-13-19 with his wife, patient no showed on 9-13-19, left message on patient's answering machine.
    - patient arrived 30-mins. late for appointment, explained to patient the importance of being on time. Patient said he had a hard time finding parking, but he would come early next time.
    - called on 9-15-19 to confirm PM appointment for 9-16-19, patient cancelled appointment.
    - Very important to keep the text or email thread of patient communication and present to lead faculty

GENERAL FORMS

The following guidelines describe the forms, when they are filled out, what signatures are needed and include the specialty forms.

ALL PATIENTS

- **Consent for Treatment** - read and signed by the patient before treatment begins
- **Notice of Privacy Policy - HIPAA** – read and signed by the patient before treatment begins
- Health History - HH- - filled out by the patient, then reviewed by the student and signed by student and patient then reviewed and signed by the clinical instructor and the Clinic Dentist. Health history update: performed at each appointment and signed by the patient, student and faculty. Transfer to the top of the form any highlighted box from the health history. **NOTE:** new health histories are required every 2 years or if there are significant health/medication changes.
- Vital Signs – taken at all initial visits and routinely every visit after that. Enter this information in the Health History and Record of Treatment at initial visit and in the Health History update and Record of Treatment and in subsequent visits. Signed by the patient, student and instructor as part of the treatment record.
- EOIO – full procedure performed every initial visit in **paper form** or electronic **form, and** every recall interval after that in a hard copy EOIO update. When multiple appointments are necessary, an EOIO update is complete and charted at each appointment before treatment for that appointment begins. Any condition or area noted previously needs to be evaluated at each appointment. Signed by the student and instructor as part of the treatment record.
- PSE and Tissue Description – performed at every initial visit and as needed to evaluate progress after that **in electronic form**. Signed by the student and instructor as part of the treatment record.
- Dental Charting – performed every initial visit and every recall interval after that in **electronic form**. A cursory dental exam is done at each appointment before treatment for that appointment begins. Any condition or area noted previously, or referral notes need to be evaluated at each appointment. Signed by the student and clinical dentist as part of the treatment record.
- Oral Hygiene Record – OHI – performed before NSPT procedures begin. When multiple appointments are necessary, an OHI update is performed at each appointment to check progress from previous instructions and evaluate the need for continued or new instructions. The student and instructor sign the OHI document as part of the treatment record.
- Treatment Plan and Periodontal Risk Assessment – performed before NSPT procedures begin and evaluated at each appointment after that. The care plan is tracked for changes for each care planning cycle. Signed by the student and instructor as part of the treatment record. Signed by the patient upon presentation.
- Patient Completion Letter and Dental Referral – Production of the Patient Completion letter begins with the Dental Exam; with dental concerns indicated by the clinical dentist and signed by the clinical dentist. The Patient Completion letter is then finalized at the last appointment with notes regarding treatment provided and
- Route Slip – the route slip is used by reception to record the initial appointment and patient completions. You must enter the information into the computer and fill out the route slip **before** dismissing your patient. Bring the route slip and your patient to the reception room

door and ask reception faculty or her designee to initial the route slip indicating that it has been received.

- Continued periodontal concerns. The student, patient, clinical dentist and assigned faculty member sign the document.
    - The document is given to the patient and sent to the patient's DDS or if the patient does not have a DDS, is kept in the patient's chart.
    - Patients not allowed to return to clinic until treatment needs met – make the notation on the date that the decision is made with the rationale and clinical DDS signature. This will be the last notation in the treatment record. **The patient understands that they will not be allowed to return to the clinic for any recare/reevaluation appointments until the following condition has been corrected _____**
    - An additional Patient Completion letter will be generated at the completion of the periodontal re-evaluation appointment.

NOTE: The order of documents in the patient chart is outlined in the Appendix

SPECIAL FORMS

- Authorization for Radiographs - filled out by the student and signed by the student and clinical dentist. If the patient has a dentist, radiographs must be requested from that DDS before asking for a clinical dentist authorization.
- Medical Consultation Request - filled out by the student and signed by the student and clinical dentist

All appropriate special forms are kept in the patient chart, make chart notations on the Record of Treatment where appropriate.

PATIENT COMPLETION FORM – Purple

This sheet must be complete including student and patient name to get credit for case completions. Any patient completion form turned in without this information will not count toward completion. It is the student's responsibility to get all faculty signatures at that clinic time and any correction to the electronic charting(s) corrected in that clinic session.
These sheets are to be left in the patient's record until the patient is complete. When the patient is complete, the faculty fills out the audit at the bottom of the form. The form is kept in the patient's chart until chart audit.

DOCUMENTATION NOTES FOR SRJC CLINICS-CHART DOCUMENTATION

All notations made in the treatment document must be done in blue or black non-erasable ink and end with your initials and department assigned student number.
Faculty are responsible for all procedures recorded on the Record of Treatment; document only those procedures that a faculty has checked. Do not write up the Record of Treatment document until you have completed the procedure and the faculty has checked it
Date: Must include full date with slash between numbers - 9/22/19
Area: If you are treating a specific area use the abbreviations of the area by quadrant notation or by tooth number if a quadrant was not completed or only a specific tooth was addressed.
Treatment: Use a separate line for each treatment component and department approved abbreviations when applicable. Do not skip lines. Place components in the order they are performed. Begin each line with the treatment component followed by a semicolon and then the information. If there is more than one item in each component, use a comma between each.

Date	Area	Treatment
8/22/18		Health History reviewed, **OR** Health History updated,
		Also, included here: Medical Referral with the DDS signature,
		Premed: what medication taken, when taken and who prescribed.
		Latex Allergy; the operator wore non-latex gloves
		Vital Signs; BP_____, P_____, R_____
		Treatment Prerinse
		EOIO: See notes (hard copy, or electronic)
		EOIO update: WNL, No Δ or See notes **OR** Cursory OE
		PSE: Electronic- See Electronic Notes
		Dental Charting: See Electronic Notes
		OHI See notes **OR** OH Update
		Treatment Plan and Periodontal Risk Assessment See Notes
Area		Treatment notes to include: x-rays, anesthesia, N202, NSPT, intraoral camera, fluoride varnish, & Interim therapeutic restorations (ITR)
		Give specific tooth numbers and surfaces for: sealants, ITR's, desensitizing and irrigation and fluoride varnish, give areas or quadrants to indicate the location of NSPT, anesthesia
		Selective CP - type of Prophy Paste; coarse, medium, fine
		Patient tolerated treatment well (if not, make additional notes as **previously** agreed upon with your instructor)
		At the time of completion Patient completed – recommended recall __ months. The patient understands that the SRJC clinic may not be able to accommodate the recommended recall suggested by the student
		Patient Completion letter given
		Student initials and number
		Faculty signature

Charting Notations for Local Anesthesia-To be written within the body of the record of treatment notes

Type of anesthetic administered
Presence or absence of vasoconstrictor and what strength
Area(s) anesthetized
Injections given, IO, PSA, etc.
Total amount of anesthetic delivered
Patient response
Profound anesthesia achieved or not achieved
Any unexpected or unusual responses
Post-operative instructions given

Example: 2%lido, epi 1:100,000 for Rt. PSA, IO, NP, GP, 1.5 cartridges used. Patient responded well with profound anesthesia. POI given.

Charting Notations for Nitrous Oxide- To be written within the body of the record of treatment notes

Tidal volume
Time of start
Baseline for 02 and N20 and time reached
Total time of sedation
Post-operative oxygenation
Post-operative Vital signs
Negative or adverse reactions
Patient's condition on dismissal

Example: Patient tidal volume was_____. Time of start of nitrous was_____.
Baseline was reached at _____O2L/min and _____N2OL/min at _____time.
Total time of nitrous-oxide /oxygen sedation was ____ minutes.
Post-operative oxygenation time was _____mins. Post-procedural vital signs_____.
Negative or adverse reactions. Patients condition upon dismissal

ABBREVIATIONS FOR SRJC FORMS

No Δ - no change

HH - health history
VS - vital signs
BP - blood pressure
Tx – treatment
EOIO - extra oral intraoral examination
P – pulse
R - respiration

Medical and Dental History Department Protocols

GENERAL PROTOCOLS

1. All patients must have a medical and dental history completed and reviewed with the faculty before any procedure may begin.
2. The assigned faculty are responsible for the safety of the treatment of the patients under their supervision. For this reason, **only the assigned faculty** may review the initial health history and/or the health history update. Exceptions to this guideline; if a faculty request another faculty to review a HH or update, they must also review the HH/update and initial the form to indicate that they are familiar with the case.
3. If the patient is a minor, the parent/guardian must be present for at least the initial review of the health history. The need for the parent/guardian on subsequent health history updates will be dependent on the age/abilities of the patient and the complication of the medical information.
4. Health history updates are done before the beginning of each appointment.
5. A new health history is completed every 2 years or when it is determined that there is a need due to changes in the patient's health.
6. The document is completed in non-erasable red and blue/black ink
7. Confidentiality is important; use a low voice when taking the information from your patient and delivering the summary to your faculty.
8. The patient should be seated in the upright position. The operator should be seated facing the patient and uses a low, non-confrontational tone.
9. All questions must be answered completely
10. If the patient does not have a physician, ask where they would go if they were sick. Note – patients who are SRJC students may indicate – SRJC Health Services

DOCUMENTATION PROCEDURE

1. Circle all "Yes" answers in RED – exception is if the patient responds "poor or fair health" you will circle this in red ink
2. Write patient's responses to clarifications in RED on the Medical History Form
3. For any corrections; the patient and operator must initial
4. Make sure the patient and you (student) have signed and dated the form
5. The medical/dental write-up is completed in blue/black ink
6. Triangulation – for each drug, condition, physician
    - Condition – physician and medication
    - Medication – physician and condition
    - Physician – condition and medication
7. All medications taken within 24 hours (including OTC) are triangulated.
8. Give **brief notes** on condition, MD, drug class and dosage.

PROTOCOL FOR MEDICAL/DENTAL HISTORY WRITE UP & ORAL CASE

Introduce Your Instructor

Introduce your patient to your instructor – "**Mrs. Jackson,** this is my **Professor_____, Professor_____** this is my patient **Mrs. Jackson**"

Always introduce the patient first then introduce your instructor.

It is not necessary to introduce them again during that appointment. You will need to do this for each appointment. If you have a different instructor on during same clinic session you will need to reintroduce patient to your new instructor.

Reporting Medical Information

You will be expected to give a brief report of your Medical History findings before the faculty Begins their exam. To avoid breaches in confidentiality, this report must be given at chair side with the patient present. You will be asked to give complete findings to your faculty.

Personal/Social History: Student will orally present the following information

- Patient's Chief Complaint
- One or two tidbits about the patient ex. pt. is a student at SRJC, pt. is my father, pt. took a trip to Spain over the summer, etc.…

Medical History: Student will orally present the following write up

- Circle all "Yes" answers in RED
- Write patient's responses to clarifications in RED on the Medical History Form
- Make sure patient and you (student) has signed and dated the form

Complete the Health History Write-up Form for your oral presentation to your faculty

- For each medication the patient is taking, Triangulate: My pt. is being treated for (name the condition or disease, each disease/condition separately), by physician's name with list the medication and dosage also write the dental hygiene implication (only what is pertinent to dental hygiene care). Write the **DDR ONLINE** here and next to the medication on the Original Medical History form in the medicines taking section

- If patient is in need of a medical consultation before dental hygiene treatment or invasive treatment can begin, write: "Pt is in need of medical consultation before dental hygiene treatment (or invasive treatment) can begin."
- When reporting the HH - questions 28 – 33, please say, questions 28-33 are answered on the HH

Dental History: Student will orally present the following write up

Write up DENTAL HISTORY clarifications on the Dental History write-up form

Health History Update

When presenting the HH update, you must present all pertinent findings from the original HH as well as any new or changed information.

You must give the original HH to the faculty when you are presenting the HH update.

MEDICAL CONSULTATION REQUEST
SRJC DENTAL PROGRAMS

If a consultation with the patient's physician is necessary the operator must: (1) first obtain and document information needed from the physician and (2) obtain and document informed consent from the patient.

1. Review the patient's health history obtaining an accurate appraisal of the patient's current health status.
2. Review the findings with the SRJC Clinical Dentist.
3. Determine if a phone consultation is sufficient (always follow-up with the written Medical Consultation Request form)

If a phone consultation is sufficient:

1. Identify yourself and the SRJC Dental Programs to the receptionist
2. Identify the patient
3. Inform the receptionist that the SRJC Clinical Dentist wishes to speak to the physician.

If a phone consultation cannot be obtained or is not sufficient:

1. Mail or FAX the Medical Consultation Request to the patient's physician.
2. Make the appropriate notations on the patient's treatment record and have the clinical dentist sign the record
3. If the patient is going to obtain the medical release, give the top copy of the medical request to the patient and file the second copy in the patient's chart for future reference
4. Keep the physician signed release in the patient's chart on the left side under the health history update

MEDICAL CONSULTATION MAY BE REQUIRED

Prophylactic Antibiotics - **MAY REQUIRE PHYSICIANS CONSULTATION REQUEST**
Refer to Cardiac Conditions Associated with Endocarditis and American Heart Association Recommendations for Prophylactic Antibiotic Coverage **OR** Patients at Potential Increased Risk of Hematogenous Total Joint Infection and Suggested Antibiotic Prophylaxis Regimens for Patients at an Increased Risk for Hematogenous Total Joint Infection.

Vital Signs - **MAY REQUIRE PHYSICIANS CONSULTATION REQUEST**
Refer to Classification of Adult Blood Pressure and Dental Treatment Modifications Patients in Stage III and IV and some in Stage II blood pressure categories will not be seen in our clinic.

ASA Categories - **MAY REQUIRE PHYSICIANS CONSULTATION REQUEST**
ASA category IV and V will not be seen for routine dental care.

Bleeding Disorders - **MAY REQUIRE PHYSICIANS CONSULTATION REQUEST**
Affirmative responses to medical history questions identifying abnormal bleeding, bleeding disorders, leukemia, liver disease or taking drugs that might identify coagulation disorders such as anticoagulants (Coumadin).

Cancer Treatment - **MAY REQUIRE PHYSICIANS CONSULTATION REQUEST**

Oral complications resulting from radiation therapy of the head and neck and chemotherapy might include salivary changes, xerostomia, mucositis, difficulty swallowing, and loss of appetite, loss of taste and radiation caries. Patients in acute stages of leukemia will not be seen for routine dental care in the clinic.

Psychiatric Treatment - **MAY REQUIRE PHYSICIANS CONSULTATION REQUEST**
Patients taking drugs for psychiatric treatment such as antidepressants and antianxiety drugs may have an interaction with epinephrine or nitrous oxide.

Medications - **MAY REQUIRE PHYSICIANS CONSULTATION REQUEST**
Medications may affect NSPT with side effects of xerostomia, limited use of vasoconstrictors in local anesthesia, gingival hyperplasia, oral candidiasis and oral ulcerations.

Infectious Disease - **MAY REQUIRE PHYSICIANS CONSULTATION REQUEST**
If a patient is in an active stage of tuberculosis they will not be seen in the dental clinic. An active state is determined by a productive cough, production of sputum and night sweats. Routine dental treatment should be postponed until a physician confirms, using recognized diagnostic evaluation, that the patient does not have active tuberculosis.
Patients with active measles, mumps or chicken pox will not be seen in the clinic.
Patients with acute herpetic, RAU or ANUG symptoms will not be seen in the clinic for routine dental care.

At Risk of Incident - **MAY REQUIRE PHYSICIANS CONSULTATION REQUEST**
Patients with a history of myocardial infarction, angina pectoris, cerebral vascular accident, asthma, epilepsy or insulin-dependent diabetes are considered "at risk of incident" during stressful procedures. The following questions must be asked to determine how to proceed.

- How often do you have attacks?
- When was your last attack?
- What brings on the attacks?
- Are you under a physician's care for the attacks?
- Are your normal activities limited?
- How do manage the episodes?
- Do you use medication and if so is the medication with you?

After questioning, the clinical choices are: (1) consult with the physician, (2) postpone treatment or (3) proceed with treatment.

Cardiovascular Disease and Other Acute Conditions - **MAY REQUIRE PHYSICIANS CONSULTATION REQUEST**
If a patient has experienced a myocardial infarction, stroke, or cardiac bypass, transplant, or cardiac bypass surgery within the last six months, they will not be seen for routine dental care in our clinic.

Diabetes Mellitus - **MAY REQUIRE PHYSICIANS CONSULTATION REQUEST**
A person with diabetes is of concern during NSPT due to the potential risk of hypoglycemia. Appointments should be scheduled for the morning after breakfast and insulin administration. Confirmation and documentation that insulin was taken and of blood glucose level results as well as the time of the last meal are needed. Medical complications of

diabetes tend to manifest during periods of poor control of blood glucose levels; therefore, a physician's consultation may be necessary.

Immunosuppression - **MAY REQUIRE PHYSICIANS CONSULTATION REQUEST**
Oral complications which require a physician's consultation might exist in patients with HIV infection, leukemia, Lupus, transplants and other conditions which result in immunosuppression.

IF IN DOUBT ASK A CLINICAL INSTRUCTOR

SRJC - REFERRAL FOR DENTAL TREATMENT AS PART OF THE PATIENT COMPLETION LETTER

Dental referrals are an important part of delivering comprehensive dental care to the patients who are treated in our clinic. In general patients need to see their private dentist every six months for a routine dental examination. Some patients require more frequent examination and some patients will need specialty referrals. You will be responsible for educating your patient of their need for regular dental examinations and the limitation of examinations and treatment rendered in our clinic. Patients may believe that, by coming to our clinic, they have received a dental examination and do not need to see their general dentist. We are **strongly suggesting** that patients comply with the recommendation for a dental examination by a licensed dentist at least yearly. They need to be educated about this, and you are the one to do this. In addition, you will need to follow-up on their compliance with this recommendation and inform the clinical faculty if compliance has not been met.
In some cases, this recommendation may become a requirement. The patient **will be refused treatment** in the SRJC clinic unless their dental office submits documentation of a dental exam and/or definitive treatment before they will be able to be seen in our clinic.
You must review the Referral for Dental treatment found in the Patient Completion document with your patients and have them and the assigned faculty(s) sign the form. <u>One copy must be given to the patient</u> and the other copy must be filed in the patient's chart. If the patient has a DDS, one copy will be sent to them as well.
Some patients do not have a general dentist or wish to make a change in their dentist. If this is the case we will be referring them to the Redwood Empire Dental Society phone number 707 546-7275 **or** a clinic listed. It is both <u>unethical and unprofessional</u> to refer a clinical patient to any other source or to make a comment positive or negative regarding their choice of dentist. We are representing the college and must remain neutral regarding other professionals

ONLY REFER PATIENTS TO THEIR PRIVATE DENTIST or the list of low cost clinics we have provided.

Fill out the Referral For Dental Treatment found in the Patient Completion form and have the clinical faculty sign at the bottom. Give the patient the document. The next time you or anyone else sees or contacts the patient this information needs to be followed-up by questioning the patient about compliance.

Patient Completion Letter

When you have completed NSPT you will be giving your patient a patient completion letter. It is to be completed and signed by the student, patient and faculty(s). If the patient has a dentist, a copy of the letter will be mailed to the dentist. Please make sure the dentist's name and address is complete and correct in the patient's health history. Please complete the letter in dark ink, no red. If the patient has a dentist, give the patient their copy and paperclip the top copy to the front of the chart before returning it to reception. This will communicate to the students in reception that the letter is to be copied and mailed to the dentist.

SRJC - DENTAL HYGIENE CLINIC RADIOGRAPHS

Dental radiographs play an important role in the evaluation and treatment of periodontal diseases disclosing information about the periodontal ligament, alveolar bone and teeth within the periodontium. The condition and location of bone support, the distribution and severity of loss may help in making the dental hygiene diagnosis and treatment decisions. Periodontal risk factors such as overhanging restorations, faulty restoration margins, furcation involvement, root length, shape and position, condition of implants and calculus may also be detected through radiographs. Radiographs also assist in accurate dental charting.

Radiographs are never authorized for sole purpose of fulfilling requirements.

- All radiographs must be used for diagnosis of periodontal conditions and/or sent to the referring dentist for diagnosis of dental conditions.
- Clinical dentists **will not authorize radiographs** unless the student can demonstrate the need for the radiographs for diagnosis of periodontal conditions.
- Patients who display risk factors for periodontal disease **will most likely need to** have radiographs to assist in establishing a dental hygiene diagnosis and providing nonsurgical periodontal treatment. In addition, any patient with furcation's of II or greater or periodontal tissue that would indicate possible clinical pathology, such as periodontal abscesses, cysts or subgingival infections, must have radiographs

1. Whenever possible, vertical bitewings are used in place of horizontal bitewings in all FMX exposures
2. Bitewing radiographs may be required before sealants and IT Restorations
3. A request for radiographs from another clinic or private dentist must be made whenever possible. The request for radiographs should be directed to that office/clinic by phone or FAX. The department will duplicate these films before returning them to the office or origin.
4. If a patient does not have a dentist, a request for radiographs may be submitted to the clinical dentist. Authorization will only be given after the student has sufficiently demonstrated the need for the radiographs for their periodontal diagnosis and treatment.
5. All radiographs must be graded within 1 week of exposure. If films are not graded they will not be counted towards state requirements.

Procedure for requesting radiographs from private dentists or SRJC clinical dentists:

1. Determine if radiographs are needed to make the dental hygiene diagnosis and treatment plan
2. The type, number and frequency of radiographic exposures will be evaluated on a case by case basis. An FMX, Panoramic or vertical bitewing series may be ordered. In specialized cases, individual radiographs may be authorized. Prior radiographs must be evaluated before new radiographs are authorized.
3. Explain the benefits and risks of radiographs to your patient and obtain the signature for consent on the Authorization for Radiographs form.
4. Obtain an "Authorization for Radiographs" from the patient's DDS or if necessary, a SRJC clinical dentist.
5. Obtain the patient's signature on the notice of "x-rays are not diagnosed for caries"

Note: you must have the authorization **completed, including signatures** and have the patient present and seated during a scheduled clinic before you approach a SRJC clinic dentist for authorization.

ORAL HYGIENE RECORD

Note; Disclosing solutions discolor tissue as well as plaque, do not disclose before you perform your cursory EOIO or ask your faculty to check an initial EOIO or cursory EOIO.

Calculus Case - CC Refer to document based on subgingival calculus only – calculus case 1– 4

Plaque	**Based on Sextants - Posterior and Anterior** Light - 3 teeth 1/3 or less Moderate - 3 teeth 1/3 to 2/3 Heavy - 3 teeth 2/3 or greater
Calculus Supra	**Based on the Entire Mouth** Light - less than 1/3 or any Moderate - 1/3 to 2/3 of 6 to 12 teeth Heavy - greater than 1/3 of 12 teeth **or** greater than 2/3 of 6 teeth
Calculus Sub	**Based on the Entire Mouth** Use CC case type
Stain	**Based on the Entire Mouth** Light - less than 1/3 of any Moderate - 1/3 to 2/3 of 6 - 12 teeth Heavy - greater than 1/3 or 12 teeth **or** greater than 2/3 of 6 teeth

Fees for Oral Hygiene Aides

- Toothbrushes: patients are to receive one free toothbrush when used for OHI
- Floss: patients are to receive one sample container of floss when used for OHI
- Proxy brush: $1.00
- End tuft toothbrush $1.00
- Perio Aide $1.00
- Rubber tip stimulator $1.00
- Tongue scraper $1.00

APPENDIX

Clinical Protocols
Classification of Blood Pressure
Physical Status Classification
Medically Compromised
AHA Recommendations for Prophylactic Coverage
Disease Classification – Dental Hygiene Diagnosis
Gingival Tissue Description
Calculus Definitions
Notations on EOIO and PSE
Instructions Following Dental Hygiene Therapy
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ADULT VITAL SIGNS / BLOOD PRESSURE GUIDELINES

From: American Heart Association, A Report of the American College of Cardiology/AHA Task Force on Clinical Practice Guidelines

Updated: **January 2018**

SRJC Dental Hygiene Clinic Protocols have been established using this information

Blood Pressure Category	Systolic mm Hg	Diastolic mm Hg	Follow-up Recommended/Clinical Dental Hygiene protocol
Normal	<120	<80	Recheck in 1 year No Restrictions Routine Dental Management
Elevated	120-129	<80	Recheck in 3-6 Months No Restrictions Routine Dental Management
Hypertension			ALWAYS RECHECK IN 5 MINUTES
Stage 1	130 – 139	80 - 89	Retake each appointment Refer for MD check within 2 months Routine Dental Management Stress Reduction Protocol
Stage 2	≥140	≥90	Retake each appointment Refer for MD check within 1 month Routine Dental Management with stress Reduction Protocol - avoid vasoconstrictors/use cardiac dose
SRJC Dental Hygiene Clinic Guideline:	**≥175**	**≥103**	**Immediate medical referral; NO DENTAL HYGIENE PROCEDURES**
Hypertensive Urgency	>180	>120	**Immediate medical referral; NO DENTAL HYGIENE PROCEDURES**
Hypertensive Emergency	>180 + target organ damage	>120	**Immediate medical referral; NO DENTAL HYGIENE PROCEDURES**
Other Vitals Normal range:	Pulse Rate 60 to 100 bpm		Respiration 14 to 20 per minute

PHYSICAL STATUS CLASSIFICATION SYSTEM

The ASA physical status classification system is used *as a part* of risk assessment for treatment modifications and takes into consideration the physical limitations of a patient with systemic disease. Modifications to treatment may also be indicated for other issues such as the medications taken for the systemic disease, however that does not change the ASA classification of the patient.

ASA I A patient without systemic disease - no modifications

ASA II A patient with mild systemic disease - proceed with caution

- Well-controlled non-insulin dependent diabetes mellitus
- Well- controlled epilepsy
- Well-controlled asthma
- Well-controlled hyperthyroid or hypothyroid under care with normal thyroid function
- Healthy pregnant women
- Healthy patients with allergies
- Healthy patients with extreme dental fears
- Healthy patients over the age of 60

ASA III A patient with severe systemic disease that limits activity but is not incapacitating - proceed with extra caution, serious consideration is given to patient treatment modifications, review finding with instructor **prior** to treating patient and at each appointment. Follow medical referral and appropriate consultation to determine an appropriate treatment plan

- stable angina pectoris
- post myocardial infarction > 6 months
- post cerebrovascular accident > 6 months
- well-controlled insulin dependent diabetes
- congestive heart failure (CDF) with orthopnea and ankle edema
- chronic obstructive pulmonary disease
- chronic obstructive pulmonary disease (COPD), emphysema of chronic bronchitis
- exercise induced asthma
- less well-controlled epilepsy

ASA IV a patient with incapacitating systemic disease that is a constant threat to life. No treatment.

- Unstable angina
- Myocardial infarction or CVA with the past 6 months
- Severe CHF or COPD
- Uncontrolled epilepsy
- Uncontrolled insulin dependent diabetes

Medically Complex/Special Needs Patients

The SRJC Dental Hygiene Clinic defines Medically Complex/Special Needs Patients as any patient who requires special considerations in their treatment as it relates to a medical/dental condition discovered in any assessment. Those patients whose medical, physical, psychological, or social situations make it necessary to modify normal dental routines in order to provide dental treatment for that individual. These individuals include, but are not limited to, people with developmental disabilities, complex medical problems, and significant physical limitations. These conditions may be permanent or may be temporary.

The condition must be found in one of more of the assessment documents. Some of these conditions may require a Medical Consultation and/or deferring of treatment.
Indicate the determination of Medically Complex on the Route Slip and Treatment Plan
The list below contains a representation of conditions that would classify a patient as medically compromised. The student should check with the lead faculty if they have any question regarding a condition presented that is not included on this list.

Including conditions such as:

1. **Heart Conditions:**
   - Heart murmur
   - Heart surgery
   - Mitral valve prolapses
   - Myocardial infarction
   - Rheumatic fever
   - Congenital defects
   - Prosthetics
   - Angina
   - Previous endocarditis
2. **Prosthetic Devices:**
   - joint
   - shunts
   - stints
3. **Traumatic Facial Injuries:**
4. **Immunocompromised:**
   - Corticosteroid Therapy
   - Blood Dyscrasias
   - Chemotherapy
   - Organ Transplant
   - Uncontrolled Diabetes
   - Liver Disorders
   - Kidney Dialysis
5. **Endocrine Disorders:**
   - Hyper or hypo thyroidism
   - Diabetes
   - Addison's disease
   - Cushing's syndrome
6. **Autoimmune Disorders:**
   - Crohn's disease
   - Lupus
   - HIV/AIDS

7. **Cardiovascular Disorders:**
   history of CVA
   hypertension >160/100
   hypotension <90/60
8. **Respiratory Disorders:**
   Asthma
   Chronic Bronchitis
   Emphysema
   Congestive Heart Failure
   Pulmonary Disorders
9. **Neuromuscular Disorders:**
   Multiple Sclerosis
   Muscular Dystrophy
   Paralysis
   Myasthenia gravis
10. **Psychological Disorders:**
    Panic disorder
    Substance abuse
    Tourette syndrome
11. **Cerebral Disorders:**
    Uncontrolled Seizure Episodes
    Mental Retardation
    Cerebral Palsy
    Parkinson's Disease
    Epilepsy
    History of CVA
12. **Allergies**
    latex, fluoride, mint oil, any materials or drugs used in dentistry
13. **Dental Management**
    Motor Impairments, Reflux Diseases, Sensory Impairments,
    Pregnancy, Pediatric Patient, Patient with Alcohol Problems, Patient With Implants,
    Orthodontic Patient, Edentulous Or Partially Edentulous Patient

SRJC Dental Hygiene Clinic Policy on Antibiotic Premedication

The purpose of this statement is to update the recommendations by the American Heart Association for the prevention of infective endocarditis.

The major changes in the updated recommendations include the following:

1. An extremely small number of cases of infective endocarditis might be prevented by antibiotic prophylaxis for dental procedures
2. Infective endocarditis prophylaxis for dental procedures should be recommended only for patients with underlying cardiac conditions associated with the; highest risk of adverse outcome from infective endocarditis.
3. For patients with these underlying cardiac conditions, prophylaxis is recommended for all dental procedures that involve manipulation of gingival tissue or periapical region of teeth or perforation of the oral mucosa.
    a. Prosthetic cardiac valve
    b. Previous infective endocarditis
    c. Congenital heart disease
        1. Unrepaired cyanotic congenital heart disease, including palliative shunts and conduits
        2. Completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention during the fires six months after procedure.
        3. Repaired congenital heart disease with residual defects at the site or adjacent to the site of a prosthetic patch or prosthetic device.
4. Cardiac transplantation recipients who develop cardiac valvopathy.

SRJC POLICY

Any patient who previously premedicated under the old guidelines will need to be evaluated for continued use of premedication. If the patient does not fall under one of the categories listed above, they will no longer be required to premedicate or have a physician's release for premedication.

All new patients will be evaluated under the above guidelines to determine need for antibiotic premedication.

Resource;

Prevention of Infective Endocarditis – Guidelines from the American Heart Association

Antibiotic Coverage for Patient with Total Joint Replacements

For All patients with prosthetic joint replacement, if the patient answers the question " **For this condition, h**as your surgeon directed you to take antibiotics before dental treatment "

- Yes = patient must request Rx from orthopedic surgeon and take pre-medication before treatment
- No = patient does not take antibiotic before treatment
- Don't Know = Medical clearance is indicated before treatment

In 2014, the ADA Council on Scientific Affairs assembled an expert panel to update and clarify the clinical recommendations found in the 2012 evidence report and 2013 guideline, *Prevention of Orthopedic Implant Infection in Patients Undergoing Dental Procedures*.1, 2 As was found in 2012, the updated systematic review undertaken in 2014 and published in 2015 found no association between dental procedures and prosthetic joint infections. Based on this evidence review, the 2015 ADA clinical practice guideline states, **"In general, for patients with prosthetic joint implants, prophylactic antibiotics are not recommended prior to dental procedures to prevent prosthetic joint infection."**

A co-published editorial by Meyer also states:
"The new CSA guideline clearly states that for most patients, prophylactic antibiotics are not indicated before dental procedures to prevent [prosthetic joint infections]. The new guideline also takes into consideration that patients who have previous medical conditions or complications associated with their joint replacement surgery may have specific needs calling for premedication. In medically compromised patients who are undergoing dental procedures that include gingival manipulation or mucosal inclusion, prophylactic antibiotics should be considered only after consultation with the patient and orthopedic surgeon. For patients with serious health conditions, such as immunocompromising diseases, it may be appropriate for the orthopedic surgeon to recommend an antibiotic regimen when medically indicated, as footnoted in the new chair-side guide."

The ADA encourages dental professionals to review the full 2015 guideline and take this recommendation into account, consult with the patient's orthopedic surgeon as needed, and consider the patient's specific needs and preferences when planning treatment. According to the ADA Chairside Guide, **in cases where antibiotics are deemed necessary, it is most appropriate that the orthopedic surgeon recommend the appropriate antibiotic regimen and, when reasonable, write the prescription**.

References:
http://www.ada.org/en/member-center/oral-health-topics/antibiotic-prophylaxis
http://www.aaos.org/

DISEASE CLASSIFICATION - CLASSIFICATIONS OF DISEASE
DENTAL HYGIENE PERIODONTAL DIAGNOSIS

Diagnosis - cause or nature of the problem or situation, diagnosis is a critical thinking process by which clinical data about the patient are analyzed and assigned a diagnostic label. Diagnosis is not a legal function of the dental hygienist, it is an appropriate term to describe the expression of the dental hygienist's judgment and decision-making ability.
The dental hygiene diagnosis may only be made after all assessments are complete.

Dental Hygiene Periodontal Classification

When making a periodontal diagnosis, apply a generalized and localized statement. The following table is a good summary of diagnostic criteria for periodontal conditions:

Localized ≤30% sites involved
Generalized ≥30% sites involved

Case Type	Definition	Clinical Attachment Loss (CAL)	Comments
Case Type 0	Clinically Healthy	No CAL	Maintain
Case Type I	Gingivitis	No CAL, ≤ 4mm Pseudo pockets possible, no bone loss	Important to reverse and maintain
Case Type II	Early Periodontitis	Slight CAL = 1-2 mm, BOP, ≤ 5 mm, no furcation's, redness, suppuration	Radiographic: <10% attachment loss (slight/crestal), early attachment loss
Case Type III	Moderate Periodontitis	Moderate CAL = 3-4 mm, ≤ 6mm, early furcation's, redness, suppuration	Radiographic: 30% attachment loss (crown/root ratio) horizontal and/or vertical bone loss. Possible furcation, mobility.
Case Type IV	Advanced Periodontitis	Severe CAL = 5 ≥ mm, BOP, ≥ 7mm, advanced furcation's, redness, suppuration	Radiographic: >30% attachment loss (crown/root ratio), major horizontal and/or vertical bone loss. Probable furcation, mobility.
Case Type V	Refractory Periodontitis	BOP, ≥ 7mm, advanced furcation's, redness, suppuration, patient < 30 years old.	Radiographic: >30% bone loss. Aggressive periodontitis. Recurrent disease. Fails to respond to treatment.

From: RDH magazine article "New Age of Periodontal Therapy" (Nov 2014) Source: Armitage G, 2014 Commentary: Evolution and Application of Classification Systems for Periodontal Diseases - A Retrospective Commentary

Mucogingival Deformity - MGD

Developmental or acquired deformities and conditions
Localized tooth-related factors that modify or predispose inflammatory induced gingivitis or periodontitis, conditions around teeth or occlusal trauma.

Dental Hygiene Periodontal Classifications:

Health-No inflammation, No CAL

Gingivitis- Inflammation, No CAL

Early Periodontitis- 1-2mm CAL **bone loss < 25%**

Moderate Periodontitis- 3-4mm CAL **bone loss 25-50%**

Severe Periodontitis- ≥5mm CAL **bone loss >50%**

Localized or generalized or combination -

Localized denotes a disease classification confined to one quadrant or area (the exception area), Localized ≤30% sites involved **- ALWAYS listed by the teeth numbers**

Generalized denotes a disease classification in more than one quadrant or area
Generalized ≥30% sites involved

Combination completely describes generalized areas first then completely describes localized area(s) by tooth number(s)

"Not Controlled" denotes a disease classification that includes signs of inflammation as evidenced by the tissue description and BOP or signs of continued recession due to Mucogingival deformity. This classification is not used when describing gingivitis.

"Controlled" denotes a disease classification that does not include signs of inflammation. Many diseases are arrested/controlled due to improved oral hygiene or removal of other etiologic agents. Some diseases are never associated with inflammation and continue to cause CAL, such as in the case of mucogingival deformity, a determination that the disease has stopped is necessary before categorizing it as arrested.

Extent

Papillary - involving the papillary gingiva

Marginal - involving the papillary gingiva and extending into the marginal gingiva

Diffuse - involving the papillary, marginal gingiva and extending into the attached gingiva

Periodontal Disease Risk Factors
Risk factors are listed on the Care Plan. Risk factors must be cross-referenced with assessment documents and Care Plan.

GINGIVAL TISSUE DESCRIPTION

DESCRIPTION	NORMAL/HEALTHY	DISEASE
Color	Uniformly pale coral pink Or normal pigmentation	Acute: erythematous Chronic: dark red/blue Fibrotic: pink with texture changes Amalgam Tattoo
Size	Flat, not enlarged	Edema Enlarged, increased in volume Gingival hyperplasia
Shape	Margin: knife-edge, flat follows a curved line around the tooth Papilla: pointed/pyramidal fills the IP space Diastema: flat/saddle-shaped	Margins: rounded, rolled, bulbous Papilla: bulbous, blunted, cratered
Consistency	Firm, resilient Attached gingiva firmly bound down	Soft, spongy, dents readily when pressed with the probe or hard, fibrotic
Surface Texture	Free gingiva: smooth Attached gingiva: stippled	Acute Disease: loss of stippling, smooth shiny Chronic Disease: hard, fibrotic with stippling
Gingival Position	1-2 mm above CEJ	Enlarged gingiva: margin is higher on the tooth Pseudo Pocket(s) Recession: margin is apical
Mucogingival Junction	Clear demarcation between attached gingiva and alveolar mucosa	No attached or minimal attached gingiva (MAG)
Bleeding and Exudate	none	Bleeding on probing (BOP) Exudate: released with pressure
Furcation	Furcation not discernible	Classification of furcation: I - III
Mobility	Tooth has normal mobility	Classification of mobility: 1,2,3

Extent: in addition to noting whether the gingival description is localized or generalized, the extent of involvement also is included.
Papillary - involving the papillary gingiva
Marginal - involving the papillary gingiva and extending into the marginal gingiva
Diffuse - involving the papillary, marginal gingiva and extending into the attached gingiva.

SRJC Patient Category Form will be used to Classify the Patients

Calculus Definitions

Supragingival Calculus	coronal calculus that may extend slightly (1-2mm) below the free gingival margin
Subgingival Calculus	subgingival calculus may also be supragingival in nature but also extends well below the free gingival margin
Surfaces Covered	each tooth has four (4) surfaces and may have a different category of calculus on each surface
Granular	Similar to an emery board in texture, small particles of irregular shape and size that may make the tooth surface rough in nature and may require smoothing strokes
Spicule or Click	Small sharp body of hard material. Less than 1 mm in thickness, explorer detectable clicks are readily discernable with the explorer
Ledge	1-2 mm in thickness, a stable, strong, sharp projection of hard deposit that are readily discernable with the explorer • Explorer "jumps" "binds" • Proximal surface; can be felt from both facial and/or lingual • Facial/lingual surface; exceeds more than ½ surface
Moderate vs. Heavy Ledge	moderate ledges are not as broad or thick as heavy ledges. Moderate ledges do not "bind" the explorer as much as heavy ledges. Moderate ledges do not cover as much of the proximal/lingual/facial surfaces
Ring	A continuous ledge along two or more surfaces
Veneer	A flat sheet of calculus may be granular

Western Regional Board Definition:

Distinct and easily detected with the explorer

Explorer easily catches on the upward or downward stroke

Definitive bulk, or nodular formation (may or may not catch)

Notations for EOIO Form

A B C D T

Directions; when describing a lesion state, the following: A B C D and T and give duration and symptoms

A= Anatomic Location – used to describe location in relationship to teeth or tooth bearing location

B = Border – symmetrical, asymmetrical, regular, irregular, raised, flat

C = Color, Configuration, Consistency – red, white, red and white, brown, yellow, black
Single or multiple
Soft, firm, mobile

D = Diameter – measured in millimeters

T = Type – Macule – flat, < 1cm
Patch – flat, > 1cm
Papule – raised, < 1cm
Plaque – raised, > 1cm
Nodule – marble-like, > 1cm
Vesicle – blister like with clear fluid, < 1cm
Bulla – blister like with clear fluid, > 1cm
Pustule – filled with purulent fluid
Erosion – loss of top layer of skin
Ulcer – craterlike loss of 2 layers of skin
Fissure – linear crack

Notations for PSE Form

Chart Side of Form

1. Mobility Box – Class I - III
2. MGJ Box - Place number from measurement at appropriate tooth in this box, when charting is complete place dot over appropriate tooth and then connect the lines. (each horizontal line is 1mm)

Minimal Attached Gingiva (MAG)

- Take mucogingival junction measurement and subtract probing depth
- MAG - minimal attached gingiva or inadequately attached gingiva = a total of 1mm or less

4. CAL Box – determine after probing and recession charting
5. Recession – place number on crown of tooth, after charting is complete place dot on root in appropriate location and then make a “u” shape to duplicate the area of recession. (each horizontal line is 1mm)
6. Furcation Involvement

To indicate the extent and location of furcation involvements use the following classifications.

Class I - less than 1 mm
Class II - more than 1 mm
Class III - through and through
Class IV - through and through, but clinically visible due to recession or surgery

Note: buccal furcation's are charted from the buccal surface, mesial and distal furcation's are charted from the palatal surface.

Tissue Description Side

Generalized – this is an area of the mouth, several teeth or a quadrant/arch, i.e. bleeding generalized in mandibular posterior sextants >30%

Localized – this is 1-3 teeth in an area or the mouth, i.e. recession localized #4 and 12 or bleeding localized #2-5 <30%

Papillary – involving the papillary gingiva

Marginal – involving the papillary gingiva and extending into the marginal gingiva

Diffuse – involving the papillary, marginal gingiva and extending into the attached gingival (areas of recession)

SRJC Probing Guidelines

1. All adult patients seen in the SRJC dental hygiene clinic will receive continued PSE evaluation of all previously treated areas at the beginning of each appointment during active care. Probing as determined appropriate depending on healing of previously treated area.
2. All adult patients seen in the SRJC dental hygiene clinic will receive a full month periodontal charting at every recall after active care
3. All adolescent patients over 14 years old or with full dentition will at receive at a minimum, a full mouth periodontal charting once per year.
4. All children under 14 will receive at a minimum, probing of the 1st molars and anterior central incisors once per year.
5. Patients with orthodontic appliances will receive at a minimum probing of the 1st molars and anterior central incisors once per year.

INSTRUCTIONS FOLLOWING DENTAL HYGIENE THERAPY

General Information

You have just experienced a very thorough cleaning of your teeth. The following instructions are intended to assist you in avoidance of discomfort, reduction in bleeding and healing of your gingival tissue to begin optimal gingival health.

To avoid unnecessary discomfort:

- Avoid hard, crunchy, hot or spicy foods
- Rinse your mouth every 2 hours gently with a salt-water solution of; 1/2 teaspoon of salt to 1/2 cup of warm water.
- Avoid alcohol and tobacco products
- Take medications you would normally use for minor discomfort such as Advil or Tylenol.

To reduce bleeding:

- No vigorous exercise
- No vigorous brushing or flossing
- Avoid hard, crunchy, hot or spicy foods
- Avoid alcohol and tobacco products

To assist in rapid healing of your gum (gingival) tissues:

- Use a soft tooth brush
- Use little or no toothpaste
- Floss gently
- Perform thorough and gentle plaque control daily

SRJC Protocol for the use of Arestin

1. Patient presents with perio pockets of 5mm or greater with bleeding.
2. Student has educated the patient concerning periodontal disease.
3. Student explains the product and need for therapy to the patient.
4. Medical history reviewed with no known sensitivity to minocycline or tetracycline's.
5. Tetracycline drugs should not be used before age 8, or in pregnant or nursing women.
6. The Periodontal record must be complete including: full mouth probing, recorded clinical attachment levels/recession, furcation's, mobility, and occlusion.
7. An FMX is required.
8. Therapy can be performed on 1-2 sites immediately after NSPT if there are only 1-2 sites of pockets over 5mm.
9. If there are more than 1-2 sites the therapy will be completed on the full-mouth at the 1-month Perio Re-Eval appointment.
10. The pocket sites must be free of detectable biofilm and calculus prior to placement of Arestin.
11. Follow SRJC procedure for set-up, delivery, and disposal of tips and cartridges.
12. Contraindications include: use in acutely abscessed periodontal pockets, may result in overgrowth of no susceptible microorganisms, including fungi.
13. Not to be used in patients that have a history of predisposition to oral candidiasis or on an implant.
14. Homecare instructions to include advising patient to avoid exposure to direct sunlight or ultraviolet light. Tetracycline has been observed to manifest photosensitivity (exaggerated sunburn).
15. Procedure to include a review of personalized homecare instructions.
16. Post treatment instructions to include no brushing I the site for 12 hours and no interdental cleaning in the areas for 10 days. Patient is told to abstain from eating hard, crunchy, or sticky foods.
17. Procedure recorded on the patient's chart: site-tooth #and surface, amount and product (Arestin). Example: Arestin delivered to#2MD pocket 5mm, 1mg minocycline.

SRJC Protocol for the use of MI II Paste

When to use: Patients who have sensitivity to scaling (hard tissue only)
To be used before procedure begins

Application: rub a pea-sized amount on the teeth with your finger
MI Paste requires a thick application and needs to sit on the teeth for at least 3 minutes. Do not rinse after applying. MI Paste should not be brushed on like tooth paste with a toothbrush, since it requires a thick layer.

Precautions: MI Paste contains casein and should not be used if patients have a casein allergy – it is safe for lactose-intolerant patients

SRJC Protocol for the use of Fluoride Varnish

When to use: Patients who have sensitivity to scaling (hard tissue only)
To be used at the end of the procedure, before patient is dismissed
Children less than 6 years old with moderate to high risk for caries
Children 6-18 years old with moderate to high risk for caries
Adults over 18 with moderate to high risk for caries

Application: **Occlusal Surfaces**

1. Isolate one quadrant of the patient's mouth with cotton rolls.
2. Remove excess saliva by drying with air, 2x2 gauze, and/or saliva ejector.
3. Paint the varnish on all surfaces of the teeth in the isolated quadrant.
4. Repeat steps 3-5 in the remaining 3 quadrants.
5. Gently apply water to the patient's teeth to set the fluoride varnish.

Application: **Areas of Recession**

1. Isolate the quadrant of the patient's mouth with cotton rolls.
2. Remove excess saliva by drying with air, 2x2 gauze, and/or saliva ejector.
3. Paint the varnish on all surfaces of the teeth in the isolated quadrant.

Precautions: Ulcerative Gingivitis, Stomatitis

Home Care Instructions: Give instructions included with materials

Treatment Evaluation Summary

Submit a treatment summary on the following patients – this document must be typed and submitted within 1 week to the faculty assigned to you at the completion of your patient.

Please begin with a paragraph briefly describing the patient, include all the following:
Patient's name **(first name and last initial only**), age, sex, calculus classification, DH diagnosis, how long since their last NSPT and brief description of their dental hygiene and oral hygiene needs.

1. Was this patient identified as **medically complex**? Please give the specific identifier(s). How did this affect your treatment or prognosis?
2. 1. Was this patient identified as **culturally diverse**? Please give the specific identifier(s). How did this affect your treatment or prognosis?
3. Give a brief summary of how the treatment you provided this patient was of benefit to the patient.
4. Give a brief summary of what procedures/education were most responsible for this change
5. Upon evaluation of this patient's treatment, I would do the following differently

First Year Students

Spring Semester – 1st year
All patients

Summer Semester 1st year
All patients

Second Year Students

Fall Semester 2nd year assigned evaluations
1-Medical/SN,
1-Cultural Diversity,
1-Adolescent, Child
1- moderate perio
1- advanced perio

Spring Semester 2nd year assigned evaluations
1-Medical/SN,
1-Cultural Diversity
1-Adolescent, Child
1- moderate perio
1-advanced perio

Ongoing Periodontal Evaluation

Evaluation of periodontal conditions will be done on all appointments after NSPT has begun.

- Begin by filling out the Treatment Evaluation on the Treatment Plan
  - Indicate; I for improvement – S for same – W for worse
- On the PSE **and when appropriate**, probe the previously treated quadrant(s) before beginning the next quadrant(s)
  - Chart all probe readings over 5mm or if there is a change of greater than 2mm
  - Chart all BOP
  - New tissue description if tissue conditions have changed
- Ask the faculty to initial the appropriate area of the Treatment Evaluation on the Treatment Plan

4-6-week Periodontal Re-evaluation Appointment

The purpose of the re-evaluation appointment is to evaluate the therapeutic end point of NSPT.

PROTOCOL FOR PATIENT'S RE-EVALUATION APPOINTMENT

Four to Six Week Re-evaluation Appointment

1. There is no charge for this patient. Indicate on the front desk patient list that the patient is a re-evaluation patient.
2. Student will receive a new patient credit for the re-evaluation appointment. Patient will be reclassified for calculus and disease classification
3. A new treatment plan must be filled out and signed
4. A new treatment completion letter will be sent to the patient's dentist updating them on the recommended re-care status.

The student will complete the following procedures at the re-evaluation appointment:

1. Medical History Update
2. Cursory EOIO
3. New Full mouth Tissue Evaluation (No Probing until 3months)
4. Update dental charting
5. Update OHI, make changes or add new auxiliary aides for improvement
6. **Using a new Treatment Plan Form, discuss with Dental Hygiene Faculty the results of the treatment comparing Pre-Treatment and Post-Treatment data**
    - **Is there any correlation to the patient's tissue from the Medical History?**
    - **Oral Hygiene Instruction: What work and didn't work and why? Include patient beliefs, attitude, education-instruction**
    - **What would you add or change?**
7. Use a yellow periodontal reevaluation form to gather results of your treatment – use this form to write your treatment summary of the results in the patient chart
8. Turn this form in for competency credit
9. Re-explore to locate the presence of residual and/or newly formed calculus
10. Complete a new treatment plan and have patient sign
11. Remove any calculus identified
12. Perform plaque removal procedures as necessary which in many cases will involve toothbrush plaque removal and/or polishing
13. Place Arestin, fluoride or root desensitizing agent when and where appropriate
14. Determine SPT (Supportive Periodontal Therapy) plan (3, 4, recall) or if referral to a Periodontist is necessary. Note if this is refused by the patient
15. Document SPT plan and all pertinent information in progress notes. The narrative should address the response to initial therapy by reviewing what treatment has been accomplished and comparing pretreatment and post-initial prep findings. There must also be discussion of unresolved periodontal problems with appropriate revision of the treatment plan to include periodontal referral.

Example of a written narrative for periodontal re-evaluation

Re-evaluation following initial therapy. Periodontal treatment has consisted of four quadrants of perio debridement including root planning and oral hygiene instruction. The response to initial therapy has been generally favorable with reduction of probing depths, gingival inflammation and tooth mobility. Residual deep pocketing is present between #2-3 and #18-19 and will not improve with additional instrumentation. Recommend referral to a periodontist.

OR

Re-evaluation following initial therapy. Periodontal treatment has consisted of four quadrants of perio debridement including root planning and oral hygiene instruction. The response to initial therapy has been generally favorable with reduction of probing depths, gingival inflammation and tooth mobility. Residual calculus and new biofilm removed today and OHI instructions reinforced. Patient will return on 3-month recall providing supportive periodontal therapy and re-assess periodontal status.

GUIDELINES FOR PRESENTING ASSESSMENT INFORMATION TO YOUR INSTRUCTOR

Introduce Your Instructor

Introduce your patient to your instructor - "Judy this is my Professor _____, Professor_____ this is my patient Judy" Always introduce the patient first, after you have introduced your instructor it is not necessary to introduce them again during that appointment. You will need to do this for each appointment.

Reporting Assessment Information

You will be expected to give a brief report of your assessment findings before the faculty begins their exam. To avoid breaches in confidentiality, this report must be given at chairside with the patient present. You will be asked to give complete findings when your faculty is seated and asks for your assessment findings.
When reporting your findings, please use your patient's name or the phrase "my patient".

Computer forms – EOIE, Dental Charting and PSE will be shown on the computer for your assessment report with your assigned faculty. Any corrections to the information will be noted on the back of the Patient Completion Sheet (purple sheet) and will NOT be corrected during the faculty assessment report. These corrections must be made on the computer sometime before the end of the clinic session and signed off by the faculty who conducted the assessment.

Health History

Personal/social History
- Judy is returning to the clinic; her last visit was _____
- This is Judy's first visit to the clinic, she was referred by_____

Chief Complaint
- Reason for visit
- Areas of concern to the patient

Medical History
- General health - the patient is in good health
  - Or date of hospitalization, surgery, etc.
- Need for premedication
- Need for precautions - asthma, diabetes, etc.
- Allergies - penicillin, latex, etc.
- Medications and conditions - as related to dental hygiene procedures

Treatment Concerns

Dental History
- Past history of ortho, clenching/grinding, removable appliances
- Past history of perio surgery
- Last NSPT or x-rays
- Sensitivity - to what stimuli, where

Treatment Concerns

Health History Update

Review information and give as above

Treatment Concerns

EOIO

Initial Visit: Any deviations from normal
Occlusion
Returning Visits: Present information on any changes or continued pathologic conditions
Treatment Concerns

PSE

Initial Visit: Pocket readings 5mm or over, bleeding, recession, mobility, furcation's
Tissue description - given when the faculty requests, after checking the PSE.
Returning Visits: **Periodontal Reevaluation**

- Reevaluation of periodontal conditions will be done on all appointments after NSPT has begun.
    - On the PSE **and when appropriate**, probe the previously treated quadrant(s) before beginning the next quadrant(s)
        - Chart all probe readings over 5mm or if there is a change of greater than 2mm
        - Chart all BOP
        - New tissue description if tissue conditions have changed
        - Provide a new tissue description if tissue conditions have changed

Treatment Concerns

Dental Charting

Any area that presents a risk factor to the periodontal health of the patient
Any concerns for caries risk
Treatment Concerns

OHI

Initial Visit: Present general information regarding deposits and plan for OH
Returning Visits: Present information regarding patient success and what needs further attention. Refer to the Periodontal Charting after you have reassessed the areas previously treated
Treatment Concerns

Treatment Plan and Periodontal Risk Assessment

Give a description of risk factors, how you will be planning treatment and goals

NSPT

What quad, area,
Recheck or first check

ORDER OF DOCUMENTS IN CHART

LEFT SIDE	RIGHT SIDE
Patient Completion Letter (upon completion)	Patient Completion (purple sheet)
Health History Update	Patient Category Form
Health History	Record of Treatment
Anesthesia Form	EOIO
Medical Consultation (if needed)	EOIO update
X-Ray Authorization (if needed)	PSE – Electronic Form
Patient Consent Form	Dental Charting – Electronic Form
Patient Confidentiality Form	OHI
X-ray envelope (if needed)	Treatment Plan, Periodontal/Risk

Student must adhere to this document; charts will be evaluated during chart audit

All documents must be appropriately labeled with the patient's name and full date
All documents must be arranged so that the document can be easily read
The last entry in the Record of Treatment is facing the front of the chart
All documents must be properly hole punched

AFTER HOURS EMERGENCIES

The following protocol is to be used if a patient contacts you outside clinic hours regarding a concern or emergency.

1. Talk to the patient. If they leave a phone message, return their call as soon as possible.
2. Begin the documentation process; **(write the information down)**
   1. When did they contact you? When did you return their call?
   2. Ask the following questions:
      Where does it hurt? When did it start hurting?
      Describe the pain: sharp, dull, aching, throbbing
      Does anything make the pain worse; does anything make the pain less?
      Does the pain make it difficult to: eat, sleep, and/or work?
      Do you have any symptoms in addition to pain: fever, rash?
      Have you taken any medications for the pain? What did you take and when did you take it?
   3. What did they say?
   4. What did you say or recommend
3. Assure the patient that you will be contacting a faculty member and returning their call within 45 minutes to an hour.
4. Contact the faculty as follows: Leave a message with the time you called and a phone number to reach you.

Lead instructor for **your** class:	Professor Fleckner for DH I - (707) 495-7609
	Professor Kirk for DH II –(707) 540-5863
Program Director	Professor Hatrick – (415) 892-3289

5. 30 minutes after you have contacted the appropriate instructor or the last instructor on the call list, contact the patient to give them information on your progress

Remember: if the patient is in significant pain, they may choose to go to the emergency room at their expense. Most of the discomfort that the patient will experience following NSPT will be relieved with salt water rinses or over-the-counter pain medication. Discomfort related to other dental problems needs attention from <u>their</u> DDS, our clinical dentists will only recommend that they see their dentist or refer them to REDS.

Patient's Bill of Rights

As a patient in the Santa Rosa Junior College Dental Clinics, you can expect:

Professional Care

Respectful Care

Treatment Without Discrimination

Treatment in a Safe Environment

Confidentiality of All Communications

Quality Treatment

To Have Your Concerns Heard

To Participate in All Decisions About Your Treatment

To Understand You Treatment Needs

To Have Access to Your Dental Records

Santa Rosa Junior College

DENTAL HYGIENE TEACHING CLINIC CONDITIONS OF TREATMENT

GENERAL INFORMATION: The Dental Hygiene Clinic at SRJC is primarily a teaching clinic; therefore, patients receiving dental hygiene care will be participating in the teaching program. Treatment will be performed by dental hygiene students and will be supervised by members of the SRJC faculty. Treatment under supervision requires more time than if done in a private dental office and may require multiple appointments for approximately three hours each. You should continue to visit your general dentist on a regular basis for your routine examinations and dental treatment. Following completion of dental hygiene care, patients will not be re-appointed to the SRJC Dental Hygiene Clinic unless documentation of necessary examination by a licensed dentist within a year of last treatment is provided.

APPLICATION TO BECOME A PATIENT: Only patients whose care is suitable for teaching purposes are eligible for care in the SRJC Dental Hygiene Clinic. All patients require an initial evaluation to determine if they are eligible. SRJC reserves the right to deny acceptance into treatment in the SRJC Dental Hygiene Clinic if it is determined that a patient would not be an appropriate educational opportunity. It is your responsibility to keep your contact information current so that students may contact you.

CONSENT TO DENTAL PROCEDURES: Before receiving treatment your student will discuss the recommended procedures with you. You may ask any questions you may have before you decide whether or not to give your consent for the procedures recommended. All dental procedures may involve risks or unsuccessful results and complications, and no guarantee is made as to result or cure. You have the right to be informed of any such risks as well as the nature of the procedure, the expected benefit, and the availability of alternative methods of treatment. You have the right to consent to or refuse any proposed procedure at any time prior to its performance. Conversely, Santa Rosa Junior College Dental Hygiene Clinic reserves the right not to perform specific treatment requested by you if it violates the standard of care in dentistry and/or dental hygiene care or does not contribute to the student's educational opportunity.

PHOTOGRAPHS: Patient photographs may be taken to document a condition, examination findings and/or for teaching purposes.

FINANCIAL RESPONSIBILITIES: Patients who receive treatment in the SRJC Dental Clinic will be charged for treatment according to the fee schedule in the clinic. Fees are collected prior to beginning treatment and patients must be prepared to pay for services before procedures begin. SRJC will not file any claims for dental insurance or accept credit cards.

DENTAL RECORDS: The records, x-rays, photographs, and other materials relating to your treatment in the SRJC Dental Hygiene Clinic are the property of the SRJC Dental Programs. You have the right to inspect such materials or request copies in writing. We will comply within 15 business days. SRJC may charge a reasonable fee for this service. You may also request to have your dental x-rays sent to another health care provider. In addition, your medical/dental records may be used for instructional purposes and if they are, your identity will not be disclosed to individuals not involved in your care and treatment.

KEEPING YOUR APPOINTMENTS: **Multiple appointments will be necessary to complete your care**. Patients are required to be on time for all appointments. If you find that you are unable to

keep an appointment, you must notify the student or clinic office at least 24 hours in advance. **Cancellations without 24-hour notice, missed appointments, or repeated unsuccessful attempts to arrange for an appointment may be cause to discontinue a patient from further treatment in the SRJC Dental Hygiene Clinic.**

PRODUCT DISCLAIMER: Dispensing of products does not constitute an endorsement by the College.

Your signature on this form certifies that you have read and understand the information provided on the form, that you have received a copy, and that you accept dental hygiene care under the described terms and conditions.

DATE: _____ SIGNATURE: _____

If signed by other than the patient, indicate relationship: parent/guardian/conservator

CLINICAL GRADING

At the end of each clinical session, students will receive information on any clinic point deduction from their assigned clinical faculty, however; any faculty may contribute information to the student's clinical point deduction.

The student is evaluated on clinical process and patient care including, but not limited to the following: rotation assignments, extramural experiences, appointment preparation, infection control, assessments, patient/operator positioning, provision of NSPT, local anesthesia, instrumentation, adjunctive services, time management, appointment planning, communication, safety and professional behavior.

As the student progresses through each semester of the Dental Hygiene Program, the levels of competence and efficiency demonstrated in the above areas are expected to increase. This will be demonstrated in increased competence in the performance of skills and the care of more difficult patient classifications.

The performance level expected of the student at that particular time in their clinical experience determine the clinical point deduction. **Clinical errors** are deducted in categories of **expected competencies** and **performance errors**. Expected competency errors are tracked and deducted on the student's daily clinical assessment journal. Performance errors are tracked and deducted on the student's daily clinical tracking sheet (green card) **and** patient completion form (purple sheet). Performance points are not deducted from the grade unless the student achieves less than a total of 75% in patient performance. The description of each type of error is included below. Points deducted, and those areas included in each category will vary as the level of the student's expected performance increases. (novice, beginner, competent)

A remedial plan will be required for students who are unable to exhibit the expected performance level in any semester.

EXPECTED COMPETENCIES

Errors in the area of *Expected Competence* are critical errors that demonstrate competence well below the standards expected of the student at this point in their clinical experience. These include errors that compromise the safety of the patient, operator, faculty or other individuals.
If any faculty identifies any of these areas as deficient, you may be asked to discontinue patient treatment. A conference will be arranged to discuss a plan to correct the deficiency. If you are asked to discontinue treatment during a clinic session, no arrangements will be made for additional clinic time.

Point deduction increases as errors or errors in like categories are repeated. When necessary, point deductions may be determined by the assigned clinical faculty in consultation with the lead faculty. All point deductions in Expected Competencies are noted on the Clinical Assessment Document, **not** on the Patient Completion Form.

The following are identified as expected competencies:

Infection Control

Students are expected to show competence in: Infection control protocols including prevention of cross contamination, patient and operator safety.

Errors include:

- Failure to follow clinical dress codes whenever in clinical or sterilization areas
- Improper use of or lack of use of over gloves
- Wearing contaminated gloves outside the unit
- Using the wrong door when exiting with contaminated instruments
- Using contaminated instruments or equipment
- Cross contamination of clean instruments, equipment, disposables or forms
- Cross contamination of masks, glasses, over gloves
- Failure to follow SRJC department SOP's

Health History

Students are expected to show competence in: Health history protocols including prevention of emergencies and patient safety.

Errors include:

- Failure to record and review or chart an accurate health history or update
- Failure to recognize conditions requiring premedication, physician's consult or clearance
- Failure to have an instructor evaluation of the health history or update before beginning any procedures
- Failure to bring to the instructor’s attention any area of the health history or vital signs that would alter or affect treatment

NSPT and Related Treatments

Students are expected to show competence in: NSPT and Related Treatments protocols including prevention of emergencies and patient safety.

Errors include:

- Patient's not wearing safety glasses
- Unsafe practice including; working with unsafe instruments; excessively thin or lacking sharpness, examining or passing instruments over the patient's face
- Tissue trauma/laceration
- Failure to notify instructor of broken instruments, needles
- Failure to notify instructor of broken teeth, restorations or the loss of a restoration which occurred during treatment

Local Anesthesia

Students are expected to show competence in: Local Anesthesia protocols including prevention of emergencies and patient safety. A 10-point deduction will <u>always</u> be taken from the student’s grade under expected competency regardless of their status as an independent operator in local anesthesia.

Errors include:

- Failure to request the appropriate anesthesia
- Failure to anesthetize the appropriate area
- Failure to aspirate or perform the correct number of aspirations for the injection site

- Leaving a patient unattended before adequately determining the patient's reaction to the injection of local anesthesia
- Unsafe handling of the syringe/needle, including recapping
- Not disposing of sharps in sharps container

If any of the competencies in the above list are found in error after the students has been determined competent to practice anesthesia independently, the independent privileges will be revoked, and the student will need to perform all anesthesia with direct faculty supervision.

Professionalism

Students are expected to show competence in: Professionalism protocols including interactions with patients, faculty and fellow students.
Errors include:

- Failure to protect the patient's right to privacy
- Failure to act with discretion and respect in interactions with faculty, patients and fellow classmates
- Inappropriate communication with patients
- Removal of patient records from the clinical facility (exceptions are made with the permission of the faculty for classroom assignments)
- Failure to notify assigned faculty of activities every 30 minutes if you are not seeing an assigned patient.

PERFORMANCE ERRORS

Performance errors are errors in the performance of patient services or clinical assignments at the level expected of the student at this time in their clinical experience. Performance errors are noted on the patient completion form **and** on the daily clinical tracking sheet (green card). It is expected that students will correct performance errors. Repeated performance errors will be addressed through a remediation plan.

The following would be considered performance errors for all clinical courses; the amount of point deduction will be determined by the course:

Extra/Intraoral Examination

Examples include errors in:

- Recognizing and completely describing obvious atypical findings including occlusion

Dental Examination

Examples include errors in:

- Recognizing, describing and recording: missing teeth, dental restorations, changes in dentition (abrasion, erosion, abfraction)
- Recording areas of unsound dentition in comments area

Periodontal Examination

Examples include errors in

- Recognizing, describing and recording periodontal findings including: probe depths, BOP, recession, MGJ, mobility, furcation's and CAL
- Recording an accurate tissue description
- Recording an accurate Dental Hygiene Diagnosis

Oral Hygiene Index

Examples include errors in

- Recognizing and recording OHI findings
- Updating treatment evaluation in each subsequent appointment
- Evaluation of previous OH instructions

Treatment Plan/ Risk Assessment

Examples include errors in

- Determining treatment needs in appropriate appointment time
- Identifying periodontal risks
- Obtaining patient signature
- Obtaining faculty signature

NSPT and Related Treatments

Examples include errors in

- Supragingival calculus removal
- Subgingival calculus removal
- Biofilm and Stain removal

Treatment Documentation

Treatment documentation protocols involving accurate and complete treatment information and signatures are expected protocols.

- Failure to enter accurate or complete treatment information

Rotations

Failure to follow rotation protocols; Examples include

- Failure to arrive on time to complete pre-clinic duties
- Failure to check or complete daily duties

All point deductions in Expected Competencies are noted on the Clinical Assessment Document not on the Patient Completion Sheet

Point Deduction for Clinical Errors

DH 71B **Expected Competence** – point deduction determined by the clinical faculty in consultation with the lead faculty. Point deduction increases as errors or errors in like categories are repeated - minimum of 5-point error.
Performance Errors - There are no point deductions for performance errors in DH 71B

DH 71C **Expected Competence** – point deduction determined by the clinical faculty in consultation with the lead faculty. Point deduction increases as errors or errors in like categories are repeated – minimum of 10-point error
Performance Errors - There is a **1**-point deduction for each performance error

DH 71D **Expected Competence** – point deduction determined by the clinical faculty in consultation with the lead faculty. Point deduction increases as errors or errors in like categories are repeated– minimum of 10-point error
Performance Errors - There is a **2**-point deduction for each performance error

DH 71E **Expected Competence** – point deduction determined by the clinical faculty in consultation with the lead faculty. Point deduction increases as errors or errors in like categories are repeated - minimum of 10-point error
Performance Errors - There is a **3**-point deduction for each performance error

Absence from clinic/rotation or no patient for clinic session

If you are absent during a clinic session, there will be no opportunity to make up the lost clinical time. Having an empty unit for the clinical session is a loss of valuable clinic time and may jeopardize your ability to successfully complete patient care and clinical requirements. *

If you do not have a patient for a clinical session, you must complete the Missing Clinical Assignment form and obtain your faculty's signature at the end of the session. You will be required to actively recruit a patient for the session, and/or perform other assigned tasks during this session. DH71A-A 10-point deduction will be made from the clinical grade for each empty unit documented.

* During DH 71B and 71C, you must have experience in each rotation assignment. Therefore, absence during a rotation in these clinics may result in a loss of additional clinic time to obtain the missed rotation experience.

Missing Clinical Assignment

DIRECTIONS: Top portion to be completed by student. Submit to your faculty for signature at the end of the clinical session.

Student Name/DH #: _____Session Date: _____ AM ☐ PM☐

Reason for no patient in chair:

_____

Recruitment efforts: Patient located? ☐Yes ☐No

Time Out: Time In: Where Recruited:

Time Out: Time In: Where Recruited:

How was the clinic time used?

_____

I understand that missing clinical assignment time can have a direct effect on my ability to successfully complete my patient care and minimum requirements for the semester.

Student Signature: _____

Faculty Use Only

Assignment given: _____

_____

☐ Assignment completed ☐ Point deduction noted on clinical assessment form

Faculty Signature: _____Date: _____

*give completed form to lead faculty at end of session

Patient Requirements- Per Semester-

See Specific Course Syllabus for Requirements

	Patient Category	Clinical Sessions Pt. Contact	Health	Gingivitis	Early Perio	Mod Perio	Adv Perio	MC/SN	CD	Child	Teen	Adult	Senior
	1 2 3 4									6-12	13-17	18-54	55+
DH71B													
DH71C													
DH71D													
DH71E													

MC/SN: Medically Compromised/Special Needs- Those patients whose medical, physical, psychological, or social situation make it necessary to modify normal dental routines in order to provide dental treatment for that individual. These individuals include, but are not limited to people with developmental disabilities, complex medical problems, and significant physical limitations.

CD: Cultural Diversity- Competence in cultural diversity is developed through interactions with a patient who is different from you background, belief system (including health care belief), culture norms, tradition or language.

*Within the minimum total patient requirements, the required calculus levels must be met.

Program Competencies

Competencies/outcomes for Dental Hygiene graduates describe the knowledge, skills and attitudes our graduates must attain for entry into dental hygiene practice in public and private settings.

The value of these competencies/outcomes is related to two areas. First, the competencies define the core content of the curriculum. By stating publicly what graduates must know and be able to do after completing our program, we establish a basis for the content of all courses. The competencies/outcomes provide guidance for identifying relevant content when making decisions related to our educational program.

Second, these competencies/outcomes are useful for outcomes assessment. The quality of any curriculum must be judged by its results. The program sets forth competencies/outcomes that a student must demonstrate to qualify for graduation and entry into the profession. This list provides a basis for establishing outcome measures to evaluate the degree to which a student has acquired and can demonstrate the competencies/outcomes needed to care for individuals and promote the health of the public.

Competencies/outcomes for Dental Hygiene Graduates should be viewed as dynamic standards that are responsive to any clear need for change. The competencies/outcomes are intended to serve as a framework for the dental hygiene curriculum and require regular review and revision.

Competency – Program Outcomes as an Educational Concept

The term competent is defined as the level of special skill, knowledge and attitudes derived from training and experience. Competencies/outcomes for dental hygiene graduates can be more specifically described by several basic characteristics.

Program Student Learning Outcomes

Upon successful completion of this major, the student will be able to:

1. Discern and manage the ethical issues of dental hygiene practice in a rapidly changing health environment. Dental Hygiene Goal – 1

2. Advance the profession through active participation and affiliation with professional and community service, and display lifelong professional growth and development. Dental Hygiene Goal - 3

3. Initiate and assume responsibility for health promotion and disease prevention activities for diverse populations. Dental Hygiene Goal – 2 and 3

4. Formulate comprehensive dental hygiene care plans that are patient centered and based on current scientific evidence. Dental Hygiene Goal – 2 and 4

5. Provide treatment that includes preventive and therapeutic procedures to promote and maintain oral health and assist the patient in achieving oral health goals.

Dental Hygiene Goal 2 and 4

6. Evaluate the effectiveness of patient treatment, patient education, planned clinical and community educational services and make necessary modifications.

Dental Hygiene Goal 2 and 4

LEVELS OF COMPETENCY – Program Outcomes

NOVICE Requires preclinical/lab to learn procedure (typodont practice)
Needs frequent guidance and evaluation via skill testing
Unable to work independently
Consistently needs further development of skill to progress to acceptable level of defined standards
Lacks full understanding of concept and/or skill
Beginning development of professional demeanor and sound judgment
Motivated externally

BEGINNER Practices effectively most of the time, but needs frequent supervision and guidance
Requires practice in multiple applications with varying situations.
More independent acquisition of knowledge
Understands theory but cannot always connect it to clinical situations.
Establishing a professional demeanor and developing sound judgment.
Frequently demonstrates internal motivation characteristics

COMPETENT Demonstrates master of technical skill at or above acceptable level of defined standards
Demonstrates basic abilities of a safe independent practitioner.
Uses deliberate, analytic thinking and judgment.
Integrates theory and practice using evidence-based approaches
Independent performance that integrates knowledge, skill and values.
Consistently demonstrates a professional manner and uses critical thinking skills in problem solving.
Can interpret comprehensive case presentations
Motivated Internally

Evaluation Methods; Evaluation Methods are measured throughout didactic, laboratory and clinical instruction that provide the information and experience needed for satisfactory mastery of the competencies. Evaluation Methods evaluate the student's knowledge, psychomotor skill and attitudes. Evaluation Methods evaluate the student's ability to use information and correctly answer specific questions when asked. Psychomotor skills are evaluated to follow specific rules to produce acceptable results in standardized situations. Attitudes are evaluated in positive intellectual and behavioral actions.

SUMMARY Competencies for Dental Hygiene Graduates define to a level of practice for the new graduate, rather than predict the higher level of practice that will be attained by dental hygiene practitioners over their career lifetimes. Ultimately, the true measure of the value of these competencies will be the quality of our graduates and the health care they render to the public. These competencies are linked with our program goals.

Dental Hygiene Program – Program Student Learning Objectives – Curriculum Competencies **Spring 2015**

Upon successful completion of this major, the student will be able to:

1. Discern and manage the ethical issues of dental hygiene practice in a rapidly changing health environment;
2. Advance the profession through active participation and affiliation with professional and community service, and display lifelong professional growth and development;
3. Initiate and assume responsibility for health promotion and disease prevention activities for diverse populations.
4. Formulate comprehensive dental hygiene care plans that are patient centered and based on current scientific evidence;
5. Provide treatment that includes preventive and therapeutic procedures to promote and maintain oral health and assist the patient in achieving oral health goals; and
6. Evaluate the effectiveness of patient treatment, patient education, planned clinical and community educational services and make necessary modifications.

Skill Level = N – Novice, B – Beginner, C - Competent
Instructional Method = D – Didactic, L – Laboratory, C - Clinical
Evaluation Method = W – Written Exam, P – Presentations, L – Laboratory Exams, C – Clinical Skill Assessment

Course/Semester	Competency 1	Competency 2	Competency 3	Competency 4	Competency 5	Competency 6
DE 50 1	N B D W P	N D W P	N D W P	NB D WP	NB D W P	
DE 51 1	N B D W P	N D W P	N D W P		N D W P	
DE 55A 1	N B D L W L					
DE 55B 2	B C D C W C		C D C W C	C D C W C	C D C W C	C D C W C
DH 68 1	C D W			N D W		
DH 69 2	B C D C W C		N D W P	N B D C W C	N B D C W C	
DH70 1			N D L W L	NBC D L W L		
DH71A 1	NBC D C W C	N D C W C	B DC W C	N D C W C	N D C W C	

Course/Semester	Competency 1	Competency 2	Competency 3	Competency 4	Competency 5	Competency 6
DH71B 2	NB D C W C	B D C W C	N D C W C P	NB D C W C	NB D C W C	N D C W C P
DH71C 3	NBC DC WPC	B D C WP C	BC D C WP C	BC D C W C	BC D C W C	NB D C W C
DH71D 4	BC D C WPC	B D C W C	BC D C WP C	BC D C W CP	BC D C W C	C D C W CP
DH71E 5	BC D C WP C	C D C WP C	BC D C W C	C D C W C	C D C W C	C D C W C
DH72 2	BC D W P	N D WP	NB D WP	NB D W P	NB D WP	NB D W P
DH74 2				NB D L W L		
DH75 2	NBC D W P	B D W P	B D W P	NB D W P	N D W	
DH76 2	NBC D L W L				B D L W L	B D L W L
DH78 3	BC D C W C	BC D C W C	B D C W C	BC D C W C	BC D C W C	B D C W C
DH79 4		B D W P	B D W P	BC D W P	N D W P	
DH80 4	BC D W	N D W P	N D W P	C D W	N D W P	
DH81 4	BC D W P	C D W P	C D W P	C D W P		
DH83 5	BC D W P	C D W P		C D W P		
DH85 5		C D W P	C D W P	C D W P	C D W P	
DH86 5	BC D W C	C D W	N D W P	C D W		

Course Coverage and Competencies

1. The dental hygienist must be able to discern and manage the ethical issues of dental hygiene practice in a rapidly changing health care environment.

Course	Competency Measurement Methods
DE 50	Written reports, didactic testing, Case studies, Ethical Dilemma case
DE 51	Didactic testing regulations OSHA, ADA, CDC
DE 55A	Safety test prior to radiation exposure
DH 68	Charting within Medio-legal standards
DH 69	Didactic testing on emergency process
DH 70	Charting with Medio-legal standards
DH 71A	Professionalism evaluation, charting with Medio-legal standards
DE 55B	Operate and monitor radiographic equipment and patient exposure with in ALARA
DH 71B	Professionalism evaluation, clinical assessment record, clinical patient treatment, charting with Medio-legal standards, case studies
DH 72	Case presentation
DH 74	
DH 75	Didactic testing on federal/state laws on drug prescription and usage
DH 76	Didactic testing re: DH Scope of Practice guidelines involving dental materials procedures
DH 71C	Professionalism evaluation, clinical assessment record, clinical patient treatment, charting with Medio-legal standards
DH 78	Didactic testing re: DH Scope of Practice involving anesthesia, Medio-legal charting standards, monitor of patient anesthesia safety standards
DH 71D	Professionalism evaluation, clinical assessment record, clinical patient treatment, charting with Medio-legal standards
DH 79	Case Studies, scope of practice
DH 80	Didactic testing re: ability to recognize normal/abnormal, refer abnormal finding to DDS
DH 81	Formulation of lesson plan/community presentation with in scope of practice, case studies
DH 71E	Professionalism evaluation, clinical assessment record, clinical patient treatment, charting with Medio-legal standards, case studies
DH 83	Didactic testing re; Ethics and Jurisprudence Exam, Ethical Dilemma case
DH 85	Case studies – scope of practice
DH 86	Didactic testing re: dental specialties and scope of practice

2. The dental hygienist must be able to advance the profession through active participation and affiliation with professional and community service, and display lifelong professional growth and development.

Course	Coverage and Evaluation
DE 50	Case presentations- research project
DE 51	Case presentations – consumer advocate, OSHA standards
DE 55A	
DH 68	
DH 69	
DH 70	
DH 71A	Didactic testing and self-assessment, clinical professional evaluation
DE 55B	Provide evidence-based patient care
DH 71B	Self-assessment, clinical evaluations of treatment for each clinical patient session, Provide evidence-based patient care, clinical professional evaluation
DH 72	Research oral hygiene care based on evidence-based patient care
DH 74	
DH 75	Research internet and web resources
DH 76	
DH 71C	Self-assessment, clinical evaluations of treatment for each clinical patient session, provide evidence-based patient care, didactic testing on special needs patients, clinical professionalism evaluation
DH 78	Self-assessment, clinical evaluations of treatment for each student-patient session
DH 71D	Self-assessment, clinical evaluations of treatment for each clinical patient session, provide evidence-based patient care, case studies, clinical professionalism evaluation
DH 79	Literature review and research in conjunction with oral presentations
DH 80	Didactic testing on evidence-based patient care, research for review of oral pathology in specific topics
DH 81	Community Outreach project
DH 71E	Self-assessment, clinical evaluations of treatment for each clinical patient session, provide evidence-based patient care, case studies, clinical professional evaluation
DH 83	Didactic testing re; code of ethics, patient bill of rights, ethics and jurisprudence, oral health care as change agent
DH 85	Literature review and research in conjunction with oral presentations
DH 86	Review of correlation of each specialty to the dental hygiene process of care

3. The dental hygienist must be able to initiate and assume responsibility for health promotion and disease prevention activities for diverse populations.

Course	Coverage and Evaluation
DE 50	Didactic testing communication and cultural diversity of populations
DE 51	Didactic testing re: universal and standard precautions
DE 55A	
DH 68	
DH 69	Didactic testing re: condition that predispose patients to medical emergencies
DH 70	
DH 71A	Didactic testing re: assessments, clinical testing; assessments, instrumentation, universal precautions, sterilization
DE 55B	Daily clinical assessment: all patients
DH 71B	Daily clinical assessment; all patients, chart audits
DH 72	Component of Nutritional counseling, individual data collection, communication and evaluation
DH 74	
DH 75	Demonstrate ability to accurately assess patient's health status related to conditions/meds/reactions
DH 76	
DH 71C	Daily clinical assessment; all patients, special needs group homes
DH 78	Demonstrate knowledge of anesthesia needs/dosage
DH 71D	Daily clinical assessment; all patients, off site clinical dental health care rotations, chart audits
DH 79	Didactic testing re: AAP periodontal classification, systemic factors
DH 80	Demonstrate knowledge of health/disease and ability to relate information/concerns to patient
DH 81	Component of Community Outreach project
DH 71E	Daily clinical assessment; all patients, off site clinical dental health care rotations, chart audits
DH 83	Didactic testing on Scope of Practice and Dental Practice Act
DH 85	Demonstrate knowledge of periodontal surgical needs and relate information/concerns to patient
DH 86	Demonstrate knowledge of referral to dental specialties and relate information/concerns to patient

4. Formulate comprehensive dental hygiene care plans that are patient centered and based on current scientific evidence

Course	Coverage and Evaluation
DE 50	Demonstrate knowledge of informed consent, communication with diverse populations
DE 51	
DE 55A	
DH 68	Demonstrate knowledge of electronic documentation of assessments
DH 69	Didactic testing on protocol for emergencies
DH 70	Lab proficiencies re: recognize and document dental and oral facial anomalies Didactic testing on head & neck structures as related to EOIO exam and dental exam
DH 71A	Clinical proficiencies on assessments designed to identify dental health care needs to plan treatment and goals Didactic testing on data collection/assessment
DE 55B	Daily Clinical Evaluation on recommended radiographic exams and retakes, correlate radiographic findings with treatment plan
DH 71B	Daily Clinical Evaluation on individualize, evidence-based care plan for diverse population of patients, chart audit, case studies
DH 72	Case presentations to identify dental health care needs
DH 74	Lab proficiencies re: recognize intraoral structures for anesthesia Didactic testing on head & neck structures as related to anesthesia
DH 75	Demonstrate knowledge of appropriate assessment in relation to evaluation of medications and treatment plan
DH 76	
DH 71C	Didactic testing on Special Needs patients, Daily Clinical Evaluation on individualize, evidence-based care plan for diverse population of patients, chart audit
DH 78	Demonstrate knowledge of anesthesia needs based on treatment plan
DH 71D	Daily Clinical Evaluation on individualize, evidence-based care plan for diverse population of patients, chart audit, case studies
DH 79	Didactic testing on periodontal assessment modalities, case studies
DH 80	Didactic testing on evaluation of oral conditions and referral
DH 81	Demonstrate ability to recognize accurate and complete documentation in reviewing evidence-based research.
DH 71E	Daily Clinical Evaluation on individualize, evidence-based care plan for diverse population of patients, chart audit, case studies
DH 83	Demonstrate knowledge of informed consent/refusal and communication of treatment alternatives
DH 85	Case presentations to analyze and identify dental health care needs
DH 86	Demonstrate knowledge of recommended consultations and referrals

5. The dental hygienist must be able to provide treatment that includes preventive and therapeutic procedures to promote and maintain oral health and assist the patient in achieving oral health goals.

Course	Coverage and Evaluation
DE 50	Didactic testing re communication, cultural diversity
DE 51	Didactic testing on infection control methods and universal precautions
DE 55A	
DH 68	
DH 69	Didactic testing re: conditions that predispose patients to medical emergencies
DH 70	
DH 71A	Clinical proficiencies data collection/evaluation, appropriate instrumentation, sterilization proficiency
DE 55B	Daily Clinical Evaluation: obtain radiographic of diagnostic quality
DH 71B	Daily Clinical Evaluation: provide care for clinical patients, clinical principles and techniques, chart audit
DH 72	Nutritional Counseling Project, Oral Hygiene Instruction Project
DH 74	
DH 75	Demonstrate ability to accurately assess patient's health status related to conditions/meds/reactions
DH 76	Lab proficiency on coronal polish
DH 71C	Daily Clinical Evaluation: provide care for clinical patients, clinical principles and techniques, chart audit
DH 78	Demonstrate knowledge and technique in pain control modalities
DH 71D	Daily Clinical Evaluation: provide care for clinical patients, clinical principles and techniques, chart audit
DH 79	Didactic testing re; AAP Periodontal classification systemic factors
DH 80	Demonstrate knowledge of health/disease and ability to relate information to patients
DH 81	
DH 71E	Daily Clinical Evaluation: provide care for clinical patients, clinical principles and techniques, chart audit
DH 83	
DH 85	
DH 86	

6. The dental hygienist must be able to evaluate the effectiveness of patient treatment, patient education, planned clinical and community educational services and make necessary modifications.

Course	Coverage and Evaluation
DE 50	
DE 51	
DE 55A	
DH 68	
DH 69	
DH 70	
DH 71A	
DE 55B	Daily Clinical Assessment re: retakes and patient satisfaction surveys
DH 71B	Daily Clinical Assessment re: evaluation of assessment outcomes, recall, referral, individualized health maintenance programs, chart audit, patient satisfaction surveys, case studies
DH 72	Didactic testing re; individualized health maintenance programs
DH 74	
DH 75	
DH 76	Clinical Assessment re: remaining biofilm/stain
DH 71C	Daily Clinical Assessment re: evaluation of assessment outcomes, recall, referral, individualized health maintenance programs, chart audit, patient satisfaction surveys, patient evaluation summary
DH 78	
DH 71D	Daily Clinical Assessment re: evaluation of assessment outcomes, recall, referral, individualized health maintenance programs, chart audit, patient satisfaction surveys, patient evaluation summary, case studies
DH 79	
DH 80	
DH 81	
DH 71E	Daily Clinical Assessment re: evaluation of assessment outcomes, recall, referral, individualized health maintenance programs, chart audit, patient satisfaction surveys, patient evaluation summary, case studies
DH 83	
DH 85	
DH 86	

Patient Care - Services

Patient Service	Beginner	Novice	Competent
MH + D History	71A	71B, 71C	71D
Vital Signs	71A	71B	71C
EOIO	71A	71B, 71C	71D
Dental Exam	70	71B, 71C	71D
Periodontal Exam	71A	71B, 71C, 71D	71E
Radiographs	55A	55B	71D
Indices	71B	71C	71c
Risk Assessment	71B, 72	71C, 71D	71E
Planning	71B	71C, 71D	71E
Infection Control	71A	71B	71C
NSPT	71A, 71B	71C, 71D	71E
Pain Management	71C, 78	71D	71E
Chemotherapeutic	71D	71D	71E
Fluoride	71B, 72	71C	71D
Pit + Fissure Sealant	76	71D	71E
Coronal Polish	76 and 71B	71C	71D
Care of Prostheses	76	71C	71B
Maintenance of Restorations	76		71E
Health Education	71B, 72	71C, 71D	71E
Nutritional Counsel	72	71D	71E
Evaluation	71A, 71B, 72	71C, 71D	71E
Interim Therapeutic Restorations (ITR)	71B,	71C 71D	71E

LEVELS OF COMPTETENCY

NOVICE: Needs frequent guidance and evaluation, lacks full understanding, motivated externally

BEGINNER: Understands theory but cannot always connect it to clinical situations. Requires practice in multiple applications with varying situations

COMPETENT: Demonstrates basic abilities of safe independent practitioner. Uses deliberate, analytic thinking and judgment; integrates theory and practice, Independent performance that integrates knowledge, skill and values

Quality Assurance

Overview

The purpose of the Quality Assurance Program at SRJC is to continually improve the quality of care provided to patients and the quality of education provided for the dental hygiene students.

An on-going quality assurance program is used to ensure that the dental programs adhere to the standards of care. These standards have been identified as guiding principles for patient care. The Quality Assurance Program (QAP) encompasses several components; a Patient Bill of Rights, comprehensive patient care, chart audit and review, patient clinical evaluation, faculty calibration, patient satisfaction surveys, infection control, radiology standards, incident reports and hazard management.
The Program Director is responsible for the oversight of the QAP: data is continually collected and analyzed. Pertinent data is brought to faculty or clinical coordinator meetings for discussion and recommendations.
Continued improvement to patient care as identified by the QAP has resulted in several revisions to the medical history and other assessment documents, referral forms and policies on use of electronic record keeping and release of documents.

Components

Patient Bill of Rights
A patient bill of rights is posted in English and Spanish in the reception area of the Dental Clinics along with a list of services and fees. The patient Bill of Rights will be distributed to each patient and the students will receive a copy of this in the Clinical Policy Manual.

Patient Satisfaction Surveys
Patient perceptions of their quality of care are assessed by Patient Satisfaction Surveys and through daily interaction in the clinics. This survey is directly related to the criteria listed on the Patient Bill of Rights.
The patients at the end of their final appointment complete the patient surveys. The information received is anonymous. The clinic receptionist, who tabulates and maintains the data in a binder, collects the survey. This binder is kept in the reception office. The information is evaluated by the clinic lead instructors for need of immediate attention and for opportunities for improvement.

Quality Assurance for Faculty
The faculty/Instructors are Dentists, Registered Dental Hygienists, and Registered Dental Assistants whose licenses are renewed every two years with the State of California, requiring 50 - 25 Continuing Education units every cycle. This requirement keeps faculty current in Standards of Care in their assigned courses/clinics: Dental Hygiene and Dental Assisting and Dental Radiology. License information is kept in a binder in the lead radiology faculty's office, along with current CPR Certification, and is monitored for currency and compliance. Compliance with teaching methodology and course content currency is carefully tracked and a "condition of teaching assignment" for each class/clinic. - Faculty Bio sketch and Teaching Assignment Binder.
Quality assurance for the clinics/labs that include multiple faculty is accomplished through calibration during clinics in the areas specific to their teaching assignment.

- For clinical dental hygiene faculty, this may be in areas such as patient case typing, periodontal charting, and calculus detection. Some clinical forms (test case and

calculus classifications 2 and 3) require two faculty signatures; this process assists in establishing and reinforcing faculty calibration.

- For radiology clinic faculty, this may be in areas of radiographic evaluation of diagnostic criteria, accounting and computer entry, radiation safety for patients and operators and testing format criteria.
- For dental assisting faculty, this may be in areas of clinical board requirement criteria, performance evaluations on laboratory procedures, internship protocols.
- Communication is accomplished through regular meetings, weekly lesson plans emailed to each faculty and a binder of faculty communication available to all faculty for their assigned clinic/lab.

Course Evaluation Surveys

Course Evaluation surveys are completed at the end of each semester to evaluate, communicate, and plan for changes and improvements to the courses. These surveys are completed by both the students in the programs and the faculty(s) teaching the classes/clinics. Surveys are compiled and evaluated by the Director, lead instructors of 1st year; 2nd year dental hygiene clinics and Radiography and dental assisting instructors for immediate action, long term planning and opportunities for improvement. The results are discussed during faculty meetings to determine needed changes or alterations.

Radiography

- Written authorization must be obtained before radiographs are exposed. All radiographs taken in the SRJC clinic must be either ordered by the patient's dentist of record or by the supervising clinical dentist to facilitate dental hygiene diagnosis and treatment planning.
- Patients must be informed by the student, of the indications, risks and benefits of dental radiographs as well as the fee for this service.
- Radiographs taken at SRJC will not be used to diagnose dental caries. The radiographs are forwarded to the patient's dentist of record to diagnose dental diseases. A letter explaining the limitations of the radiographic series will be sent to the referring dentist. Radiographs taken on dental hygiene patients will be used to establish the Dental Hygiene Periodontal Diagnosis.
- Radiographic equipment is inspected by qualified experts as specified by government regulations and manufacture's recommendations at regular intervals as recommended by state regulations.
- Students must follow ALARA concept for radiographic exposure.
- Students must follow the SRJC Policy for the Control and Use of Ionizing Radiation and the Infection Control Protocol for Imaging Radiographs found in the DE 55B syllabus.
- Abdominal and thyroid shielding. All protective shields are evaluated for damage (e.g. tears, folds, and cracks) monthly using visual and manual inspection.
- The condition of digital sensors and cords is checked before each clinic.
- Retake policy-students will be allowed to retake films that do not meet diagnostically acceptable criteria (3 retakes per FMX and 1 retake per BTW). Final retake determinations are made by the supervising DDS faculty.
- If a traditional film is needed. Quality Assurance includes:
    - Prior to exposing radiographs on patients, quality assurance procedures are used to maintain processing standards. This procedure includes a test film, processed in each processor/tank to match with a standard check film.

    - Running transport cleaning films through processors.
    - A maintenance schedule is used by faculty to schedule roller cleaning and changing /replacing chemicals.
- Area dosimeter monitors are placed on the control panel area of each radiology operatory to check for scatter radiation. A control dosimeter is placed in a separate area. The dosimeters are returned to the monitoring company each quarter and records maintained in the clinic reception office.
- Warning signs for radiation are posted at entry doors and into the radiology facility as required by state regulations.

Infection Control

The quality assurance relating to infection control consists of many components including:

- Utilize standard precautions in all practices (SOP)
- Use of personal protection equipment
- Use of integrator strips on each package/cassette
- Monitoring sterilizers on a weekly basis
- Maintaining records of sterilizer monitoring – Spore Tests results
- Scheduled maintenance of sterilizers
- Daily dental unit waterline maintenance – Waterline treatment-cartridges and yearly shocking procedures
- Established hand hygiene protocol – Hand sanitizer vs. Hand wash
- Use of single-use disposables items when possible
- Evaluation of infection control included in clinics – clinical check sheets
- Didactic and clinical evaluation of infection control policies and procedures

Hazard Management

The quality assurance relating to the management of hazardous materials and chemicals include:

- Regulated waste is properly identified, and picked up and disposed of by the SRJC Environmental Health and Safety Office.
- All containers containing chemicals are properly labeled with Chemical Hazard Labels that meet OSHA Communication Standards.
- Sharps are contained in puncture proof containers meeting OSHA Communication Standards.
- Recapping of needles is accomplished by a safe technique
- Binders containing current SDSs are maintained in the clinic office and are updated on a regular basis by the assigned faculty
- Eye wash stations are located in sterilization, the plaster lab and darkroom. These stations are tested monthly.
- Fire extinguishers are monitored monthly by the department and yearly by the District.

Oxygen and Nitrous Oxide

- Check that the nitrous oxide and oxygen lines are properly installed and identified – each time used
- Check tank regulators – each time used
- Check the scavenging system – each time used
- Check the alarm system – each time used

- Check fail safe system for proper function – each time used
- Inspect for wear, cracks, holes or tears all system components – hose, couplings, reservoir bag, tubing, masks, connectors – monthly

Emergency Procedures, Emergency Kit, Oxygen and AED

- AED is checked 3 times a year by a qualified technician through Simplified Office Systems
- The emergency kit is checked monthly by the clinical dentist to determine completeness of armamentarium, expiration dates on drugs and sugar beverage.
- The oxygen tanks are checked monthly to determine oxygen levels are adequate for 30 minutes of oxygen delivery – lead clinical faculty DH II
- Check the function of and condition of the positive pressure resuscitation bag, hoses and ambu bag. – yearly, lead clinical faculty DH II
- Clinical emergency protocols are reviewed with faculty yearly and signed off by each faculty using the clinic – yearly, faculty binder – Programs Director
- Students are evaluated for competency in emergency protocols during each clinical class.

Student and Faculty - CPR, TB and HBV

Students

- Records are reviewed by the Director and assigned Department Faculty upon entrance into the program
- The assigned department faculty updates the records as needed (minimum yearly)

Faculty

- Records are reviewed by the Director and assigned Department Faculty upon hire.
- The assigned department faculty updates the records as needed (minimum yearly) for CPR compliance
- The District Human Resource office updates TB vaccinations as needed – current TB clearance is a condition of employment for the District

Post exposure management protocol

- Exposure incidents should be documented and managed according to clinical guidelines.
- All Students working in clinic/lab classes and all Faculty
- These students/faculty are covered by Worker's Compensation
- District policy and procedure is reviewed yearly by the Human Resource Department

Sharps protocols

- Incidents reports are reviewed yearly to determine needed modifications in policy and procedure on exposure

The SRJC Dental Programs Quality Assurance Program as it relates to patient care is found in the following manuals

Clinical Policy Manual – dental hygiene students

Radiology Syllabus – dental radiology classes (DA and DH)

Patient Treatment Quality Control

The dental hygiene program defines the standards of care as the optimal level of patient-centered care maintained during the planning and delivery of all aspects of patient treatment. The standard of care is a benchmark for all clinicians to adhere to and is a part of their ethical responsibility. Student clinicians are assessed and graded on the standards of care they provide each patient treated.

Professional conduct
Aseptic techniques
Process of Care
    Assessments
    Diagnosis
    Care plan development
    NSPT procedures
    Evaluation
    Documentation
Time utilization
Attendance
Dress code and PPE adherence
SOP compliance

Comprehensive Patient Care

All clinical procedures are checked and signed off by the assigned faculty upon completion of the procedure or treatment area. During the treatment, an instructor is available to assist the student, observe clinical skills and interact with the patient. The assigned instructor evaluates each patient prior to their dismissal and signs the clinical records.

Standards of Care

- Students must report to clinic on time to prepare units and as rotation assigned students, to prepare clinic. – Daily Clinical Assessment Record
- Students must provide comprehensive care to all patients. – Treatment Completion Letter
- Students are required to complete all patients assigned to them. - Chart Audit
- Only the lead clinical instructor may re-assign a patient to another student, or discontinue a patient, and this is done on an individual basis. – Chart Audit
- Patients are provided with comprehensive assessments using health history, intra/extra- oral examination, radiographs (when indicated), periodontal assessment, dental assessment, oral hygiene assessment, periodontal risk assessment and other data collection procedures to assess the patient needs. – Assessment Documents
- Patients receive an individualized treatment plan using the data collected. - Treatment plan/risk assessment.
- Patients have their oral hygiene and periodontal status evaluated, using a quantitative measure to determine degree of deposits and inflammation, biofilm, calculus classification and AAP indices. – OHI and Periodontal Assessments
- Patients are provided with health education strategies for prevention of disease and promotion of health. – OHI assessment
- Patients are provided with preventive and therapeutic dental hygiene services. – Record of Treatment

- Patients with identified risk factors associated with oral disease(s) receive counseling, referral to reduce or eliminate such factors. - Patient Completion and Dental Referral Document
- At the completion of the treatment, patients identified with risk factors for periodontal disease that can be modified by the dental hygiene student, will have been eliminated or reduced - Treatment Evaluation Summary, Periodontal Reevaluation.
- All patients receive a referral to either their own dentist or to REDS. – Dental Referral Patient Completion Letter
- Students are responsible to make sure all documentation exhibits neatness, accuracy, and correct spelling and faculty signatures as required – chart audit

The Dental Hygiene Standards of Care are based on the dental hygiene process of care:
Assessment; the systematic collection, analysis and documentation of the patient's health history, vital signs, clinical dental and periodontal examinations, dental disease risk assessment and necessary diagnostic procedures.
Dental Hygiene Diagnosis; synthesize, analyze and interpret assessment data to formulate a dental hygiene diagnosis. In formulating a dental hygiene diagnosis, seek from or provide to the patient's health care provider(s) the appropriate information to facilitate comprehensive patient centered care.
Planning; the establishment of goals and outcomes based on patient's needs, expectations, values and current scientific evidence. Make clinical decisions within the context of ethical and legal principles. Establish a plan of care consistent with the assessment findings and dental hygiene diagnosis
Implementation; perform dental hygiene interventions based on the dental hygiene care plan
Evaluation; evaluate the outcomes of the implemented clinical, preventive and educational interventions and modify as needed
Documentation; document all assessments, treatment, outcomes and referrals using appropriate and consistent Medio-legal terminology and processes.

Medical History

- Students must have faculty approval prior to beginning any treatment.
- The assigned faculty member signs the medical history or medical history update at each visit. In addition, the Clinical Dentist reviews the medical history to establish the patient as a *Patient of Record* for the clinic.
- All medications must be referenced from drug reference book.
- Students must be able to report to the faculty what medications the patient is taking, what it is for, any oral manifestations, and any contraindications to dental treatment.

Assessments

- All patients receive vital signs, extra oral inspection, intraoral inspection (including dental charting, periodontal charting), dental hygiene diagnosis and treatment planning, oral hygiene instruction, and necessary radiographs. Each of the assessments is evaluated by the assigned faculty. Student must obtain patient consent for treatment plan.
- At subsequent visits the periodontal status will be reevaluated, and treatment planning modifications will be implemented.
- Risk factors will be identified, and appropriate counseling and/or referral will be provided.

NSPT and Additional Treatment Services

- Presence of deposits is identified before NSPT is initiated – Patient Completion Sheet
- Supra and subgingival scaling to include hand instrumentation and ultrasonic instrumentation as necessary, and selective polishing to remove all supragingival and subgingival deposits and polish able stains without damage to hard or soft tooth structures or periodontium. Each of these procedures will be evaluated by the assigned faculty – Patient Completion Sheet
- Additional services such as ITR'S, pit and fissure sealants, local anesthesia, application of chemotherapeutic agents, desensitizing agents and application of anticarcinogenic agents shall be approved and evaluated by the faculty. Patient Completion Sheet

Ongoing Periodontal Evaluation

Evaluation of periodontal conditions is competed on all appointments after NSPT has begun.

- On the PSE **and when appropriate**, probe the previously treated quadrant(s) before beginning the next quadrant(s)

  Chart all probe readings over 5mm or if there is a change of greater than 2mm

  Chart all BOP

  New tissue description if tissue conditions have changed

Patient Clinical Evaluation

Each instructor who oversees a student's provision of dental hygiene patient care evaluates patient care. Documentation of such care is entered on the Student Record and the Treatment Plan. These forms are presented at subsequent appointments so that previous appointment evaluations can be compared with the immediate treatment. The entire sequence of appointment evaluation is documented on Clinical Assessment Record for easy comparison of student performance of dental hygiene care.

Remediation

- Any student achieving less than 75% in any clinical competency or patient care evaluation is required to arrange a meeting with the instructor to discuss deficiencies in their grade and arrange remediation. Faculty will document need for remediation by completing a counseling form (ICARE). It is the student's responsibility to attend any remediation clinics made available by the faculty.
- Areas of deficiencies will also be noted on the Clinical Assessment Form by the assigned clinical faculty. These notes will be flagged for faculty follow-up at two subsequent clinical sessions. These notes may then be carried forward to the semester end chart audit and be made available to the faculty of the following semester to evaluate the student's progress in these areas.

Treatment Evaluation Summary

The student will produce a brief summary describing their patient, include all of the following: Patient's name **(first name and last initial only**), age, sex, calculus classification, DH diagnosis, how long since their last NSPT and brief description of their dental hygiene and oral hygiene needs.

- Was this patient identified as **medically complex**? Please give the specific identifier(s). How did this affect your treatment or prognosis?
- Was the patient identified as **culturally diverse**? Please give the specific identifier(s). How did this affect your treatment or prognosis?
- Give a brief summary of how the treatment you provided this patient was of benefit to the patient
- Give a brief summary of what procedures/education were most responsible for this change
- Upon evaluation of this patient's treatment, I would do the following differently

Chart Review and Audit

The chart review process ensures that record/keeping and standards of care are followed and appropriately documented in patient records. The chart review process will occur on four levels.

1. The dental hygiene students and assigned faculty daily review patient charts, as patients are seen. Instructors evaluate patients several times during the course of treatment. Faculty sign off the chart at each appointment indicating the procedures completed. – Assessment Document and Record of Treatment
2. Clinical coordinators review and audit each chart of patients are in-progress and completed and on the chart audit schedule. – Chart Audit Record
3. The clinical coordinator regularly communicates student progress, assessments and forms needing attention and competency completion concerns with the clinical faculty.
4. The clinic coordinator complies all the data from the chart review/audit conducted with each student at the end of the semester and presents the findings to the faculty at the faculty meeting.

Weekly Chart Audits

Each time you are assigned to clinical rotation you will be participating in the chart audit process. The chart audit process is a component of the dental hygiene program's Quality Assurance Program. The chart audit process also insures that you and the department have the same records of the procedures you have completed, and you are given credit for the patients and procedures you have seen. You will be accounting for all patients in progress and those completed. This process will be conducted at the convenience of the clinic and must be done prior to 30 minutes before the end of the clinic.

The Chart Audit process

1. Get your binder and all charts of any patient you have seen in your unit.
2. Make sure you have pink and green tracking sheets
3. Make sure you have any competencies completed since your last chart audit
4. We will be auditing all assessment forms in the charts of your "in progress" and "completed" patients
5. You must have your assigned Patient Evaluation Summary completed and signed by the appropriate faculty within 1 week of patient completion.

1. Patient Charts

Patient charts will be reviewed at the time of chart audit. You will need all charts of "in progress" patients as well as your patient "completions". Once we have checked and signed the charts of those patients who are "completed", you will not need to bring these charts back to the next audits.

2. Requesting Discontinued Status for a Patient

Patients are only deemed "discontinued status" at the end of the semester. You will need detailed documentation of your contact activity. This documentation must be written on the record of treatment in the patient's chart. Once the patient has had a chart audit in the semester and is identified as a possible "discontinued" patient, you will not need to bring this chart back until the final semester chart audit.

3. Pink Progress Sheet and Green Student Record and Patient Completion Sheets (purple sheet)

Your pink tracking sheet and green student record must be completely filled out and accurately reflect all procedures complete. If you have patient completions the Patient Completion sheet must be completely filled out. Make sure you have all signatures from your faculty.

4. Competency Sheets

If you have any competencies completed they must be signed and ready at the time of chart audit, these competencies will be kept in you file after entered into the computer.

5 Patient Chart

We will be checking all components of the patient record; it is expected that you are charting legibly, completely and accurately and that all forms are complete and in the proper order and location, all names are on all forms, all dates are complete, and the last entry of the record of treatment at the top of the chart

- **All Assessment Forms**

We will be checking all assessment documents for organization, completion and accuracy. We will also be looking for the required faculty signatures on the forms indicating that you have reviewed these with your faculty during the faculty consultation times.

6. Patient Evaluation Summary

Following the instructions contained in the Clinical Policy Manual

This document must be reviewed and signed by the faculty who participated in your patient completion. This must be completed within 1 week of your patient completion.

Chart Audit Credit: Points will be deducted for any errors in charting, chart organization or in route slip information not corrected before chart audit. Repeated errors in charting or route slip entries will be deducted.

Error	**DH71B**		**DH 71C**	**DH 71D DH71E**
Chart is organized according to the Clinic Manual Criteria	-3	-4	-5	-6
Charts – charting notes – each error	-3	-4	-5	-6
Pink Tracking Sheet Complete and Green Student Record Sheet Complete	-3	-4	-5	-6
Patient Evaluation Summary complete	-3	-4	-5	-6

Sterilization – Clinical – Reception Rotation Objectives

The multitude of skills the student clinicians develop during their sterilization, clinical and reception rotations will help to make the student clinician a valuable dental team member.

Instructional Objectives – Sterilization/Clinical Rotations

- Demonstrate competency in operating and maintaining the sterilization equipment.
- Demonstrate competency in clinical preparation to ensure an aseptic, organized, well-stocked sterilization area.
- Demonstrate competence in preparing and processing instruments for sterilization
- Demonstrate competency in operating and maintaining dental radiographic equipment
- While assisting student clinicians, demonstrates knowledge of protocols for dental and periodontal charting
- Demonstrate competency in the clinical area for closing procedures to ensure the clinical/sterilization/radiology areas and/or equipment are properly cleaned and maintained.

Instructional Objectives - Reception Rotation

- Demonstrates competence in making patient appointments
- Demonstrates competence in confirming patient appointments
- Demonstrates competence in entering patient information using practice management software
- Demonstrates competence in sending patient referral forms and radiographs to the patient's dentist.
- Demonstrates competence in asking screening questions to properly route patients to clinicians or the screening book.
- Demonstrate competency in explaining the Patient Bill of Rights, HIPAA policies and Consent for Treatment to SRJC dental hygiene patients.
- Demonstrate competency in maintaining charts: labeling, pulling files, filing in file cabinet and monitoring.
- Demonstrate competency in collection of fees

Reception Rotation Evaluation **Student's Name**_____

Class	Performance Standard	Error Points	Skill Level
DH 71A	not graded	NA	Novice
DH 71B	75-80%	-2	Novice
DH 71C	80-85%	-3	Beginner
DH 71D and E	96-100%	-4	Competent

Critical Errors for this Competency include; any breach of critical errors will result in a failure for this competency
Failure to use appropriate PPE
Failure to use aseptic procedures
Failure to comply with professionalism criteria

Criteria	71A	71B	71C	71D/ E
Arrives on time and ready for rotation				
Performs opening activities without prompting				
Checks in patient using department criteria without prompting				
Accurately assembles charts using department criteria				
Accurately enters patient information into computer				
Demonstrates competence in obtaining and scheduling screening patients				
Demonstrates competency in explaining the patient Bill of Rights, HIPAA policies and Consent for Treatment				
Maintains charts accurately without prompting				
Reviews and completes daily check list in reception binder without prompting				
Demonstrates competence in sending patient referral forms and radiographs to the patient's dentist				
Reports to instructor for sign off				
Competency Verified	_____	_____	_____	_____

Sterilization/Clinical/Dispensary Rotation Evaluation Student's Name _____

Class	Performance Standard	Error Points	Skill Level
DH 71A	not graded	NA	Novice
DH 71B	75-80%	-2	Novice
DH 71C	80-85%	-3	Beginner
DH 71D and E	96-100%	-4	Competent

Critical Errors for this Competency include; any breach of critical errors will result in a failure for this competency Failure to use appropriate PPE
Failure to use aseptic procedures
Failure to comply with professionalism criteria

Criteria	71A	71B	71C	71D/ E
Arrives on time and ready for rotation				
Checks water level of sterilizers				
Fills ultrasonic appropriately with tablets and empties and rinses at the end of clinic				
Processes instruments in Miele				
Properly labels and bags cassettes/instruments				
Processes instruments in ultrasonic properly				
Properly labels and bags loose instruments				
Loads instruments into Midmark's with paper up and to not overload machines.				
Immediately closes Midmark and starts cycle				
Empties Midmark's and places instrument in appropriate cubbies/containers				
Performs daily and monthly Midmark Maintenance				
Performs monthly Statum Maintenance				
Performs weekly spore test				
Prepares and supervises vacuum system disinfection				
Empties trash from clinic and sterilization areas				
Cleans sinks in clinic and sterilization				
Cleans required counters in clinic and sterilization				
Maintain supplies in sterilization				
Maintains paper towels/cups/barrier tape				
Maintains barriers bags for clinicians				
Replenishes OHI cart				
Maintains radiographic equipment/units				
Maintains radiographic log book				
Reports to instructor for sign off				
Competency Verified	_____	_____	_____	_____

Sterilization Evaluation Student's Name _____

Class	Performance Standard	Error Points	Skill Level
DH 71A	not graded	NA	Novice
Throughout the semester evaluated during group rotations with assigned faculty			
DH 71B	75-80%	-2	Novice
Beginning of semesterevaluated during group rotations with assigned faculty			
DH 71B	80-85%	-3	Beginner
Clinical competency exam	evaluated as a part of the Clinical Competency Exam		
Critical Errors for this Competency include; any breach of critical errors will result in a failure for this competency	Failure to use appropriate PPE Failure to use aseptic procedures Failure to comply with professionalism criteria		

Equipment	**Criteria**	**DH71A**	**DH71 B first**	**DH71B CC exam**
Ultrasonic Cleaner	Solution is mixed according to directions Instruments/cassettes placed in the cleaner are completely submerged Equipment timer is adjusted for the correct amount of time – minimum 10 minutes, loose instruments, Cassettes 15-20 minutes Instruments/cassettes are removed and rinsed appropriately Instruments/cassettes are removed and rinsed appropriately			
Miele	Cassettes are placed in the Miele with knobs facing up. Cassettes are placed to prevent overloading the racks; 1 large cassette per slot or 2 small cassettes per slot on the bottom rack The top rack must be pushed all the way in The Miele is started The machine is checked in 5 minutes to make sure the machine is running and no error messages. • If ANY ERROR light is activated, notify the lead faculty immediately and receive instruction on the process. After the cycle begins, **do not open the door** until the Disinfection is complete Instruments are removed from the machine			
Bagging/ Labeling	Instruments/cassettes are grouped together to facilitate easy identification The appropriate size sterilization bag is labeled in upper corner with the following: Date, student number, color code Instruments/cassettes are placed in the selected bag without puncturing or tearing the bag			

	The bag is properly sealed along the perforation			
Midmark				
	Criteria	**71A**	**71B first**	**71C CC exam**
Prepare	The water level is checked Deionized water is used to fill to the green zone Contaminated bagged instruments/cassettes are loaded onto the racks from the dirty side using utility gloves Contaminated bagged instruments/cassettes are loaded with the paper side of the bag facing up and making sure not to overload the racks. Only 2 large cassettes on a large rack and do not overlap instrument bags excessively. Paper is not touching the sides of the chamber. The number of the sterilizer is written on the bag to correspond to the sterilizer used: 1,2 or 3. The student on the clean side does not touch contaminated bagged instruments/cassettes; this student loads the Midmark trays using clean hands and touches the sterilizer racks only. The Midmark's are started immediately upon loading. **Midmark's are not loaded unless the student loading the machine can start the machine immediately; never leave the racks of non-sterile instruments in the Midmark.** The student selects the packs icon and then presses start to begin the cycle			
Removal	The student opens the Midmark after the drying cycle is complete The student checks the indicator to make sure the color has changed The student places instruments/cassettes into the appropriate cubby making sure that the paper side is up. Do not load cubbies if the bags are still wet. Wet instruments are left in Midmark and the green start button is pushed to activate an additional dry cycle; if this is not possible, wet packs may be placed on top of Midmark to complete drying. The department instruments are placed in appropriate bins or if the appropriate location is not known the instruments are placed in the cubby labeled for this.			

Faculty Comments – Date/ Faculty initials

INFECTION CONTROL PROTOCOL FOR CLINICAL PROCEDURES

PPE:
Gloves, mask, protective eyewear, and clinic gowns must be worn at all times while providing direct patient care.
Utility gloves, protective eyewear, and clinic gowns must be worn while disinfecting the unit and handling any contaminated instruments/sharps.

HAND WASHING:
Hand washing is an integral part of preventing disease transmission in the dental environment. Use antimicrobial soap at beginning AND end of the clinic and whenever you have removed utility gloves. Use antimicrobial soap before setting for a patient.
Within this SOP document the work "wash" will be used to signify the use of antimicrobial soap

ALCOHOL-BASED HAND RUBS:
Use alcohol-based hand rub immediately after removing operator gloves
Use alcohol-based hand rub before re-gloving; if during the same patient treatment
Within this SOP document the work "sanitize" will be used to signify the use of alcohol rub.

CROSS CONTAMINATION:
CONSTANTLY BE AWARE OF THE POTENTIAL FOR CROSS CONTAMINATION.

1. Cross contamination can be avoided while charting by wearing over gloves, or having a student/patient assist you with charting
2. After washing hands and putting gloves on ONLY touch areas that have be disinfected or have barriers. Do not touch your gown, goggles, mask, etc.
3. Students may not leave the operatory wearing patient gloves.
   Over gloves are to be worn over your operator gloves when:
   - Using the computer keyboard
   - Handling the patient's chart
   - Handling the Clinical Policy Manual or OHI Manual
   - Handling any item in your operatory that may not be adequately sterilized or disinfected
4. During treatment, bioburden should be carefully removed from instruments with gauze. DO NOT wipe instruments on patient napkin. Blood soaked gauze should be placed in debris bag.
5. When students are wearing utility gloves, enter/exit clinic through east door. Students may not wear green gloves through the main Dental Hygiene clinic entrance.
6. Student will provide safety glasses to patient. Patients may wear their own glasses if those glasses provide appropriate coverage.
7. Make sure you take your patient's bib off if they have to leave the clinic area.

When is a clinic gown necessary, when is a lab coat needed.
You will never be in clinic in only scrubs; you must wear a clinic gown over your scrubs whenever you are working as an operator including screening.

A clean neatly pressed lab coat, closed from the neck through the bottom snap, may be worn for sterilization, dispensary and clinical rotation. The lab coat is also worn when on reception rotation.

OPERATORY PREPARATION	MASK, UTILITY GLOVES, SAFETY GLASSES

1. Wash hands upon entering clinic.
2. Put on mask, safety glasses and utility gloves. Using **designated cleaning solution and paper towels** clean the operatory **housekeeping** surfaces: all cabinets, counters, paper towel and soap dispensers, operator and assisting chair,

patient chair including base, foot pedal and delivery system. Only use cleaning solution on chair upholstery if it is visibly soiled.
3. Clean floors along baseboards, in corners and under sink controls – look for "dust bunnies" and remove.
4. Get 2 disinfectant wipes; one for initial cleaning and one for disinfecting.
5. With the first wipe clean contact surfaces to remove bioburden; counter tops, computer base including area **behind** and around the computer, computer keyboard, bracket tray, touch pad, hoses, connectors, holders, light switch and handles, **and plastic portions** of patient chair, operator and assisting chairs. **Repeat wiping to disinfect with a second wipe. Surfaces do not need to dry between wipes. Surface must remain wet for 3 minutes for proper disinfection – use additional wipes for this step as needed**. **Do not wipe computer monitor with disinfectant.**
6. While wearing the utility gloves, wash them with soap and water to remove visible debris, dry gloves with paper towels, remove them and leave in designated area under sink, remove your mask then wash with antimicrobial soap and dry your hands.
7. Turn on the delivery system, place the keyboard onto the counter and turn on the computer. Login the computer and open schedule.

OPERATORY SET - UP FOR PATIENT CARE
NO PPE NEEDED

1. Review patient record for proposed treatment; retrieve supplies, instruments, and additional equipment as indicated.
2. Wash with antimicrobial soap and dry hands.
3. Using clean, dry hands place barriers on the following: headrest cover, bracket tray assembly barrier, tray cover, both light handles, saliva ejector connector and air/water syringe, and both operator chair adjustment levers.
4. At the beginning of the clinical session **fill the water bottle to 1 inch below the top with tap water**
    - The DentaPure® cartridge provides 365 days (or 240L of water) of safe, compliant dental unit water
    - Connect bottle to the dental unit.
    - Run line for 2 minutes =1 full bottle of water
    - The solution is used during clinical procedures and is completely harmless to the patient.
5. Open sterilization bag and arrange instruments, materials and equipment. (If opened for sharpening, place patient bib over instruments).
6. If you are using a paper bag for debris, please tape to **your bracket tray.**

CLEANING OF COMPUTER SCREENS

At the beginning of the clinic session, before the computers are turned on, the student in charge of the clinical rotation duty will clean the computer screens using the following method:

1. Wipe the display screen gently with an LCD cleaner cloth by stroking gently in one direction, moving from top to bottom.
2. When cleaning the laptop LCD screen, be sure to allow screen to dry before closing the laptop.

Note: One disposable cleaner cloth can be used for 2 – 3 computer screens.

HAND WASHING BEFORE GLOVING NO PPE NEEDED

Within this SOP document the word "wash" will be used to signify the use of antimicrobial soap

1. Regulate handle to middle position. Activate water and wet hands – leave water running for rinse. Push sleeve cuff away from wrists to avoid getting wet.
2. Dispense liquid soap and scrub hands.
3. Wash between finger, thumbs, fingertips, back and front of hands, lather at least 15 seconds.
4. Rinse hands with cool water.
5. Use paper towel to thoroughly dry hands and fingers.
6. Dry sink area of splashed water.

NOTE: Use antimicrobial soap at beginning AND end of the clinic and whenever you have removed utility gloves.

APPLYING ALCOHOL-BASED HAND RUBS

Within this SOP document the word "sanitize" will be used to signify the use of alcohol rub.

1. Use one full pump of alcohol rub into the palm of your hand.
2. Rub the product between your fingers, thumbs, and fingertips, back and front of hands, rub at least 15 seconds. (It is important to thoroughly cover both of your hands).
3. Rub the product over your hands until the alcohol is dry for antimicrobial effectiveness.

NOTE: Use alcohol-based hand rub immediately after removing operator gloves

NOTE: Use alcohol-based hand rub before re-gloving; if during the same patient treatment

PLACING AND REMOVING PPE MASK, GLASSES, GLOVES

PLACING

1. Put on mask (mask must be changed between patients or when noticeably moist).
2. Put on glasses (glasses must cover eyes and have side shields; a face shield may be worn in place of glasses, **but a mask must still be worn**).
3. Wash hands and put on gloves (gloves must be changed between patients, never washed)

REMOVING

1. Remove gloves (do not pull off rapidly) Remove one glove and place into the hand with the remaining dirty glove. Pull the second glove over the first.
2. Remove mask (handle by periphery or band only).
3. Remove glasses (glasses may be washed with soap, never disinfectant).
4. Wash or sanitize hands as appropriate.

NOTE: All patients must wear safety glasses for any intraoral procedures in Dental Hygiene Clinic. Safety glasses must be washed with soap before giving to the next patient.

Operatory Reprocessing

1. Before escorting patient from treatment room; remove and discard mask, eyewear and treatment gloves and wash and dry hands.

NOTE: Contaminated eyewear is considered PPE and should not be worn outside treatment area.

2. After returning to treatment room, with your safety glasses on, put on your mask and utility gloves.
3. Place all sterilizable instruments on tray or into cassette.
4. Dispose of all contaminated waste into the garbage and/or sharps container.
5. Flush air/water lines for at least 30 seconds into the HVE.
6. Remove all barriers into headrest cover.
7. Place barriers firmly into the trash; make sure the mass does not get caught in the trash tube.
8. Use 2 disinfectant wipes per area: with the first wipe to remove bioburden, the second wipe to wet with disinfectant. **Surfaces do not need to dry between wipes. Please spread wipe out to use entire surface.**
   Areas include:
   - Counters, including area behind and around the computer, computer base, computer keyboard (**do not wipe screen with disinfectant wipe**)
   - Bracket tray, touch pad, hoses, connectors, holders
   - Light switch and handles, plastic portions of patient chair, operator and assisting chairs, rheostat.
9. Take the instrument to the dirty side of the sterilization area.
10. When you return from sterilization, while wearing the utility gloves, wash them with soap and water to remove visible debris, dry gloves with paper towels, remove them and leave in designated area, remove your mask then wash and dry your hands. Dry area around sink.
11. Remove protective eye wear and wash them with antimicrobial soap under running water, pat dry with soft paper towel.

NOTE: Although the clinic dental chairs are designed to be a non-touch surface; exposed areas of the chair may become contaminated by the patient's hands, therefore, the dental chair arms may be disinfected using wipes between patients. If the chair is visibly soiled, clean using soap and water and damp paper towel.

End of Clinic - Hygiene

1. Check all counters and sink area for equipment, materials and disposables.
2. Wipe sink or end counter in your area.
3. **At the end of the clinic day**; empty the water bottle, replace the empty bottle on the unit and flush out the lines until dry, remove the water bottle and place it on the bracket tray.
4. Move chair to full upright position with light directly over chair.
5. Place delivery system behind patient chair.
6. Place operator and assistant's stools to back wall one on each side of chair.
7. Place rheostat on delivery base.
8. Turn off delivery system, **double check to make sure it is off.**

9. Turn off the computer and store the keyboard under the monitor.
10. Wash your hands before leaving clinic.

INSTRUMENT RECIRCULATION – Student Operator	MASK, UTILITY GLOVES, GLASSES

1. **If using the Miele Thermal Disinfector**
    - Place the instrument cassette in the Miele Thermal Disinfector with the knobs up.
    - If using the Miele Thermal Disinfector **do not** place handpieces into Miele.
2. **If using the ultrasonic cleaner**
    - Place all instruments into ultrasonic cleaner (with the exception of the handpiece) and run for 5 - 10 minutes
    - Wipe the handpieces with moistened 4 x 4 gauze.
    - Place handpieces in a labeled sterilization bag
3. Place bag in designated dirty area.
4. Spray and wipe instrument tray with disinfection solution
5. Return to your unit before removing mask, utility gloves and safety glasses.

ULTRASONIC CLEANER	MASK, GLASSES, UTILITY GLOVES

1. Remove disposable items from cassettes.
2. Completely submerge instruments in ultrasonic cleaner.
3. Cover tank and set timer for 10 minutes for loose instruments and 20 minutes for cassettes.
4. When cycle is completed, lift lid of tank and remove basket.
5. Rinse instruments under running water in a deep sink.
6. When ultrasonic cleaner cycle is completed; rinse basket contents and empty into paper towel, carefully dry.
7. Pat instruments carefully to dry, be sure to dry mirror face completely.
8. Bag instruments in labeled bags.

ULTRASONIC CLEANER MAINTENANCE	MASK, GLASSES, UTILITY GLOVES

1. Place ultrasonic cleaner solution/tablets into machine and add water to cover basket. Check the bulletin board to determine the correct number of tablets based on the size of the ultrasonic cleaner you are using. (1 tablet per ½ gallon of water)
2. Change solution as indicated.
3. Empty solution from ultrasonic cleaner and rinse machine thoroughly, wiping the inside with a paper towel to remove debris.

MIELE THERMAL DISINFECTOR - Rotation	MASK, GLASSES, UTILITY GLOVES

1. Load instruments into machine in cassettes <u>with cassette locks facing up</u> (DO NOT DOUBLE STACK “LARGE” CASSETTES)
2. Make sure the top rack is pushed all the way in
3. Verify there are no error messages on the front panel. Notify your lead faculty if there are any error messages lighting up on the panel.
4. Push "power" button. (Far left button).
5. Close door (pull out on handle) and it will close automatically, then push green start button.(Far right upper button)
6. Wash and dry utility gloves. Remove utility gloves, then mask, wash with antimicrobial soap and dry hands.

Error Lights: **If an error message comes on; notify Lead faculty.**
EXTREME DANGER: **NEVER OPEN THE DOOR AFTER THE CYCLE HAS BEGUN.**

NOTE: Bags must be labeled with **student number, color code, date, and which sterilizer used.**

STERILIZER	UTILITY GLOVES on dirty side/ CLEAN HANDS on sterile side

NOTE: DO NOT PLACE INSTRUMENTS IN THE STERILIZER UNLESS <u>YOU</u> ARE IMMEDIATELY GOING TO RUN THE MACHINE.
If loading from Dirty Side – wear utility gloves

1. Label the packaged instruments with student colors, number, and stamp the # midmark the instruments are going into.
2. Load chamber with packaged instruments, **paper side down - wear utility gloves.**

Wash and dry hands when entering clean side
1. Check water level.
2. Select sterilization program.
3. Close and latch the door.
4. Press the START button, sterilizer automatically begins processing.
5. When the exposure time is complete, the sterilizer vents the chamber.
6. When the venting is complete the door will open after 5 audible beeps.
7. The drying cycle takes 30 minutes - do not remove instruments until the drying cycle is complete, the bags will be wet, and instruments may rust.
8. Open door and unload sterilizer.

NOTE: If an error is indicated, notify Lead faculty.

PORTER NITROUS UNIT SETUP AND MAINTENANCE

Setup: After signing up for nitrous use and verifying system has been turned on by clinic dentist:

1. Retrieve a nose hood and mask from dispensary.
2. Donning appropriate PPE, wipe unit, including delivery hoses with disinfectant wipes, allowing appropriate disinfectant time, then follow with a damp paper towel wipe to remove disinfectant residue
3. Plug unit into corresponding connectors in wall
4. Connect unit to scavenger system
5. Install nose hood and mask
6. Verify that the unit operates properly, check fail-safe function
7. Assure that hoses are neat and untangled for use and that the unit is easily accessible for reading gauges and adjusting settings

Breakdown: **Don appropriate PPE for use of disinfectant wipes**

1. Disconnect unit from wall
2. Remove mask and wash in soapy water. Dispose of nitrous liner
3. Dry and bag for sterilization
4. Wipe hoses and control panel down with disinfectant wipes
5. Return unit to storage with hoses neatly stowed on hangers

Weekly Maintenance:

1. Tubing will be washed weekly according to the protocol in dispensary

Monthly Maintenance: Performed by clinic dentist following the Porter Monthly Maintenance Protocol.

1. Inspect tubing and bag for cracks/leaks

NOTE: ALWAYS properly stow hoses on unit hanger

- **Hoses should be neatly looped and placed on hanger. Hoses should not be kinked, bent, twisted, dragging on ground etc**.

STERILIZER MAINTENANCE MASK, GLASSES, UTILITY GLOVES

External Surfaces - Weekly

Wipe with a soft cloth and mild soap or detergent.

Internal Surfaces - Weekly

1. Drain water from reservoir – discard.
2. Wipe with mild soap or Speed-Clean sterilizer cleaner and distilled water.
3. Wipe inside of chamber trays, door gasket, and door gasket surface.
4. Refill reservoir with clean distilled water.

Monthly - Flush system

1. Drain reservoir – discard.
2. Use 1 oz of Speed-Clean sterilizer cleaner directly into the bottom of the sterilizer chamber, check diagram for specific location

3. Run 1 ‘packs’ cycle (30-minute cycle).
4. Drain cleaning solution from reservoir.
5. Refill reservoir with 2 quarts of clean distilled water.
6. Run 2 separate ‘unwrapped’ cycles.
7. Drain reservoir and refill reservoir completely with clean distilled water.

WATERLINE MAINTENANCE	MASK, GLASSES, UTILITY GLOVES

Daily (At the beginning of the clinic and when refilling water bottle during a clinical session)

Procedure:

1. At the beginning of the clinical session fill the water bottle to 1 inch below the top with tap water
2. The DentaPure® cartridge provides 365 days (or 240L of water) of safe, compliant dental unit water
3. Connect bottle to the dental unit.
4. Run line for 2 minutes=1 full bottle of water
5. The solution is used during clinical procedures and is completely harmless to the patient.

Daily (At the end of the clinic)

1. Remove all water lines from connectors.
2. Turn off master switch.
3. Remove and empty water bottle, reinstall it
4. Turn the master switch back on.
5. Hold down buttons on air/water syringe and direct into the HVE until waterline is dry.
6. Turn off master switch
7. Remove the water bottle and place it on the bracket tray.

CONTAMINATED CLOTHING:	CLINIC GOWNS, SCRUBS, AND LAB COATS

1. Contaminated personal protective wear should be handled carefully.
2. When taking these items off the school premises or rotation sites, they must be contained in a plastic bag or container.
3. Launder contaminated personal protective wear separately from other items in hot water and when possible bleach.

SHARPS CONTAINMENT AND DISPOSAL	MASK, GLASSES, UTILITY GLOVES

1. Sharps are considered to be needles, irrigation cannulas, etchant tips, bonding tips and any item that can puncture skin
2. Sharps containers are used to dispose of these items. Located under the sink areas in clinic, items must be placed here before taking tray to sterilization.
3. Sharps containers are monitored in clinic by students on rotation, and when the fill line is reached must be replaced. Lead faculty must be informed when this takes place.
4. Full sharps containers should be properly closed before transporting to the sterilization area where the sharps disposal tray is located.
5. When containers are placed for disposal, lead faculty must be notified so the containers can be logged, and a disposal pickup arranged.