This Dental Hygiene Program Student Handbook should serve you well during your tenure as a student. It provides general student and professional information as well as general clinic information and clinical procedures. You will want to keep the Handbook close at hand at all times.

In a desire to live by our Philosophy to “be the model Dental Hygiene Program for the 21st century, dedicated to advancing the health of the people of the State of Texas, the nation, and our global community through educating compassionate health care professionals and innovative scientists and through discovering and translating advances in the social and biomedical sciences to treat, cure, and prevent disease now and in the future” our goals are as follows:

- Recruit well-qualified, diverse students and educate them to be qualified oral health care professionals in dental hygiene by preparing them for future practice in a highly-technologic world—amid a population that is aging, ethnically diverse and consumer-oriented.
- Graduate students competent to practice up-to-date, comprehensive, humanitarian, patient-centered care
- Assess curricula to find ways of integrating new methods and new content as appropriate
- Pursue means to continually improve the quality of care provided to its patients and the methods used to deliver care

In addition to the faculty being committed to providing the best education as possible, the Houston area dental community is involved with the process as well. Via the Dental Hygiene Community Liaison Council, interaction is conducted between the dental hygiene faculty and local dentists and dental hygienists. Following is the Mission Statement of the Community Liaison Council with the stated roles of the members:

“In compliance with and at the suggestion of the 1998 American Dental Association Commission on Dental Accreditation, the Dental Hygiene Community Liaison Council was formed. The Council will act as a more active liaison between the dental hygiene program and the dental and dental hygiene professions in the community, as well as to provide information on current trends in dental and dental hygiene practice; and to assist in determining community health and dental hygiene employment needs.

To develop an active liaison with more of an advisory role to the program, the dental hygiene administrator and faculty selected eight dental professionals and a second-year dental hygiene student. Members will be practicing dental hygienists, general practice and specialty dentists from the Houston metropolitan area. The Council will hold two meetings, once in the fall and once in the spring of each year.”

Students are encouraged to maintain close communication with their assigned facilitators and advisors, and other faculty in order to make their education as smooth as possible. If faculty feels the student would benefit from counseling, they may recommend the University of Texas Student Counseling Center or you may make an appointment on your own by calling 713-500-3327. Counselors are available to provide counseling in regards to personal and/or academic issues.

Please refer to the School of Dentistry Catalog for more information about the Americans with Disability Act (ADA) if you feel that you may require any disability accommodations. The Catalog will also provide additional information on life at the UT-Houston, School of Dentistry.

Jayne A. McWherter, R.D.H., M.Ed.
Program Director and Associate Professor
Dental Hygiene Program
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SECTION A

STUDENT INFORMATION
DENTAL HYGIENE PROGRAM PHILOSOPHY AND GOALS

The Dental Hygiene Program has a philosophy to aspire to be the model Dental Hygiene Program for the 21st century, dedicated to advancing the health of the people of the State of Texas, the nation, and our global community through educating compassionate health care professionals and innovative scientists and through discovering and translating advances in the social and biomedical sciences to treat, cure, and prevent disease now and in the future.

The goals of the Dental Hygiene Program are to:

- Educate students to be qualified oral health care professionals in their chosen field of dental hygiene by preparing them for future practice in a highly-technologic world-amid a population that is aging, ethnically diverse and consumer-oriented.
- Assess curricula to find ways of integrating new methods and new content as appropriate.
- Educate clinically competent health care professionals.
- Pursue means to improve the quality of care provided to its patients and the methods used to deliver care.

This philosophy and goals are in line with the mission of The University of Texas School of Dentistry at Houston which is to:

- Attract and retain high-quality, culturally diverse faculty, staff and students;
- Develop and present comprehensive and contemporary dental education programs;
- Generate and disseminate new knowledge through basic, transitional and clinical research;
- Provide comprehensive, compassionate and ethical oral health care; and
- Improve the overall health of the citizens of Texas and beyond, in a professionally enriching and collegial educational environment

As a student at The University of Texas School of Dentistry at Houston, you are well on your way toward your goal of being a member of the dental profession. Certain responsibilities are part of being a professional. As it was your choice to enter the field of dental hygiene, you are expected to accept these responsibilities.

Your motivation toward learning those skills required to practice dental hygiene should not need constant reinforcement, for your goal is before you. Your attitudes toward your patients, your contemporaries, and your chosen profession are expected to reflect mature judgment. Dental hygiene and dental faculty and administration will support you as you develop your skills to become competent practicing dental hygienists.
ADMINISTRATION

John A. Valenza, D.D.S.  Dean and Professor
Leslie Roeder, D.D.S., MS  Associate Dean for Academic Affairs & Associate Professor
Matthew L. Seals, D.D.S.  Interim Associate Dean for Patient Care & Associate Professor
Peter T. Triolo, Jr., D.D.S., MS  Interim Associate Dean for Research & Chief Information Officer; Associate Professor
H. Philip Pierpont, D.D.S.  Associate Dean for Student & Alumni Affairs; Professor
Paula N. O'Neill, M.Ed., EdD  Associate Dean for Educational Research & Professional Development; Professor
Arthur H. Jeske, D.M.D., PhD  Associate Dean for Strategic Planning & Professor
James A. Katancik, D.D.S., PhD  Chair, Department of Periodontics & Dental Hygiene; Associate Professor
Joe Morrow, BBA  Director of Finance, School of Dentistry
Jayne A. McWherter, RDH, M.Ed.  Director, Dental Hygiene Program & Associate Professor
GENERAL GUIDELINES

The University of Texas Health Science Center at Houston uses email as its primary and official method of communication. This is the policy of the Dental Hygiene Program and is done in the interest of the student. It is your responsibility to monitor your official UT email on a daily basis.

A change in your name, address or telephone number should be reported promptly to the secretary of the Dental Hygiene Program. Summer addresses and telephone numbers are to be reported at the end of the school year.

Permission of the Director is to be obtained before soliciting funds or conducting any type of campaign in the school.

Before notices can be posted on the bulletin boards, they must be approved by the Dean’s office.

Smoking is not permitted on the UTHSC premises. Smoking in public while in scrubs is considered unprofessional.

Dental Hygiene students are permitted in the clinic and laboratory only for officially scheduled activities or when such facilities are not being used by authorized groups.

The school is unable to provide secretarial services for students.

Students are expected to clear seminar rooms, laboratories and cubicles by 4:50 p.m. each day. Students are not permitted in these areas on weekends or holidays.

A dental supply store is located in the basement to allow students to purchase the necessary instruments and supplies as specified in the Student Instrument List.

NOTE: All rules and regulations formulated for The University of Texas School of Dentistry at Houston, will also apply to Dental Hygiene students.

DENTAL HYGIENE COMMUNITY LIAISON COUNCIL

The Dental Hygiene Program has a good relationship with the Houston area dentists and dental hygienists. A formal active liaison exists among these professional groups by way of the Dental Hygiene Community Liaison Council. Members of the Council meet twice a year to discuss current trends in dental and dental hygiene practice; and to assist in determining community health and dental hygiene employment needs. Eight dental professionals, a second-year dental hygiene student, and the dental hygiene faculty serve on the council.

DISABILITY ACCOMMODATION

The University of Texas Health Science Center at Houston (UTHSC-H) ensures equal educational opportunity for all disabled individuals who are otherwise qualified, with or without reasonable accommodation.

If any student has questions about a disability or accommodation, or feels that he or she has been discriminated against on the basis of a disability, he or she should contact the UTHSC-H Office of Equal Opportunity and Diversity. Policies and procedures regarding disability accommodation can be found online at http://legal.uth.tmc.edu/hoop/06/6_02.html.

If you believe you have a disability requiring an accommodation, please contact:

   Dr. Leslie Roeder  
   504 Disability Coordinator for UTSD  
   713-500-4166

For additional information, please contact:

   Jennifer M. Smith  
   EO Advisor  
   713-500-3079
As an entering student into the Dental Hygiene Program, you were asked to read and sign the following policy. If you believe that you have not done so, please contact the Secretary of the Office of Dental Hygiene and she will see that one is on file for you.

“The Commission on Dental Accreditation will review complaints that relate to the program’s compliance with the accreditation standards. The Commission is interested in the sustained quality and continued improvement of dental and dental-related education programs but does not intervene on behalf of individuals or act as a court of appeal for individuals in matters of admission, appointment, promotion or dismissal of faculty, staff or students.

A copy of the appropriate accreditation standards and/or the Commission’s policy and procedure for submission of complaints may be obtained by contacting the Commission at 211 East Chicago Avenue, Chicago, IL 60611-2678 or by calling 1-800-621-8099 extension 4653.”

I have read and I understand that I have the right to contact the Commission on Dental Accreditation if I so desire.

Print name __________________________________________________

Signature __________________________________________________

Date _____________________________

ADVISORY SYSTEM

The Advisory System allows development of student/faculty relationships and provides a faculty counselor that the student can contact for assistance. Each advisor is assigned a group of students at random from each dental hygiene class. The advisory groups remain fixed for the entire year, except where an unproductive relationship exists between the advisor and student. It is then the prerogative of the Director to transfer the student to another advisor.

The purposes of the advisory system are:

1. To allow faculty to facilitate, monitor, and assist in the attainment of students’ individual goals;
2. To allow students the opportunity to discuss academic and clinical progress with a faculty member;
3. To encourage students to direct questions to a faculty member or share problems that may affect scholastic performance; the advisor may refer the student to outside agencies for additional assistance; and
4. To allow the advisor to monitor the students’ progression or regressions in their professional development and to plan remedial or enrichment work accordingly.
The University of Texas-Houston, Dental Hygiene Program Mutual Pact for High Expectations

The faculty members of the Dental Hygiene Program have high expectations of themselves, the students, and for the program. In order to reach and maintain these expectations, students and faculty have obligations to each other. A few of the expectations are as follows.

Students will:
- Treat everyone (fellow-students, staff, faculty, and patients) with the respect due to all human beings.
- Attend every class and clinic, giving full attention to the material and conduct yourself in an appropriate manner.
- Agree to do the work outlined in each syllabus on time.
- Not plagiarize or otherwise steal the work of others.
- Not make excuses for your failure to do what you ought to do.
- Accept the consequences—good and bad—of your actions.

Dental Hygiene Faculty will:
- Treat students, fellow-faculty, staff, and patients with the respect due to all human beings.
- Treat each student as an individual.
- Manage the classroom and clinic in a professional manner.
- Prepare carefully for each class and clinic session.
- Begin and end class on time.
- Pursue the maximum punishment for plagiarism, cheating, and other violations of academic integrity.
- Investigate every excuse for nonattendance of classes and non-completion of assignments.
- Make ourselves available to you for advising.
- Maintain appropriate confidentiality concerning your performance.
- Provide students with professional support and role models for professional behavior.
- Be honest and fair with the students and adhere to the ADHA Code of Ethics.

It is the hope of the Dental Hygiene Program that the faculty and students will rise to high expectations with the results of producing the best Dental Hygienists possible.

ETHICS AND PROFESSIONALISM

Ethics is the part of philosophy that deals with moral conduct and judgment. There are several principles that health care professionals must be aware of in the practice of their profession. The major principles are:

- **Autonomy** – self determination in a person; the right to participate in and decide on a course of action without undue influence
- **Beneficence** – promoting good or well-being
- **Nonmaleficence** – the duty to avoid harming the patient, summarized in the phrase “do no harm”
- **Confidentiality** – the precept by which information shared by a patient during the course of receiving health care is kept in confidence by the health care provider
- **Veracity** – a duty to tell the truth when information is disclosed to patients about treatment
- **Societal Trust** – maintaining a bond of trust in the relationships between healthcare professionals, patients, and the public

Professionalism is defined as “the conduct, aims, or qualities that characterize or mark a profession or a professional person”. While these characteristics may vary from profession to profession, the practice of dental hygiene requires professionalism which goes far beyond basic honesty and integrity.

While you will be evaluated on the basis of your intellectual and psychomotor abilities, you are also required to be exemplary in your grooming, personal conduct, and relationships with faculty, peers, and patients.
The students' responsibilities at UTSD may be classified in five broad areas, which are as follows:

- academic performance
- academic integrity
- professional conduct
- conduct associated with the University, but not directly related to academic or professional training of the student
- off-campus conduct, not associated with the University, which may reflect adversely on the image and reputation of the University

The faculty and administration are dedicated to the development of professionalism in all School of Dentistry students. The aim of the institution is to create a learning environment which offers students the opportunity to develop standards of excellence which will sustain them throughout their professional careers.

DENTAL HYGIENE LICENSURE ELIGIBILITY

According to Laws of the State of Texas and the Texas State Board of Dental Examiners a person applying for initial licensure to practice Dental Hygiene in the State of Texas may be ineligible for licensure due to a previous conviction or deferred adjudication for a felony or misdemeanor offense. Reference rule 103.8 at the following link: http://www.tsbde.state.tx.us/index.php?option=com_content&task=category&sectionid=12&id=36&Itemid=109

ACADEMIC INTEGRITY

It is imperative that students maintain high standards of integrity in their scholastic endeavors. It is the responsibility of the faculty to see that such standards are maintained. Scholastic dishonesty is the submission, as one's own, of material that is not one's own. As a general rule, it involves, but is not limited to, one of the following acts: cheating, plagiarism, and collusion.

**Cheating** is defined as receiving unauthorized aid on an examination, quiz, paper, or laboratory project such as:

- Copying from another student's test paper or laboratory project.
- Using unauthorized materials during a test (pagers, cell phones, IPods or laptops).
- Possession of unauthorized material during a test such as class notes, crib notes, etc. The presence of textbooks and/or other course material such as class notes, crib notes, etc. is prohibited for that test unless explicitly allowed by the Course Director.
- Knowingly using, buying, stealing, transporting, or soliciting, in whole or in part, the contents of an unreleased test.
- Collaborating with or seeking unauthorized aid from another student during a test.
- Substituting for another person, or permitting another person to substitute for oneself, when taking a test or performing a laboratory procedure, managing clinical patient records, signing class attendance records or requisitions for supplies and materials.
- Bribing another person to obtain an unreleased test or information about an unreleased test.

**Plagiarism** means the appropriating, buying, receiving as a gift or obtaining by any means, another’s work and the unacknowledged submission or incorporation of it into one’s own written work and offered for credit.

**Collusion** means the unauthorized collaboration with another person in preparing academic assignments which are offered for credit. This includes organized efforts to collect test questions from exams that are not normally released and / or the use of other students Automated Response System (ARS) for the expressed purpose of taking exams, test, or quizzes.

The penalty for scholastic dishonesty, as described in the Board of Regents' Rules and Regulations, can be: disciplinary probation, withholding of transcript or degree, barring against readmission, failing grade, denial of degree, suspension
from the institution for a period of time not to exceed one calendar year, or expulsion from the institution for a specific period of time not less than one year or dismissal from the institution. Suspected breaches of academic integrity will be reported to the Associate Dean of Student Affairs. If such charges are found to have merit, disciplinary proceedings will commence as described in the Student Guide to Academic Studies. More detailed information about Professionalism and Academic Integrity can be found in the Student Guide to Academic Studies.

**PROFESSIONAL CONDUCT**

Students are expected to perform in a professional and ethical manner in all aspects of the delivery of patient care. The School of Dentistry responds to inappropriate clinic performance or behavior (“infractions”) by students through academic corrective action. Infractions which are deemed more serious in nature (“cardinal”) may be referred to the appropriate Student Evaluation & Promotion Committee or the Associate Dean for Student Affairs. Investigation and, if indicated, appropriate action taken will be in accordance with policies described in the Student Guide to Academic Studies and/or the Board of Regents’ *Rules and Regulations*, Part One, Chapter VI, Section 3 (available in the Office of the Dean and through the Health Science Center world wide web site, [http://www.utsystem.edu](http://www.utsystem.edu), or the University of Texas Health Science Center at Houston Handbook of Operating Procedures (available at [http://legal.uth.tmc.edu/hoop/06/6_03.html](http://legal.uth.tmc.edu/hoop/06/6_03.html)). All students are responsible for knowing and observing these regulations as well as state and federal law and the policies of both the Health Science Center and the Dental Branch. A complete copy of School of Dentistry policy may be found in the school’s *Student Guide to Academic Studies*.

**Corrective Action**

The Associate Dean for Patient Care and the Director of Predoctoral Clinical Education are responsible for executing UT-Houston/UTSD policies as they relate to the clinical academic program and patient care. As all clinical faculty share responsibility for student compliance of clinic policy and procedure, most minor clinical infractions may be resolved by an attending faculty member. However, in those instances where, in the judgment of a faculty or appropriate staff member, referral to clinic administration for assessment, investigation and possible corrective action is indicated, the following persons will be responsible for determining the appropriate actions as follows:

For infractions involving a dental hygiene student, the Director of the Dental Hygiene Program is to be contacted immediately. Further referral, if indicated, would be to the Dental Hygiene Student Evaluation & Promotion Committee or the Associate Dean for Student Affairs.

Faculty, students or staff may report infractions by completing a *Clinic Incident Report*, which is available from the Dental Hygiene Office. Reports should be completed and returned as noted above.
CLINICAL INCIDENT REPORT

Date of Incident: ______________________________________________

Location: ___________________________________________________________________________________________

Name of Student(s) Involved: ___________________________________________________________________________

Name of Faculty or Staff Member(s) Reporting Incident: ______________________________________________________

Reason for Report:

☐ Attendance
☐ Patient treatment
☐ Policy/Procedure
☐ Professionalism
☐ Other: ______________________________________________

Comment: ___________________________________________________________________________________________

____________________________________________________________________________________________________

Student Signature: ____________________________________________  Date: ___________________________________

Faculty or Staff Signature: _____________________________________   Date: ___________________________________

DISTRIBUTION:
WHITE – Office of Clinical Education
CANARY – Faculty/Staff
PINK - Student

(Return this form to Director of Predoctoral Clinical Education, DB 230)

Clinical infractions which warrant corrective action may include, but will not be limited to:

- Failure to comply with infection control protocol *
- Improper management of patient records
- Verbal or physical misconduct involving a patient, student, faculty, or staff member
- Use of instruments or materials not approved for use in SD clinics
- Misuse of instruments or materials, or failure to return excess unused materials
- Removal of patient-sensitive information from the School of Dentistry building
- Failure to attend mandatory clinical meetings, exercises, or assignments
- Failure to attend and successfully complete required annual clinical updates
- Violations of an ethical and/or professional nature
- Misuse or inappropriate use of electronic patient record, including downloading or unprotected printing of PHI

Violation of clinic policies will be dealt with on an individual basis. In general, and dependent upon the severity of the infraction, violations will carry one or more academic penalties unless otherwise stated, and not necessarily in the following order:

- Verbal warning
- Written warning
• Required action by the student (i.e., writing of a report and/or presentation of information)
• Suspension from clinical activities for a minimum of one (1) week and for as long as necessary for remediation in the area of the infraction. Students on clinical suspension may continue to access the EPR and view patient records. They may not, however, perform the following:
  1. Schedule, treat, assist or observe patients in clinic
  2. Obtain clinical instruments, equipment or materials from clinical dispensaries

Documentation of violations of clinic policy will be maintained in appropriate University files.

*See UTSD Clinical Manual Section 2.40 – Infection Control Monitoring for additional details regarding infection control infractions.

**Cardinal Infractions**

Cardinal infractions are considered serious in nature. Students face automatic and immediate suspension from clinic, if deemed appropriate, until such reasonable time as a final course of action is determined by the Dental Hygiene Student Evaluation & Promotion Committee. Examples of cardinal infractions include:

• Acts which may seriously endanger the health of a patient, student, faculty or staff member
• Intentional or reckless violation of infection control protocol*
• Verbal and/or physical abuse
• Falsification of a patient record or clinic document
• Abandonment of a patient
• Extreme or multiple acts of unprofessionalism or unethical behavior
• Use of a password or identification card that is not the student’s own

*See UTSD Clinical Manual Section 2.40 – Infection Control Monitoring for additional details regarding infection control infractions.

**ATTENDANCE**

Attendance is expected at all scheduled lectures, clinics, laboratories, seminars, case presentations, rotations, and individual faculty appointments. Attendance is considered one measure of a student's professional conduct. Students who abuse attendance requirements will be considered for academic action. All excused absences must be approved by the Director of the Dental Hygiene Program. To receive an approved excused absence the student must submit appropriate documentation to the Dental Hygiene Office within 3 days upon return to class/clinic. This will allow the student to make up missed exams.

At the discretion of the course director, attendance may be taken through the use of various methods such as sign-in rosters, assigned seating and/or quizzes. Students are expected to be in their seats at the beginning of class. Tardiness or leaving class early may be counted as an absence at the discretion of the course director. Attendance records are official school documents, and thus falsification of these records by any student will constitute a significant act of dishonesty. At the discretion of the course director, attendance may play a part in the course grade as described in the course syllabus.

If a student observes religious holidays that are not official UTHSC-H holidays, he/she should make arrangements for completing any academic work missed as a result of such absence. Students who are absent from classes for the observance of a religious holiday are allowed to take an examination or complete an assignment scheduled for the religious holiday within a reasonable time after the absence. To be eligible to take an examination or complete an assignment scheduled for a religious holiday, the student must inform the instructor of each class to be missed of the planned absence(s) not later than the fifteenth day of the semester. The notification must be in writing and may either be
delivered by the student personally to the instructor(s), with receipt of the notification acknowledged and dated by each instructor, or mailed by certified mail, return requested to each instructor.

In the event of severe weather, UTHSC-H students and employees may call 713-500-9996 to find out if the university is open or go to the website at http://www.uth.tmc.edu. Information will also be available on KPRC radio 950 AM, KTRH radio 740 AM and television Channels 2, 11, 13, 26, 45 and 48. In the case of an unanticipated absence necessitating cancellation of patient appointments, it is the student’s responsibility to notify their patients. For other emergencies please contact UT Police at 713-794-HELP (4357).

PROCEDURES FOR REPORTING ABSENCES

Students are responsible for calling the secretary of the Dental Hygiene Program at 713-500-4084 prior to 8:30 am if unable to attend school all day or part of it. If it is necessary to leave school early for the day, the secretary must be notified. Students are responsible for contacting instructors regarding assignments prior to an absence (if known) or after the absence.

In the case of an unanticipated absence necessitating cancellation of patients, it is the student’s responsibility to notify the patients, clinic coordinator and the department secretary by 8:30 a.m. on the day of the absence. Absences reaching three or more days will require a physician’s letter or other suitable documentation for the absence.

It is the student’s responsibility to contact the course directors of missed classes within five days of return to the school to determine what, if any, arrangements are to be made for missed coursework (examinations, practical exams, etc.). If a scheduled examination, quiz, or required activity will be missed, the course director should also be contacted, preferably before the scheduled start of the examination or required activity.

Anticipated absences, e.g. advanced program interviews, doctor appointments, etc., should be discussed with the appropriate course directors prior to the absence so that arrangements can be made as needed.

ID BADGES

ID badges are required to be visibly worn at all times by students, staff, and faculty when in the Health Science Center. Individuals who are not wearing valid ID badges or are unable to produce them upon request may be asked to leave the building. ID badges are used for entrance into the building, the LRC, and are used to check out books from the Library. The replacement fee for a lost or damaged identification badge is $10.00.

APPEARANCE GUIDELINES

Each individual involved in the Dental Hygiene Program is a reflection of how others view the program and the profession. The attitude, manner, and physical bearing displayed in relationships with patients, colleagues, and the public are a serious responsibility which we must exhibit in an ethical, safe, and professional fashion. The following guidelines are given to assist all persons in understanding and accepting this responsibility.

Efforts toward change and improvement in our professional lives will also greatly impact our personal lives. Our goal is to enjoy good health, be happy, feel confident, and look our best. This will create an aura of confidence and enthusiasm and enhance our interactions, as well as have a transferable effect on others.

Students, faculty, staff, and administration are all responsible for assisting one another in being good influences on the perception of our program to each other and the public. These guidelines are not presented to cover every detail and situation. It is expected that individuals know proper and appropriate behavior, and that they will support it by their own example.
A. **Classroom/Clinic Attire**

Misty green scrubs (as required by the School of Dentistry) are the only attire permitted. A clinic gown must be worn over scrubs while in clinic, radiology, x-ray processing room and patient assessment area.

A clinic gown must be changed after each patient’s (or sooner if visibly soiled) treatment. Clinic gowns must not be worn outside patient treatment areas.

Shoes must be clean leather-like or heavy duty fabric closed toe shoes. Hose or socks must be worn at all times.

Protective glasses with permanent side shields and mask or a face shield and mask will be worn in all clinical situations.

Rings, large or dangling earrings must not be worn when treating patients. Only one earring per ear is permissible and no facial jewelry is allowed. No visible tattoos or body piercing are allowed.

I.D. badges are to be worn on clinic gowns. Badges are to be disinfected when the clinic gown is changed. The badge may also be covered with a plastic barrier cover. The barrier must be changed when the clinic gown is changed.

Writing pens are not to be attached to the outside of the clinic gown.

Gum chewing is **NOT** acceptable in clinic.

**INFRACTIONS OF THE DRESS CODE WILL BE REFLECTED IN THE PROFESSIONALISM / CASE MANAGEMENT DAILY GRADE.**

B. **Personal Hygiene**

Close proximity with patients requires meticulous personal hygiene at all times. It is necessary to bathe daily and use a dependable deodorant/antiperspirant. Strong perfumes or colognes should be avoided.

Hair must be neat and clean. When in clinic attire, hair must be up, pinned securely enough to stay in place away from the face and be styled so as not to fall forward when leaning toward the patient.

Fingernails must be short, clean, and well manicured. Clear fingernail polish is acceptable. The fingernails should not extend beyond the fingertips. This eliminates injury to soft tissue while working in the mouth and allows easy hand cleaning.

Plaque control must be practiced; mouth odors must be controlled. Smoking, alcohol, and spicy food consumption contribute to bad mouth odors. If you have a problem with your breath, brush your teeth and tongue and use a breath spray, mouthwash, or breath mint prior to seating your patient.
EXAMINATIONS

Numerous examinations are given during each course. These examinations serve as a method of instruction and provide both students and instructors the opportunity to evaluate the student’s level of achievement. Final examinations are given at the conclusion of each course, each semester. The final grade in a course may include evaluation of the student in all aspects (didactic, laboratory, or clinical) of the entire course, and failure in any one aspect may result in a failing grade for the entire course.

1. No student is permitted to leave the examination room before completing the examination, unless the instructor’s permission has been granted.
2. No student is permitted to enter the examination room to begin an examination after another student has completed the examination and left the room.
3. Written or paper examinations are to be written in ink or #2 pencils as designated by the instructor. All scantron answer sheets must be marked in #2 pencils.
4. Computer generated examinations may be given online or on computers in testing rooms or labs.
5. All books, purses, cell phones, IPods, laptops and pagers must be left at the front of the room during an examination. Students will not be allowed to have any of these materials at their desks.
6. If you are absent when a major examination will be or was given, it is your responsibility to notify the faculty member. Make-up examinations may be rescheduled after finals have been given.
7. Students may be videotaped while taking exams within the School of Dentistry building.
8. If a student is found cheating, disciplinary action will be taken against the guilty.

ACADEMIC STANDARDS

<table>
<thead>
<tr>
<th>Grading System for Clinic and Clinic Related Classes:</th>
<th>Grading System for Non-Clinic Related Classes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>93 – 100 = A</td>
<td>93 – 100 = A</td>
</tr>
<tr>
<td>84 – 92 = B</td>
<td>84 – 92 = B</td>
</tr>
<tr>
<td>75 – 83 = C</td>
<td>75 – 83 = C</td>
</tr>
<tr>
<td>&lt;75 = F</td>
<td>&lt;70 = F</td>
</tr>
</tbody>
</table>

Passing
Grades for didactic and clinic courses are letter grades. Letters A, B, C, and D will be considered passing, except in pre-clinical and clinical courses where a minimum grade of C will be required. However, an overall average of C (2.00 GPA) must be maintained. Organization officers must maintain a 2.00 GPA to remain in office. An acceptable level of clinical proficiency must be demonstrated in each clinic before the student will be permitted to begin the next clinic.

Failing
A grade of 69 or below designates failing work in non clinic-type courses; a grade of 74 or below designates failing work in clinic-type courses.

Incomplete
A grade of incomplete (I) may be given under rare circumstances and only upon approval by the Director of the Dental Hygiene Program and the Evaluation and Promotion Committee. A grade of incomplete may be either incomplete while passing or incomplete yet failing. A grade of Incomplete yet failing generally results in a Final course grade of F. This is determined by each course director.
GRADE GRIEVANCE PROCEDURE

In attempting to resolve any student grievance regarding grades or evaluations, it is the obligation of the student first to make a serious effort to resolve the matter with the faculty member with whom the grievance originated. Individual faculty members retain primary responsibility for assigning grades and evaluations. The faculty member’s judgment is final unless compelling evidence suggests discrimination, differential treatment or a mistake. If the evidence warrants appeal, the student must submit a request in writing with supporting evidence to the Associate Dean of Academic Affairs who, upon receipt of the request, will review the case and submit a written recommendation to the Dean within 10 working days. The determination of the Dean is final and there is no further appeal.

WARNING, PROBATION, AND DISMISSAL

Warning: Students will receive a letter of warning at mid-semester for unsatisfactory progress in didactic, laboratory, or clinical courses. Students will be expected to show sufficient improvement with a passing grade in those areas of deficiency by the end of that semester to avoid being placed on probation or considered for dismissal. In addition, the student is expected to satisfactorily progress in the other courses in the curriculum.

Probation: Students having a semester GPA of 1.7 or cumulative GPA below 2.00 may be placed on probation if not dismissed from the program. Students who have been placed on probation must show acceptable improvement and satisfy the conditions of the letter placing them on probation within the following semester, or they may be dismissed for academic reasons. Students on probation become ineligible for financial aid and ineligible to hold class or SCADHA offices.

Dismissal: Students will be considered for academic dismissal if they have a cumulative grade point average below 2.00 at the end of the academic year. Students will be considered for academic action that could include dismissal if they have one or more failing course grades in a given semester.

ACADEMIC ACTION AND APPEAL PROCESS

If a student demonstrates the inability to progress either didactically or clinically, he/she will be considered for dismissal from the Dental Hygiene Program by the Student Evaluation and Promotion Committee – Dental Hygiene Subcommittee. The decision will be made by the committee members at a meeting held at the end of the semester. Specific guidelines for academic dismissal are listed above.

A School of Dentistry student may appeal any academic action by an Evaluation and Promotion (“E & P”) subcommittee to the Associate Dean for Academic Affairs, in writing, within three calendar days after receipt of notice of the academic action. The student must provide the Associate Dean for Academic Affairs a “complete” appeal, which includes at least a written statement clearly explaining all rationale for the appeal and any additional documentation the student possesses that the student believes supports the student’s rationale for the appeal.

The Associate Dean for Academic Affairs will refer each complete appeal to an Ad Hoc Appeal Committee (“Appeal Committee”). The Office of the Associate Dean for Academic Affairs will assist by scheduling the meetings of the Appeal Committee.

- The Chair of the Appeal Committee will be selected and appointed by the School of Dentistry Committee on Committees and approved by the Faculty Senate (an alternate Chair will also be selected from among the faculty of the School of Dentistry). The Chair will preside over the Appeal Committee. The length of the Chair’s term will be three years. The alternate will preside over the Appeal Committee in the event that the Chair is unable to attend.

- The Appeal Committee will be made up of the chairs of each of the E & P subcommittees not involved in the academic action being appealed. Vice chairs of the E & P subcommittees may serve in this role in the event a subcommittee Chair is unable to participate. In addition, an additional member of the Appeal Committee will be appointed by the Associate Dean for Academic Affairs and approved by the Faculty Senate.
Committee will be selected by the Associate Dean of Academic Affairs from among School of Dentistry faculty. This member of the Appeal Committee cannot be the student’s faculty advisor or a member of the E & P subcommittee making the decision being appealed.

- Each of the Appeal Committee members will have one vote. In the case of a tie vote, the Chair of the Appeal Committee will vote to break the tie.

The Appeal Committee will review the student’s appeal letter and/or written statement and documentation, if any, submitted by the student, meet with the student, the student’s faculty advisor, the Chair of the E & P subcommittee taking the academic action being appealed, and other individuals at the discretion of the Chair of the Appeal Committee. The Chair of the Appeal Committee shall submit a final recommendation to the Dean within seven calendar days of the final Appeal Committee meeting. The Dean shall consider the recommendation of the Appeal Committee, may review the materials submitted to the Appeal Committee, and may interview other individuals. At his or her discretion, the Dean may meet with the student. The student will be notified of the Dean's decision within 10 calendar days after the Dean's receipt of the Appeal Committee recommendation. The Dean's decision regarding the academic action of the E & P subcommittee is final.

The student, upon written request to and approval in writing from the Associate Dean for Academic Affairs, may continue academic studies while the appeal of an academic action is under review and until the student receives notification of a final decision by the Dean.

If after the appeals process is completed an academic action of dismissal is upheld, a dismissed student must immediately discontinue participating in all School of Dentistry educational activities. All personal belongings must be removed from the School of Dentistry facilities immediately upon following receipt of the final decision of the Dean.

The School of Dentistry Student Evaluation and Promotion Committee consist of four subcommittees: the First Year Dental Student Evaluation and Promotion Subcommittee, the Second Year Dental Student Evaluation and Promotion Subcommittee, the Third/Fourth Year Dental Student Evaluation and Promotion Subcommittee, and the Dental Hygiene Student Evaluation and Promotion Subcommittee. Each subcommittee is lead by a Chair and a vice chair.

UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT HOUSTON
OFFICE OF STUDENT FINANCIAL AID POLICY REGARDING SATISFACTORY PROGRESS

1. Any student on academic probation at the beginning of the academic year will be ineligible for financial aid until removed from such standing.

2. Any student on disciplinary probation will immediately become ineligible for financial aid until removed from such standing.

3. Probation may result from:
   a. a grade point average below 1.70 for any semester.
   b. a cumulative grade point average below 2.0 at any point during the student’s progression through the curriculum.
   c. a grade of “I” (Incomplete) or “F” (Fail) in didactic, laboratory, or clinic.
   d. non-professional conduct as determined by the faculty and/or administration.

4. A student suspended from financial aid eligibility may appeal that status by indicating in writing to the Director of Student Financial Aid and the Dean of the School of Dentistry, or his designee, the existence of mitigating circumstances. Each appeal will be considered on its merit by the Director of Student Financial Aid and the Dean of the School of Dentistry or his designee.

5. Financial aid eligibility will not extend beyond five semesters.

6. Course work in which the student receives a grade of “I” or “F” or in which the student repeats or withdraws will not impact eligibility unless such event imposes probation as indicated in #3 (above).
STUDENT WITHDRAWAL

Any UTSD student who does not intend to continue as a student must officially withdraw, rather than simply stop attending classes and laboratories. Students who decide to withdraw must complete a Checkout Sheet and a Student Exit Form, which are available in the Office of Student Affairs (Room 155). Following an exit interview, the student must secure clearance from the various offices noted on the Checkout Sheet and return it to the Office of Student Affairs. Completion of this process constitutes an official withdrawal.

LEAVE OF ABSENCE

Any student who wishes to stop attending classes and laboratories temporarily, intending to continue studies at a later date, must submit a written request for a leave of absence to the Director of the Dental Hygiene Program and then the Associate Dean for Academic Affairs stating the reason for the request, the length of leave requested, and the date for resuming studies.

The Associate Dean for Academic Affairs will confer, when necessary, with the Associate Dean for Clinical Education regarding the leave request. The Associate Dean for Academic Affairs will review the leave request and the student’s academic record, and will recommend whether the leave should be granted and any conditions which must be met for the student to re-enroll.

For students in academic jeopardy, the Associate Dean for Academic Affairs will refer the leave request to the Student Evaluation and Promotion Committee. The Student Evaluation and Promotion Committee will recommend to the Associate Dean for Academic Affairs whether the leave should be granted and, if so, the point in the curriculum where the student may re-enter and any necessary remediation activities following re-enrollment.

The Associate Dean for Academic Affairs will notify the student, in writing, of the action on the student’s request, including any conditions which must be met by the student, and the expected re-entry date. Following approval by the Associate Dean for Academic Affairs, the student must complete a Checkout Sheet and a Student Exit Form which are available in the Office of Student Affairs (Room 155). The student must secure clearance from the various offices noted on the Checkout Sheet and return it to the Office of Student Affairs. Completion of this process constitutes an official leave of absence.

Students taking a leave of absence will re-enter the curriculum no later than the point at which the leave began, and students may be required to repeat a portion of the curriculum. Students on leave from the School of Dentistry for more than one calendar year may be required to repeat all or a significant portion of the curriculum.
CLINICAL EQUIPMENT INFORMATION

1. Students are responsible for the cleanliness of lockers, laboratory benches, and the laboratory in general, and clinical cubicles to which they are assigned. Physical plant personnel empty waste baskets each evening.
2. Turn off laboratory and cubicle lights, gas, water, and air when not in use.
3. If repairs are needed for your equipment, report them to your instructor and call 500-4441 immediately. DO NOT use it until it has been repaired.
4. Students are responsible for all equipment loaned to them (cavitron tips, sealant light, hand piece, etc.).
5. Any damage or loss will result in payment by the student to repair or replace loan items.

INSTRUMENT RETURN / REPLACEMENT POLICY

The quality of Hu-Friedy instruments is unconditionally guaranteed. Any product that fails as a result of material defect or poor workmanship (not due to abuse) will be repaired or replaced at no charge. The Clinic Coordinators must approve all return and/or replacement of instruments.

All scalers and curettes originally purchased as part of a student kit may be traded-in for a nominal fee when their exchange is accompanied by an order for identical new instruments.

SOLICITATION OF PATIENTS

Students who choose to obtain patients through solicitations/requests or other postings on Craigslist, Facebook (or other social networking sites), etc., may not use the UTHealth and/or the UTHSC-H logos and may not use UTHealth, UTHSC-H, University of Texas or UT School of Dentistry names without first obtaining permission from the Office of Legal Affairs and Office of Public Affairs. In the past, such permission has generally not been granted under circumstances such as these. You may not quote prices for the services in the clinic as part of the solicitation/request for patients.

You may ask persons interested in dental care to contact you, and you may, in your private email response, identify yourself by name and as a UTHealth Dental Hygiene student and then inform those persons that the work is done at the clinic, the clinic sets the fees. You may only identify UTHealth or the School of Dentistry is in your telephone or private email contact, not in the solicitation/request materials/ads/postings, etc.

Violation of these restrictions may subject a student to disciplinary action.

CLINICAL PATIENTS FOR LICENSURE EXAMINATIONS

Students attempting to secure a patient for examination for licensure cannot receive assistance from faculty members in obtaining or assessing the patient. Western Regional Examining Board guidelines state that “WREB staff, state dental boards and licensing agencies of the member states, and the faculty where the examination is held are unable to supply patients”. Selection of an appropriate patient is an important factor in the clinical examination. Patient selection is the candidate's responsibility. Candidates are graded on their ability to accurately determine and effectively interpret patient qualification criteria. This is a graded procedure and an integral part of the examination. Patient qualification is the responsibility of the candidate. Therefore, other professionals should not pre-qualify patients for the examination.
SECTION B

PROFESSIONAL BACKGROUND INFORMATION
OATH OF THE AMERICAN DENTAL HYGIENISTS’ ASSOCIATION

In my practice as a dental hygienist, I affirm my personal and professional commitment to improve the oral health of the public, to advance the art and science of dental hygiene and to promote high standards of quality. I pledge continually to improve my professional knowledge and skills to render a full measure of service to each patient entrusted to my care and to uphold the highest standards of professional competence and personal conduct in the interest of the dental hygiene profession and the public it serves.

STUDENT CHAPTER AMERICAN DENTAL HYGIENISTS’ ASSOCIATION (SCADHA)

Objectives
The objectives of this Organization shall be to support the mission of the American Dental Hygienists’ Association (ADHA). The ADHA’s mission is “to improve the public’s total health by increasing the awareness of and ensuring access to quality oral health care, promoting the highest standards of dental hygiene education, licensure and practice, and representing and promoting the interests of dental hygienists.”

Goals
The goals of the Organization are to:

- Provide entry to professional socialization through participation in the organized activities of the Greater Houston Dental Hygienists’ Society, Bay Area Dental Hygienists’ Society, Texas Dental Hygienists’ Association, and the American Dental Hygienists’ Association.
- Keep abreast of current and future legislation affecting the dental hygiene profession.
- Educate the public using preventive and therapeutic practices on an individual and group basis. Activities may include an annual Community Project at a site and with a population to be determined by the Secretary of the Organization, subject to advisor(s) approval.
- Foster life-long learning through a program of expert speakers, arranged by the Vice-President, subject to approval of the officers of the Organization, and advisor(s).
- Promote the dental hygiene profession to lay persons and the dental community through UT Orientation and Open House activities; observance of National Dental Hygiene Month; GHDHS, BADHS, and TDHA functions.
- Provide for a viable financial base to support the activities of the Organization. These activities will be funded through an annual, non-refundable SCADHA Professional Fee to be determined jointly by the Director of the Dental Hygiene Program and faculty advisor(s) of the Organization. Such fees may be dispersed for, but not limited to, National SCADHA membership, social events, continuing education, GHDHS and BADHS component meetings, and the SCADHA/TDHA Annual Session, awards presentations, and installation of officers, subject to advisor(s) approval.

Officers
The officers of The University of Texas Health Science Center at Houston Student Member Organization shall be a senior SCADHA President, Junior and Senior Class Presidents, Junior and Senior Class/SCADHA Vice Presidents, Junior and Senior Class/SCADHA Secretaries, Junior and Senior SCADHA Treasurers. An ADEA delegate will be elected from the Junior Class.

Qualifications
All dental hygiene students with good academic standing (not on probation) in attendance at The University of Texas Health Science Center at Houston may be elected to serve in an organizational office. The SCADHA President shall be member of the senior class. Each class, junior and senior, shall elect a Class President, SCADHA/Class Vice President, an SCADHA/Class Secretary, an SCADHA/Class Treasurer. The exception to annual elections is Treasurer. The junior class Treasurer will serve a two-year term, which means h/she will serve as the Junior and Senior class Treasurer.
Nominations and Elections
All senior SCADHA class officers shall be elected into office at the April meeting of their junior year. All junior Class Officers shall be elected into office early in September. The following criteria shall be used when electing officers:

Guidelines for all Candidates and Elections
1. Interested parties must declare their candidacy two to three (2-3) weeks in the Office of Student Affairs prior to the election.
2. Prepare and deliver a speech before the members of the organization.
3. Election shall be by secret ballot in the Office of Student Affairs. The candidate receiving the majority of votes cast shall be declared elected.

Tenure of Office
All officers, except Treasurer, shall serve for a one-year term. The treasurer is elected for a 2 year term. The newly elected senior officers shall serve from May until the following May. The term for the junior officers shall be September-May.

Vacancies
In the event of a vacancy in one of the offices, the candidate receiving the second highest number of votes shall fill the vacancy. In the event there was only one candidate for the office, a special election shall be held.

Officer Duties
A. SCADHA President
The duties of the SCADHA President shall be to:
1. Preside at all SCADHA meetings.
2. Call special meetings.
3. Form committees, appoint committee members and set deadlines for committee work to be reported and/or completed.
4. Act as a liaison between the Greater Houston Dental Hygienists’ Society and the SCADHA organization by attending the GHDHS monthly and board meetings.
5. Preside over the following standing committees:
   5.1 Orientation – Organize Orientation Gathering with Advisor(s) and DH Program Director.
   5.2 National Dental Hygiene Month
   5.3 GHDHS Senior Night
   5.4 SCADHA/TDHA Annual Session
6. Submit an annual report of the activities to the SCADHA Advisor.

B. Junior and Senior Class Presidents
The duties of the junior and Senior Class President shall be to:
1. Preside at all Class meetings.
2. Serve on UTSD Student Council (Senior) and sit on the Dean’s Council (Junior and Senior).
3. Preside over the following standing committees:
   3.1 Fundraising
   3.2 Graduation Functions (Senior)
4. Submit an annual report of the activities to the SCADHA Advisor.

C. SCADHA/Class Vice Presidents
The duties of the Junior and Senior SCADHA/Class Vice Presidents shall be to:
1. Preside at all meetings in the absence of the President (SCADHA Senior).
2. Serve on UTSD Student Affairs Committee (SCADHA Senior).
3. Preside over the following standing committees:
3.1 Welcome breakfast (Senior)
3.2 Obtain guest speakers
3.3 Holiday Party (Junior)
3.4 Programs (Senior)

4. In the event that the SCADHA President’s term of office is terminated, the Senior SCADHA Vice President will preside as President for the duration of the office term.

5. Submit an annual report of the activities to the SCADHA Advisor.

D. SCADHA/Class Secretaries
The duties of the Junior and Senior SCADHA/Class Secretaries shall be to:

1. Keep accurate minutes of each Executive Council meeting.
2. Supervise the bulletin board display.
3. Preside over the following standing committees:
   3.1 SCADHA/GHDHS Community Project
   3.2 SCADHA/GHDHS Mentor Program
   3.3 Awards Ceremony Slide Show (not mandatory)
4. Submits application to the ADHA Community Service Award in the spring semester.
5. Keep accurate records of the annual reports of office and committees. Submit an annual report of this office and compile the annual reports of all the Organization’s activities to the SCADHA Advisor.
6. Submit a monthly article of SCADHA activities to the GHDS newsletter (Senior)

E. SCADHA/Treasurers
The duties of the SCADHA/Class Treasurer shall be to:

1. Maintain accurate records of the financial status of the Organization.
2. Collect and disburse SCADHA funds
3. Correspond with ADHA regarding membership.
4. Preside over the following standing committees:
   4.1 Fund-raising
   4.2 Market-Place /Annual Session
5. Submit an annual report of the activities to the SCADHA Advisor.

F. ADEA Delegate
The duties of the ADEA delegate shall be to:

1. Attend the annual meeting.
2. Give an oral presentation of the activities of the annual meeting to the members of the Organization.
3. Submit a written report to the Dental Hygiene Program faculty.
THE DENTAL HYGIENE PROGRAM PIN

The pin of The Dental Hygiene Program took its design in part from the seal of The University of Texas. The University Seal was designed in 1902 based on the Great Seal of the State of Texas. The Dental Hygiene pin was designed in 1957 and was presented to the first graduating class of dental hygienists.

The shape of the pin, a shield, was taken from the center of the University Seal. On the white shield is placed a blue star, blue being symbolic of sincerity. On the star is inscribed “Disciplina Praesidium Civitatis.” This is translated from Latin to mean “Education is the Safeguard of Democracy.” In the center of the star is an open book that represents an institution of learning. Above and to the right and left of the book are a wreath and branches of olive and live oak.

The pin is usually worn on the left lapel of the uniform or lab coat. It is worn only by graduates of The University of Texas School of Dentistry at Houston, Dental Hygiene Program.

Dental Hygiene Pin

The University of Texas Seal

CODE OF PROFESSIONAL ETHICS

The philosophical, practical science of ethics establishes by reason and intelligent observation principles to direct our human conduct. Professional conduct incorporates the knowledge of these principles into practice. The following principles adopted by the 1974 House of Delegates constitute a guide to the responsibilities of the Dental Hygienist.

Each member of the American Dental Hygienists’ Association (ADHA) has the ethical obligation to:

1. Provide oral health care utilizing the highest professional knowledge, judgment, and ability.
2. Serve all patients without discrimination.
3. Hold professional patient relationships in confidence.
4. Utilize every opportunity to increase public understanding of oral health practices.
5. Generate public confidence in members of the dental health professions.
6. Cooperate with all health professions in meeting the health needs of the public.
7. Reorganize and uphold the laws and regulations governing this profession.
8. Participate responsibly in this professional association and uphold its purpose.
9. Maintain professional competence through continuing education.
10. Exchange professional knowledge with other health professions.
11. Represent Dental Hygiene with high standards of personal conduct
AWARDS AND HONORS

Academic Achievement Award
This award is given in recognition of those students maintaining a 4.0 GPA throughout their 2 years in The Dental Hygiene Program.

American Association of Public Health Dentistry
The American Association of Public Health Dentistry (AAPHD) is sponsoring a national recognition award for senior dental hygiene students who have demonstrated a Special Interest / Achievement in Community Dentistry and Dental Public Health.

Colgate Oral Pharmaceutical’s Star Award
The Colgate S.T.A.R. award is offered to graduating dental hygiene students who show excellence and commitment to the hygiene profession by:

1. Demonstrating true dedication to the profession
2. Exhibiting extraordinary compassion in patient care
3. Displaying enthusiasm and follow-through for community service
4. Enjoying the practice of dental hygiene

Greater Houston Dental Hygienists’ Society Outstanding Professional Leadership Award
This annual award is presented by the Greater Houston Dental Hygienists’ Society (GHDHS) to a second year student for outstanding leadership and professional growth potential. The recipient of the award is chosen by the Awards Committee of GHDHS. The Professional Leadership Award recipient will receive a plaque and one-year membership to ADHA. In the spring of each year one student from each school will be selected to receive this award. To receive this award, the student must:

Maintain at least a 2.5 grade point average during the period of dental hygiene academic education. Write a short essay on your post-graduate goals within your professional association. Write a short essay on what it means to you to be a part of your professional organization. List and explain academic achievements and positions in which you have demonstrated leadership, volunteer work, scholarships awarded, special awards or recognition, and the number of times on the Dean’s list, etc. List any professional monthly meetings or activities in which you participated. Applicants will mail their award applications and supporting documentation to the GHDHS Awards Committee Chair.

The Hu-Friedy Clinical Achievement / Golden Scaler Award
The Hu-Friedy Clinic Award is presented by the faculty of the Dental Hygiene Program to a graduating student who excels as a clinician. The recipient will be one whose clinical judgment and technical skills are judged superior by the faculty and who has assumed professional responsibility and commitment to patient service. This award is sponsored by The Hu-Friedy Manufacturing Company. To receive this award, the student should:

1. Receive an “A” in Clinical Practice I, II, III and IV should not receive an incomplete in any clinical course or clinical case study
2. Complete clinic requirements prior to the last day of clinic. This demonstrates organizational skills needed for an excellent clinician.
3. Demonstrate a superior clinical ability in proper instrumentation, polishing and have overall rapport with patients.
4. Show genuine concern about the oral health of all her/his patients and motivate them towards good oral health.
5. Demonstrate professionalism during all phases of patient contact.
6. Organize her/his time and utilize clinic time efficiently.

All students who meet the above criteria are eligible for this award regardless of any previous awards they may have achieved. Overall GPA is not a factor in the selection of this award recipient.

**Johnson & Johnson Dental Hygiene Excellence Award**

This award is presented to a second year student who demonstrates excellent communication skills, excellent patient management skills and has excellent academic performance.

**Letter of Commendation**

The top 10% of the class, having no course deficiencies and recommended by the Dental Hygiene E&P subcommittee will receive a letter of commendation from the Dean of The University of Texas School of Dentistry at Houston.

**Mentor of the Year Award**

The Mentor of the Year Award recognizes a 2nd year dental hygiene student who has unselfishly made a positive contribution of time and counsel towards the growth and development of 1st year dental hygiene students. The candidates(s) are nominated by first year student(s) by filling out an application and submitting it to the SCADHA advisor(s). The Mentor of the Year Award nominees shall be voted on by 1st year dental hygiene students at the end of April. The nominee with the majority of the votes becomes the recipient of the award.

**Procter and Gamble Preventive Dentistry Award**

This award is presented to a second year student who demonstrates a commitment to personalized patient instruction for the maintenance of oral health and prevention of disease. To receive this award the student should:

1. Show genuine concern for the oral health of each patient.
2. Demonstrate exceptional patient education throughout her/his clinic experience.
3. Demonstrate consistently an excellent overall knowledge of preventive oral hygiene aids appropriate to individual patient needs.
4. Display professionalism during all phases of patient contact.

All students who meet the above criteria are eligible for this award regardless of any previous awards they may have received. Overall GPA is not a factor in the selection of this award recipient.

**Sigma Phi Alpha**

Sigma Phi Alpha is the national honor society of the Dental Hygiene profession. Component chapters established by schools of Dental Hygiene are widely distributed throughout the United States. To be elected to Sigma Phi Alpha is an honor and a privilege. The aim of the society is to stimulate high scholarship, professional accomplishment, and greater service to the field of Dental Hygiene. The top ten percent of the senior Dental Hygiene class who rank highest in scholarship and character and who exhibit potential qualities for future growth and attainment shall be elected to membership. This membership shall be limited to 10% of the graduating class and shall be selected from a list composed of the upper 20% of the class. Any student having been on academic probation may not be considered for this award.

**UT Dental Hygienists’ Alumni Association Award**

This award is presented to a second year student by the Dental Hygienists’ Alumni Association of The University of Texas School of Dentistry at Houston, Dental Hygiene Program. The award honors an outstanding dental hygiene student in recognition of his/her contributions to the dental hygiene profession during his/her tenure as a student at the School of Dentistry.
SECTION C

GENERAL CLINIC INFORMATION
OPERATOR / PATIENT POSITIONING

Operator Positioning

The prime objective of formulating operator/patient position guidelines is to maintain the concepts of work simplification, and provide the greatest degree of comfort, safety, and health to both patient and operator. *For the operator it is essential to:*

1. Center body weight on the stool to obtain maximum stability.
2. Keep back straight and shoulders relaxed.
3. Flex at hips so that trunk and thighs form a 60-90 degree angle.
4. Separate knees and feet to width of hips to maintain proper body support,
5. Raise or lower stool to position knees slightly higher than hip level.
6. Position one or both feet flat on the floor with thigh and calf forming an 80-90 degree angle (one foot may be placed on the rail of the stool).
7. Field of operation should be at elbow level with elbows relaxed and close to operator’s sides.
8. Hold head erect with only eyes directed downward.
9. Operator’s face should be no closer than 14-16 inches from patient.
10. Care must be taken to never lean on the patient, patient’s chair, or rest instruments on the patient’s chest.

Patient Positioning

1. Seat the patient with the chair in an upright position.
2. Recline patient so that the patient is in a supine position with head and feet at approximately the same level.
3. A semi supine position may be used to treat the mandibular arch.

Stool to Chair Relationship

Position the stool to permit access to the patient’s mouth from the side-front, the side, or the side-back. The hours of the clock can be used to designate zones of operation. The top of the patient’s head appears at 12:00 with the feet toward 6:00. More than one operator stool position is determined by a number of factors including:

1. operator’s height
2. operator’s arm length
3. patient’s size
4. cubicle size and arrangement
### Patient/Operator Position for Sextants: Right-handed Operator

<table>
<thead>
<tr>
<th>Tooth area &amp; surface</th>
<th>Operator position</th>
<th>Patient position*</th>
<th>Mirror</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mand Rt Fac</td>
<td>8 o’clock</td>
<td>away</td>
<td>retract cheek</td>
</tr>
<tr>
<td>Mand Lft Ling</td>
<td>8 o’clock</td>
<td>away</td>
<td>retract tongue</td>
</tr>
<tr>
<td>Mand Lft Fac</td>
<td>11 o’clock</td>
<td>toward</td>
<td>retract cheek</td>
</tr>
<tr>
<td>Mand Rt Ling (Or 8 o’clock)</td>
<td>11 o’clock</td>
<td>toward</td>
<td>retract tongue</td>
</tr>
<tr>
<td>Max Rt Fac</td>
<td>8 o’clock</td>
<td>away</td>
<td>retract cheek</td>
</tr>
<tr>
<td>Max Lft Ling</td>
<td>8 o’clock</td>
<td>away &amp; up</td>
<td>retract cheek *</td>
</tr>
<tr>
<td>Max Lft Fac</td>
<td>11 o’clock</td>
<td>toward</td>
<td>retract cheek</td>
</tr>
<tr>
<td>Max Rt Ling</td>
<td>11 o’clock</td>
<td>toward</td>
<td>indirect vision &amp; illumination</td>
</tr>
<tr>
<td>Max Ant Fac</td>
<td>11 o’clock</td>
<td>side to side</td>
<td>indirect vision &amp; illumination</td>
</tr>
<tr>
<td>Max Ant Ling</td>
<td>11 o’clock</td>
<td>side to side</td>
<td>indirect vision &amp; illumination</td>
</tr>
<tr>
<td>Ling surfaces-away Mand Fac (&amp;)</td>
<td>11 o’clock</td>
<td>side to side</td>
<td>---------------*</td>
</tr>
<tr>
<td></td>
<td>8 o’clock</td>
<td>side to side</td>
<td>indirect vision &amp; illum. &amp; retract</td>
</tr>
</tbody>
</table>

* Patient position always given in relation to operator
* When mirror not used, left index finger is generally used to aid with lip or cheek retraction.
**Patient/Operator Position for Sextants: Left-handed Operator**

<table>
<thead>
<tr>
<th>Tooth area &amp; surface</th>
<th>Operator position</th>
<th>Patient position*</th>
<th>Mirror*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mand Lft Fac</td>
<td>4 o’clock</td>
<td>forward</td>
<td>retract cheek</td>
</tr>
<tr>
<td>Mand Rt Ling</td>
<td>4 o’clock</td>
<td>away</td>
<td>retract tongue</td>
</tr>
<tr>
<td>Mand Rt Fac</td>
<td>1 o’clock</td>
<td>toward</td>
<td>retract cheek</td>
</tr>
<tr>
<td>Mand Lft Ling</td>
<td>1 o’clock</td>
<td>toward</td>
<td>retract cheek</td>
</tr>
<tr>
<td></td>
<td>(Or 4 o’clock)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Max Lft Fac</td>
<td>4 o’clock</td>
<td>away</td>
<td>retract cheek</td>
</tr>
<tr>
<td>Max Rt Ling</td>
<td>4 o’clock</td>
<td>away &amp; up</td>
<td>---------------*</td>
</tr>
<tr>
<td>Max Rt Fac</td>
<td>1 o’clock</td>
<td>toward</td>
<td>retract cheek</td>
</tr>
<tr>
<td>Max Lft Ling</td>
<td>1 o’clock</td>
<td>toward</td>
<td>indirect vision &amp; illum.</td>
</tr>
<tr>
<td>Max Ant Ling</td>
<td>1 o’clock</td>
<td>side to side</td>
<td>indirect vision &amp; illum.</td>
</tr>
<tr>
<td>Max Ant Fac</td>
<td>1 o’clock</td>
<td>*</td>
<td>---------------*</td>
</tr>
<tr>
<td>Ling-surfaces toward</td>
<td>1 o’clock</td>
<td>side to side</td>
<td>illum. &amp; retraction</td>
</tr>
<tr>
<td>Mand Fac (&amp;)</td>
<td>4 o’clock</td>
<td>side to side</td>
<td>---------------*</td>
</tr>
<tr>
<td>Ling-surfaces toward</td>
<td></td>
<td></td>
<td>illum. &amp; retraction</td>
</tr>
</tbody>
</table>

* Patient position always given in relation to operator.
* When mirror not used, right index finger is generally used to aid with lip.
General Principles

1. Posterior sextants - begin with most posterior tooth, and stop at canine.
2. Anterior sextants - from one canine to the other canine.
3. Individual tooth sequence:
   a. posterior tooth - start on distal line angle to proximal, continue to facial lingual surfaces and finish on mesial.
   b. anterior tooth - start at midline and continue to proximal surface.
4. The intra oral fulcrum should be:
   a. inside the mouth
   b. on the same arch as the tooth being worked on
   c. as close as possible to tooth being worked on
5. The extra oral fulcrum should be a stabilizing point on the chin or cheek.
6. The stroke will be:
   a. a light exploratory stoke
   b. a small, firm working stroke (pull) when removing deposits.

Wrist and arm movements will be used to direct the instrument blade in a vertical direction. The total instrument grasp/hand should pivot from the fulcrum.

Precautions and Variations

In all cases, health is the most important factor and adjustments may be necessary to provide safety and comfort for both patient and operator. To determine correct positioning, the operator must refer to the patient’s medical history for pertinent information.

1. A patient with a history of cardiac or respiratory problems may exhibit difficulty in breathing if the chair is fully reclined.
2. A history of back injury or muscle spasms may require an adjustment in the patient’s position to maintain comfort.
3. For patients with a history of fainting tendency or low blood pressure, ask them to remain seated for a few minutes before getting out of their chair. The sudden movement may cause orthostatic hypotension which causes the patient to become dizzy.
4. When seating an obese patient, use caution when reclining the chair. The chairs are not structured to hold the weight and have been known to break.
5. When seating a pediatric patient, remove the headrest and have the child slide up in the chair until his head is at the top of the backrest.
6. Pregnant patients in their last trimester may be uncomfortable in a fully reclined position.
7. If a patient has a sinus condition with a post-nasal drainage, the chair should be slightly elevated for comfort.
8. During ultrasonic scaling (without an assistant aid in suctioning) the water collects rapidly in the back of the patient’s mouth. Raise the back of the chair slightly for easy water evacuation and patient comfort.
HEALTH HISTORY GUIDELINES

The Patient Interview
When reviewing the health history with a patient who has indicated systematic medical conditions that could be affected by the treatment a dental hygienist would provide, you must be sure to have a thorough understanding of the patient’s medical problem and current status of treatment. The information gained from the questions you ask your patients will help you and your instructor plan the appropriate dental treatment for that patient and determine the need for a medical consultation and/or premedication.

Unacceptable Cases
Consultation with physician may be required in some cases.

You should use the health history questionnaire and patient interview to identify cases that are not acceptable in the dental hygiene clinic. This would include patients who indicate a history of the following:
1. Active herpetic lesion (labial, facial, or oral)
2. Contagious skin conditions (impetigo, ringworm, scabies)
3. Head lice
4. Conjunctivitis
5. Elevated oral temperature (in excess of 100 degrees F)
6. Respiratory infections involving inflamed throat and/or elevated temperature
7. Active tuberculosis
8. Viral hepatitis (active cases only)
9. Cardiovascular accidents, cardiac bypass surgery or stroke within the last six months
10. Unstable angina
11. Other contagious conditions or diseases

Medical Consultation
Patients with the following conditions will require a medical consultation record from his/her physician:
1. Stage II Hypertension
2. Patients with a pacemaker, ascertain whether shielded or unshielded
3. Current anticoagulant therapy
4. Heart surgery other than bypass
5. Other systemic diseases, including cardiac arrhythmias, angina, congestive heart failure, renal and hepatic disease
6. Congenital cardiac defects
7. Surgically constructed systemic-pulmonary shunts
8. Congestive heart failure
9. Diabetes if the patient has not had the condition checked by a physician within the last year
10. Uncontrolled, unstable diabetes mellitus and uncontrolled Addison’s Disease
11. Tuberculosis if the condition has been active during the last five years
12. Currently under cancer treatment (including long-term chemotherapeutic drug therapy)
13. Current or history of anticancer chemotherapy including use of chemotherapy drugs for noncancerous conditions ie. Methotrexate for rheumatoid arthritis
14. Patients who report history of chemotherapy to determine possible use of bisphosphonates
15. Post-irradiation of the mandible or maxilla with greater than 5,000 rads total dose
16. Renal transplant and hemodialysis
17. Glomerulonephritis or other active renal disorder
18. Patient receiving interferon treatment
19. Patients having had a splenectomy
20. Chronic steroid therapy (over 10 days) within the last two years (20 mg./day)
21. Blood diseases, especially acute leukemia, agranulocytosis, granulocytopenia aplastic anemia and agama globulinemia
22. Systemic lupus erythematosus
23. Any immunosuppressed patient such as those with acquired immune deficiency syndrome (AIDS)
24. Pregnant patient requiring anesthesia or any other medication
25. Organ transplant

Premedication with Antibiotics

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

1. Joint replacements (orthopedic prostheses including total hip, knees and elbows). *Given the potential adverse outcomes and cost of treating an infected joint replacement, the American Academy of Orthopedic Surgeons recommends that clinicians consider antibiotic prophylaxis for all total joint replacement patients prior to any invasive procedure that may cause bacteremia.*

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

PROPHYLACTIC ANTIBIOTIC THERAPY

All prescriptions, whether to be given to the patient or obtained from the dispensary and administered chair side, should be entered into the EPR and a paper copy of the prescription generated and signed by a dental faculty. There is not a place on the prescription form for the patient record number, but that information is needed prior to dispensing medication. Refer to Section 3.62 in the DB Clinic Manual for EPR detail. The procedure is as follows:

1. Advise clinical instructor of situation and inform patient of need for antibiotic coverage.
2. Review patient’s medical history for allergies to amoxicillin, clindamycin or cephalexin. (Other types of antibiotics must be prescribed by the patient’s physician.)
4. Review dosages for amoxicillin, clindamycin, or cephalexin.
5. Ask instructor to summon a DDS to write prescriptions.
6. Use code (D09630 Medicaments-oral) for antibiotic therapy, add to treatment plan and have faculty approve. Code D09630 is used for each capsule dispensed. So, if you are giving 2G of Amoxicillin (500 mg. each) then you must have D09630 listed in the EPR/treatment plan 4 times. Each capsule is $6.00 for a total of $24.00 charged to the patient.
7. Take the printed prescription to the first floor dispensary where the medication will be given to you.
8. Administer antibiotic tablets to patient and wait the prescribed time before instrumenting tissues.
9. Note prophylactic antibiotic therapy in treatment history.
10. If a series of appointments is required, an interval of seven days between appointments is necessary to reduce the potential for the emergence of resistant strains of organisms.
DOSAGE FOR PROPHYLACTIC USE OF ANTIBIOTICS

<table>
<thead>
<tr>
<th>Situation</th>
<th>Agent</th>
<th>Regimen – Single Dose 30-60 minutes before procedure</th>
<th>Adults</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral</td>
<td>Amoxicillin</td>
<td></td>
<td>2 gm</td>
<td>50 mg/kg</td>
</tr>
<tr>
<td>Unable to take oral medication</td>
<td>Ampicillin OR Cefazolin or ceftriaxone</td>
<td>2 g IM or IV* OR 1 g IM or IV*</td>
<td>50 mg/kg IM or IV</td>
<td>50 mg/kg IM or IV</td>
</tr>
<tr>
<td>Allergic to penicillins or ampicillin Oral</td>
<td>Cephalaxin**† OR Clindamycin OR Azithromycin or clarithromycin</td>
<td>2 g OR 600 mg OR 500 mg</td>
<td>50 mg/kg OR 20 mg/kg OR 15 mg/kg</td>
<td></td>
</tr>
<tr>
<td>Allergic to penicillins or ampicillin and unable to take oral medication</td>
<td>Cefazolin or ceftriaxone OR Clindamycin</td>
<td>1 g IM or IV OR 600 mg IM or IV</td>
<td>50 mg/kg IM or IV OR 20 mg/kg IM or IV</td>
<td></td>
</tr>
</tbody>
</table>

*IM – intramuscular; IV – intravenous.
**or other first or second generation oral cephalosporin in equivalent adult or pediatric dosage.
†Cephalosporins should not be used in an individual with a history of anaphylaxis, angioedema, or urticaria with penicillins or ampicillin

SIGNIFICANT HYPERTENSION IN CHILDREN

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

GUIDELINES FOR MANAGEMENT OF PATIENTS WITH ELEVATED BLOOD PRESSURE

The University of Texas School of Dentistry at Houston Clinics

CLASSIFICATION OF BLOOD PRESSURE FOR ADULTS AGE 18 & OLDER*

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

* Not taking antihypertensive drugs and not acutely ill. When systolic and diastolic blood pressures fall into different categories, the higher category should be selected to classify the individual’s blood pressure status. For example, 160/92 mm Hg should be classified as stage 2 hypertension, and 174/120 mm Hg should be classified as stage 3 hypertension. Isolated systolic hypertension is defined as SBP of 140 mm Hg or greater and DBP below 90 mm Hg and staged appropriately (e.g., 170/82 mm Hg is defined as stage 2 isolated systolic hypertension). In addition to classifying stages of hypertension on the basis of average blood pressure levels, clinicians should specify presence or absence of target organ disease and additional risk factors. This specificity is important for risk classification and treatment.

† Based on the average of two or more readings taken at each of two or more visits after an initial screening.
DETERMINING RISK/PROVIDING DENTAL TREATMENT

Normal/High Normal

<table>
<thead>
<tr>
<th>Systolic 139 or lower or Diastolic 89 or lower</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. No contraindications to elective dental treatment.</td>
</tr>
</tbody>
</table>

Stage 1 HTN

<table>
<thead>
<tr>
<th>Systolic 140-159 or Diastolic 90 – 99</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Retake and confirm blood pressure.</td>
</tr>
<tr>
<td>3. Monitor blood pressure during appointment.</td>
</tr>
</tbody>
</table>

Stage 2 HTN

<table>
<thead>
<tr>
<th>Systolic 160 or higher or Diastolic 100 or higher</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Retake and confirm blood pressure.</td>
</tr>
<tr>
<td>2. Emergency or non-invasive elective treatment only.</td>
</tr>
<tr>
<td>3. Monitor blood pressure during appointment.</td>
</tr>
<tr>
<td>4. Refer patient to physician for medical evaluation.</td>
</tr>
<tr>
<td>5. Medical consult required prior to elective dental treatment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Systolic &gt; 210 or Diastolic &gt; 120</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Retake and confirm with alternative device, such as mercury-manometer type sphygmamamometer.</td>
</tr>
<tr>
<td>2. If blood pressure is unchanged, consider immediate referral of the patient to a physician or emergency room for evaluation.</td>
</tr>
<tr>
<td>3. No treatment of any type should be undertaken.</td>
</tr>
</tbody>
</table>

AN EASY PHYSICAL SYSTEM FOR MEDICAL ALERT

The University of Texas School of Dentistry at Houston Department of Diagnostic Sciences has adopted D.F. McCarthy's Physical Evaluation System to assist in categorizing dental patients from the standpoint of medical risk-factor orientation. It is easily adaptable to the needs of private practice.

"The purpose of this system is to quickly and easily place each patient in an appropriate medical-risk category and to thereby provide dental therapy in comfort and relative safety. During the original physical evaluation the patient is placed in one of our four physical status classes devised by the American Society of Anesthesiologists. The physical status classification then serves as a helpful guide to the level of dental therapy, suggested management, and treatment modification for the medically compromised patient."

The following table shows the ASA system on the left; on the right are general considerations for dental therapy modification. The system is very valuable in determining relative risk prior to dental treatment and the possible need for treatment modification.

<table>
<thead>
<tr>
<th>ASA Physical Status Classification</th>
<th>Therapy Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. A normal healthy patient.</td>
<td>None (stress reduction as indicated)</td>
</tr>
<tr>
<td>II. A patient with mild to moderate systemic disease.</td>
<td>Possible stress reduction and other modification as indicated.</td>
</tr>
<tr>
<td>III. A patient with severe systemic disease that limits activity but is not incapacitating.</td>
<td>Possible strict modifications; stress reduction and medical consultation prioritized.</td>
</tr>
<tr>
<td>IV. A patient with severe systemic disease that limits activity and is a constant threat of life.</td>
<td>Minimal emergency care in office; hospitalize for complicated treatment; medical consultation urged.</td>
</tr>
<tr>
<td>V. A moribund patient not expected to survive 24 hours with or without operation.</td>
<td>Treatment in the hospital is limited to life support only, e.g. airway and hemorrhage management.</td>
</tr>
</tbody>
</table>
Classification Guidelines
(ASA classifications are discussed in the listed references.)
Brief examples, any one of which calls for ASA Class 2 placement, are as follows: present history of allergic rhinitis (hay fever), history of any drugs allergy or hypersensitivity, history of Hepatitis B that is currently antigen positive, history of arrested pulmonary tuberculosis without disability history of corrected congenital heart disease without disability, history of chronic glomerulonephritis or pylonephritis without disability, history of controlled diabetes mellitus without disability, history of controlled chronic glaucoma history of possible attitudinal problems with health care (as negative experiences with prior practitioners), history of behavioral problems with health care (as moderate to extreme anxiety), mild to moderate hypertension, anemia, extremes of age and chronic bronchitis.

Many of the preceding diseases or conditions could become Class 3 or 4, depending upon the history and physical examination. Some doctors drop the patient one class if there are two or more diseases, none of which is disabling, for example, a patient with allergic rhinitis, penicillin allergy, and chronic glomerulonephritis could be placed in ASA Class 3 rather than Class 2. This is a judgment decision and is based upon your perception of physical status related to treatment stresses. Other examples of ASA Class 3 included severe diabetes, moderate to severe pulmonary disease, angina, healed myocardial infarction, blood dyscrasias and moderate to severe hypertension.
PHYSICIANS DESK REFERENCE (PDR)

Medication prescribed by the physician as well as over the counter drugs can affect the general health status and oral tissues of the patient. The Health History Questionnaire denotes a section to that effect. Patients sometimes know the name of the drugs or bring the drugs with them to the appointment. If any question arises, consult the physician and determine the exact drugs (non-prescription, as well as prescription) being taken and dosage.

The Physician’s Desk Reference (PDR) aids in the identification of such medications. A copy of the PDR is available for your use in the Dental Hygiene clinic and in the secretary’s office. The PDR is an annual publication that makes available essential prescription information on major pharmaceutical products. It is divided into five sections, three of which are color coded to facilitate locating information on the patient’s medication.

The three color coded sections (pink, blue, and yellow, respectively) are cross references for prescription drugs according to manufacturer and brand name, particular drug categories, and generic and chemical names. Drug names are classified into two broad categories: brand names and generic names. Drug names that are controlled by one or more business firms and are registered trademarks are called “brand names”. Drug names which any business firm might use are called "generic names". For example: Procaine is a generic name that any distributor may use to describe the chemical substance B-diethylaminoethyl -p- amino benzoate. This is the chemical composition and therefore, the “chemical name”. Novacain is the registered trademark or brand name that may be used only by the owners of that mark to describe the same substance.

When information about a particular drug is needed, simply locate the name of that drug in one of the color coded sections. This will refer you to a page in the Production Information Section where detailed information about the drug in question is found.

There will be times when a patient will not know the name of his medication, but will have it with him at the time of his appointment. The medication may not be in the original container. In order to identify the drug, you may look in the Product Information Section where pictures of many different drugs are found. There reproductions show the actual size, shape, and color of the drugs plus the manufacturer’s name, brand name, generic name, and dosage forms. With this information, you may locate the drug in one of the color=coded sections which will refer you to additional information in the Product Information Section.

The last section in the PDR is the Product Information Section. This is an alphabetical listing by manufacturer of over 2,500 pharmaceuticals. Each drug is fully described as to composition, action and uses, administration and dosage, contraindications, precautions, side effects, and form in which supplied.

The student should turn to the page (with a sticky note) for each drug the patient takes. The student will fill out an index card on any drug (prescribed or over the counter) that a patient currently takes if not available in the drug reference book. The card should include the name- and type of drug, indications, and any contraindications. In the event that contraindications are not listed, indicate the warnings listed for that particular drug.

EXAMPLES:

| ERYC – erythromycin-antibiotic |
| Indication for use: in children and adults for treatment of upper and lower respiratory infections; Pertussis; Diphtheria Erythrosma; Intestinal amebiosis; Primary Syphilis; Legionnaires disease. |
| Contraindications - ERYC is contraindicated in patients with known hypersensitivity to this antibiotic. |

| Afrin – Nasal Spray – antihistamine |
| Warnings: Do not exceed recommended dosage because symptoms may occur such as burning, stinging or nasal discharge. Do not use this product for more than 3 days. |
The PDR for Non-prescription Drugs and Herbal Medications parallels the PDR for prescription drugs in that the information sections are set up in the same way. It is also divided into five sections, three of which are color coded to aid in locating information on over the counter drugs.

The PDR for Herbal Medicines provide details on more than 600 herbal medications. Because herbal products are not subject to the same safety and efficacy testing that the Food and Drug Administration requires for prescription drugs, health care professionals often have little, if any, information on which to base their recommendations about herbal medicine.

Entries in the PDR for Herbal Medicines include the scientific and common names of herbs, along with information on indications, contraindications, dosages, and literature citations.

PREGNANCY

First trimester: plaque control, oral hygiene instruction, scaling, polishing, avoid elective treatment; urgent care only
Second trimester: plaque control, oral hygiene instruction, scaling, polishing, routine dental prophylaxis.
Third trimester: plaque control, oral hygiene instruction, scaling, polishing, routine dental prophylaxis.
Radiographs: avoid during pregnancy.

If anesthesia is required, consult with attending dentist.


MEDICAL CONSULTATION RECORD: STUDENT INSTRUCTIONS

The upper portion of the form is to be completed by the student with assistance from the attending faculty.

The goal of physical evaluation by the dental team is to determine the ability of the patient to tolerate a specific procedure or series of treatments – NOT to diagnose and treat medical problems. The dental team should propose a tentative treatment plan prior to consultation with the physician. The physician will be asked to evaluate the patient, and either endorses the proposed treatment, or make recommendations for treatment modifications.

The preferred sequence of events:

1. Physical evaluation by the dental team will determine whether or not medical consultation is indicated. If doubt exists, consultation with the physician is recommended.

2. The upper portion of the consultation form will be completed by the student with assistance from the attending faculty. The form must be legibly hand written.

3. Enter pertinent information only on the upper portion of the consultation form:
   - Brief introduction of patient.
   - Medical problem of concern
   - Proposed dental treatment-including anesthesia, pre-medication, and other pertinent information.
   Request that the physician evaluate the patient and render an opinion regarding the patient’s ability to tolerate the proposed treatment. Ask for his concurrence, or his recommendations for any modification in the proposed treatment.
4. Make an entry in the Treatment History in the EPR, which documents the consultation request, and include the physician’s name, address, and telephone number if available.

5. The form is to be legibly handwritten (not typewritten), signed by the student, patient, and attending faculty, and the white and yellow copies given directly to the patient for delivery to the physician or mailed/faxed by Dental Records. The pink copy of the consult request should be taken to the Records room and scanned into the patient’s electronic record.

6. Periodically check the “Attachments” tab in the EPR to see if the consultation report has been returned and scanned into the record. Continue with patient treatment according to physician’s recommendations.

Signed by student and faculty.
CONSULTATION REPORT

Name of Physician | REQUEST | UTDB
---|---|---
To | Department/Program | School of Dental Hygiene
Student's Name | Department/Program | 
Date | Today | Patient | A. Patient | Patient Record #: 175063 | 3-19-60
Reason for Request:

This 47 year old female, who is presently under your care, states that she is currently taking an anticoagulant medication. Her proposed dental treatment includes scaling and root planing at 4 separate appts. using local anesthesia. Because this procedure produces bleeding we need to know your recommendation(s) for the management of this medication and for this procedure.

Student Signature | Your signature | Faculty Signature | A.N. Instructor

AUTHORIZATION

I authorize release of the requested medical and/or dental information for this consultation.

Patient Signature | Pt's. signature | Date | Today's date

REPORT

Signature and Title | Date
Phone Number

DISTRIBUTION:
WHITE - Consultant (File in patient record upon receipt)
CANARY - Patient Record
PINK - Dental Records Department

Please Return To: University of Texas Dental Branch
Patient Services
6516 M.D. Anderson Blvd., Ste 156
Houston, TX 77030
(713) 500-4111
(713) 500-4322 (FAX)
This 45-year-old male under your care has a blood pressure reading of 135/105. He currently takes no medication. His proposed dental treatment includes 4 quadrants of scaling and root planing with possible anesthesia containing epinephrine at separate appointments. Please evaluate blood pressure and make recommendations regarding patient management.
ABCD SYSTEM OF RECOGNIZING MELANOMA

A  Asymmetry, because of its uncontrolled growth pattern.
B  Border irregularity, often with notching.
C  Color variegation, which varies from shades of brown to black, white, red, and blue depending on the amount and depth of melanin pigmentation.
D  Diameter greater than 6 mm (which is the diameter of a pencil eraser).

GINGIVAL DESCRIPTION

Descriptive Terminology
The degree of severity and distribution of a change should be noted when examining gingiva. When a deviation from normal affects a single area, it can be designated by the number of the adjacent tooth and the surface of the tissue involved, namely, facial, lingual, mesial, or distal.

A. Severity: Severity is expressed as slight, moderate, or severe.

B. Distribution
Terms used for describing distribution are:

1. **Localized**
   This means that the gingiva is involved only around a single tooth or a specific group of teeth.

2. **Generalized**
   This means that the gingiva is involved around all or nearly all of the teeth throughout the mouth. A condition may also be generalized throughout a single arch.

3. **Marginal**
   A change that involves the free or marginal gingiva. This is specified as either localized or generalized.

4. **Papillary**
   A change that involves a papilla but not the rest of the free gingiva around a tooth. A papillary change may be localized or generalized.

5. **Diffuse**
   When the attached gingiva is involved as well as the free gingiva, it is referred to as a diffuse change. A diffuse condition is most frequently localized, rarely generalized.

6. **Chronic**
   Comes on slowly, long duration, painless unless complicated by acute or sub acute exacerbations.

7. **Acute**
   Painful condition that comes on suddenly and is of short duration.

C. Evaluation

1. **Color**
   Describe as light, regular or dark pink, (normal), red (erythema), bluish red (magenta), coral-pink or other color variations. May include normal pigmentation considering patient.

2. **Form**
   Contour (both marginal and papillary), knife-edge (normal), rounded, blunted, cratered, flattened, bulbous, clefting, festoon.

3. **Density**
   Describe as stippled (normal), fibrotic, spongy, smooth (shiny edematous).

4. **Attachment**
   Note generalized pocket depth and any localized deep pockets.

5. **Bleeding**
   Note any upon probing and describe as slight, moderate, or severe.
CRITERIA FOR DH CASE CLASSIFICATION

The conditions considered in classifying the difficulty of a case treated in the Dental Hygiene Clinic include:

A. The presence and amount of disease of the periodontium.  
The descriptions on the tables on page C-17 through C-20 are to be used as guidelines when classifying the periodontal status of the patient.

B. The presence and amount of calcified and non-calcified deposits.  
The descriptions on page C-21 are to be used as guidelines when classifying the calculus case classification of the patient.

The amount of plaque and the type of stain are important in determining the difficulty of their removal and can also be factors contributing to gingival irritation and inflammation. These deposits will be classified in the following manner:

- **O** No plaque or stain present.
- **L** Light plaque and stain (e.g. light tea, coffee or tobacco stain; green or yellow stain associated with plaque).
- **M** Medium plaque and stain. Plaque often covers up to 2/3 of the crown with the heaviest amount along the cervical 1/3 of the tooth. Medium amount of brown or black line stain may be present.
- **H** Heavy plaque and heavy brown, pipe stain or black line stain is generalized on the teeth.

The classification of the patient is determined by the amount and location of calculus and the number of teeth. The difficulty of the case may also be a determining factor, (i.e. tenacity of the calculus extensive root planing and periodontal involvement). The classifications are as follows:

- **Class 0**  No calculus present.
- **Class I** Little calculus present. Supra and/or sub marginal calculus tends to be localized to the mandibular anterior teeth and buccals of the maxillary molars.
- **Class II** Light to medium calculus present. Supra and/or submarginal calculus is located on the mandibular anterior teeth and the buccals of the maxillary molars. Supra and/or sub marginal calculus must be detectable in other localized areas.
- **Class III (Light)** Light to medium calculus present. Supra and/or sub marginal calculus is located on the mandibular anterior teeth and the buccals of the maxillary molars. Generalized supra and/or sub marginal calculus is detectable in the interproximal posterior region. Sub-marginal deposits in the maxillary anterior region may also be an indicator. 2 quads of light class III = 1 quad of heavy.
- **Class III** Moderate to Heavy calculus present. Supra and/or sub marginal calculus is located on the mandibular anterior teeth and the buccals of the maxillary molars. Generalized supra and/or sub marginal calculus is detectable in the interproximal posterior areas. Sub marginal deposits in the maxillary anterior region may also be an indicator.
- **Class IV** Heavy calculus present. Supra and sub marginal calculus is generalized and may form continuous rings around teeth.
- **Class V** (Pre-surgical) Heavy calculus is generalized with pockets of 6mm or more. Marked mobility to horizontal and vertical forces and tooth migration are present. This classification has been established for cases which are complicated by extreme sensitivity, multiple severely decayed teeth, periapical abscesses, advanced periodontitis or any other condition which, in the clinical judgment of the instructor, increases the difficulty of the case. Those patients will receive a pre-surgical scaling for a limited number of appointments, and the student will receive appropriate credit for a Class III requirement.
**Classification of Gingival and Periodontal Disease**

**DENTAL PLAQUE-INDUCED GINGIVAL DISEASES**

The following is a classification for dental plaque-induced gingival diseases:

I. **Gingival Diseases** (first category in *The Periodontal Classification System*)
   
   A. **Dental Plaque-Induced Gingival Diseases**
      
      1. Gingivitis associated with dental plaque only
         1.1. without other local contributing factors
         1.2. with local contributing factors
      2. Gingival diseases modified by systemic factors
         2.1. associated with the endocrine system
            a. puberty-associated gingivitis
            b. menstrual cycle-associated gingivitis
            c. pregnancy-associated
               i. gingivitis
               ii. pyogenic granuloma
            d. diabetes mellitus-associated gingivitis
         2.2. associated with blood dyscrasias
            a. leukemia-associated gingivitis
            b. other
      3. Gingival diseases modified by medications
         3.1. drug-influenced gingival diseases
            a. drug-influenced gingival enlargements
            b. drug-influenced gingivitis
               i. oral contraceptive-associated gingivitis
               ii. other
      4. Gingival diseases modified by malnutrition
         4.1. ascorbic acid-deficiency gingivitis
         4.2. other

The following working definitions for subcategories of, or items related to, dental plaque-induced gingival diseases were developed:

- **Ascorbic acid-deficiency gingivitis.** Inflammatory response of the gingiva to plaque aggravated by chronically low ascorbic acid levels.
- **Blood dyscrasia-associated gingivitis.** Gingivitis associated with abnormal function or number of blood cells.
- **Diabetes-associated gingivitis.** Inflammatory response of the gingiva to plaque which is aggravated by poorly controlled plasma glucose levels.
- **Drug-induced gingival enlargement.** Gingival enlargements resulting in whole or in part from systemic drug use.
- **Drug-influenced gingivitis.** Pronounced inflammatory response of the gingiva to plaque and drug(s).
- **Gingival diseases.** The pattern of observable signs and symptoms of different disease entities that are localized to the gingiva.
- **Leukemia-associated gingivitis.** Pronounced inflammatory response of the gingiva to plaque resulting in increased bleeding and enlargement subsequent to leukemia.
- **Local contributing factor.** A local feature that may influence the presentation of the disease, such as an overhanging restoration.
- **Menstrual cycle-associated gingivitis.** Pronounced inflammatory response of the gingiva to plaque and hormones immediately prior to ovulation.
- **Oral contraceptive-associated gingivitis.** Pronounced inflammatory response of the gingiva to plaque and oral contraceptives.
- **Plaque-induced gingivitis.** An inflammation of the gingiva resulting from dental plaque.
- **Pregnancy-associated gingivitis.** Pronounced inflammatory response of the gingiva to dental plaque and hormones usually occurring during the second and third trimesters of pregnancy.
- **Pregnancy-associated pyogenic granuloma.** A localized, painless, protuberant, exophytic gingival mass that is attached by a sessile or pedunculated base from the gingival margin or more commonly from an interproximal space resulting from dental plaque and hormones during pregnancy.
- **Puberty-associated gingivitis.** Pronounced inflammatory response of gingiva to dental plaque and hormones during the circumpubertal period.

### Forms of Periodontitis

**Chronic Periodontitis.**
An infectious disease resulting in inflammation within the supporting tissues of the teeth, progressive attachment, and bone loss. It is characterized by pocket formation and/or gingival recession. It is recognized as the most frequently occurring form of periodontitis. Its onset may be at any age, but is most commonly detected in adults. The prevalence and severity of the disease increases with age.

It may affect a variable number of teeth and it has variable rates of progression. Chronic periodontitis is initiated and sustained by bacterial plaque, but host defense mechanisms play an integral role in its pathogenesis. The progressive nature of the disease can only be confirmed by repeated examinations. It is reasonable to assume that the disease will progress further if treatment is not provided.

The following is a simple classification for this most common form of periodontitis:

**II. Chronic Periodontitis (second category in The Periodontal Classification System)**

A. Localized

B. Generalized

Some of the clinical features and characteristics of Chronic Periodontitis:
- Most prevalent in adults, but can occur in children and adolescents
- Amount of destruction is consistent with the presence of local factors
- Sub gingival calculus is a frequent finding
- Associated with a variable microbial pattern
- Slow to moderate rate of progression, but may have periods of rapid progression
- Can be further classified on the basis of extent and severity
- Can be associated with local predisposing factors (e.g., tooth-related or iatrogenic factors)
- May be modified by and/or associated with systemic diseases (e.g., diabetes mellitus, HIV infection)
- Can be modified by factors other than systemic disease such as cigarette smoking and emotional stress.

Chronic periodontitis can be further characterized by **extent** and **severity**. **Extent** is the number of sites involved and can be described as localized or generalized.
As a general guide, extent can be characterized as localized if ≤30% of the sites are affected and generalized if >30% of the sites are affected. Severity can be described for the entire dentition or for individual teeth and sites. As a general guide, severity can be categorized on the basis of the amount of clinical attachment loss (CAL) as follows: 

**Slight** = 1 to 2 mm CAL, **Moderate** = 3 to 4 mm CAL, and **Severe** = ≥5 mm CAL.

*Treatment is not based on attachment loss alone. Annals of Periodontology; Volume 4 • Number 1 • December 1999*

**PERIODONTAL CHART**

1. **BASELINE**  
   A baseline reading is completed on each new patient 18 years of age or older. A full perio charting is done according to patient need. For example radiographic evidence of aggressive periodontitis in a 15 year old.
   
   a. Using the EPR, probe the entire mouth and record all probing depths in the boxes corresponding to the tooth probed in the row marked PD (probe depths) ... total 6 sites per tooth( 3 on Facial and 3 on Lingual)
   
   b. Mark all bleeding upon probing sites in the row marked BOP(bleed on probe) Use Y for yes and N for no
   
   c. Measure the free gingival margin for each tooth and put numerical value for each tooth in boxes in the row marked FGM-CEJ NOTE: EPR will calculate the CAL( Clinical Attachment Level) and automatically place in the CAL row.
   
   d. Tooth mobility should be recorded in the row of boxes marked MOB using the following classification system( one number pr tooth):
      
      - **Class 0 (0)** No mobility.
      - **Class I (1)** Horizontal movement less than 1mm.
      - **Class II (2)** Horizontal movement greater than 1mm.
      - **Class III (3)** Horizontal movement greater than 1mm and depressible.
   
   e. Using a Nabors Probe, furcation involvement is usually classified by the amount of a furcation that has been exposed by periodontal bone destruction and is recorded in the FURC row of boxes. Note: EPR will not allow furcations to be noted in areas where there are no furcations
      
      - **Class I** Early, beginning involvement. A probe can enter the furcation area and the anatomy of the roots on either side can be felt by moving the probe from side to side.
      - **Class II** Moderate involvement. Bone has been destroyed to an extent that permits a probe to enter the furcation area but not to pass through between the roots.
      - **Class III** Severe involvement. A probe can be passed between the roots through the entire furcation.
      - **Class IV** Severe involvement. A probe can be passed between the roots through the entire furcation. The furcation is clearly visible upon clinical examination.

2. **PERIO RE EVAL**  
   probe 6 areas on all SRP quads and record 6 FGM-CEJ measurements on each tooth in any SPR quad, and re-probe any readings of 4mm or greater on all other quads. Note changes in the free gingival margin in quads that did not receive SRP. Note bleeding points and mobility improvements.

3. **RECARE**  
   New perio chart will be done every 12 months. Shorter intervals than 12 months probe all areas over 4mm and note changes. Complete perio charting may be indicated every 3 months according to the periodontal status of the patient. This would be completed at your instructor’s discretion.
CARIES DIAGNOSTIC CRITERIA

Caries detection is not something that is always definite and easily decided. Carious lesions differ greatly. At one end of the spectrum there is the grossly decayed tooth which is easily determined to be carious. At the other end of the spectrum there is the area in an occlusal pit which may or may not show obvious signs of caries. It is at this end of the spectrum where a judgment must be made based on the following criteria:

A. Pit and fissures on occlusal, facial and lingual surfaces.
   1. These areas are carious when the explorer “catches” after insertion with moderate to firm pressure and when the “catch” is accompanied by one or more of the following signs of decay.
      a. softness at the base of the area.
      b. opacity adjacent to the area provides evidence of undermining or demineralization.
      c. softening enamel adjacent to the area which may be scraped away with the explorer.

B. Smooth areas on facial or lingual surfaces.
   1. These areas are carious if they are etched or if there is a white spot as evidence of subsurface demineralization and if the area is found to be soft by:
      a. penetration with the explorer.
      b. scraping away the enamel with the explorer.

NOTE: These areas should be diagnosed as sound when there is apparent evidence of demineralization, but no evidence of softness.

C. Proximal surfaces
   1. For areas exposed to direct visual and tactile examination, the criteria are the same as for Section B.
   2. For areas exposed to direct visual and tactile examination, any of the following criteria may serve as an indication of decay:
      a. Visual: if a marginal ridge shows opacity as evidence of undermined enamel, the proximal surface beneath that marginal ridge is carious.
      b. Tactile: a discontinuity of the enamel in which an explorer will “catch” is carious if there is softness.
      c. Radiographic: a definite radiolucency, which indicates a break in the continuity of the proximal enamel and DEJ is carious. If the radiolucency does not extend through the DEJ, the lesion may be incipient or arrested.
      d. Transillumination: if a bright light directly labiolingually at a tooth produces a characteristic shadow or loss of translucency on the proximal surface, it is carious.

A few general considerations also should be listed relative to these written criteria:

1. Stain or pigmentation alone should not be regarded as evidence of decay as either can occur on sound teeth. Ask yourself: is the lesion soft and light brownish, or hard and dark pigmented?

2. Each subject should be examined in the same manner. An examiner, for example, should avoid temptation to examine a subject more carefully that appears highly susceptible to dental caries and a person less thoroughly who is relatively free of apparent decay.

Any written definitions of diagnostic criteria are bound to be interpreted and applied differently by different examiners. Some variation in observational procedures, however, may add strength to one’s total knowledge about an agent or a procedure, particularly when the results of different clinical investigators agree.
PEDODONTIC CHART

Clinical Charting

(Diagram caries, restorations, fractures and other conditions detected during examination)

Extracted/missing teeth (cross out in black)
Erupted teeth (circle in black)
Restorations (black)
Sealant in place (black S)
Radiographic pathology (red)
Fractured teeth (red)
Deep pits and fissures (red S)
Caries (red)
OCCLUSION–PATIENT EVALUATION

Normal (Ideal) Occlusion

Molar relationship: mesiobuccal cusp of maxillary first permanent molar occludes with the buccal groove of the mandibular first permanent molar.

Malocclusion

Class I: Neutroclusion
Molar relationship same as Normal, with malposition of individual teeth or groups of teeth.

Class II: Distocclusion
Molar relationship: buccal groove of the mandibular first permanent molar is distal to the mesiobuccal cusp of the maxillary first permanent molar by at least the width of a premolar.

Division 1: mandible is retruded on all maxillary incisors are protruded.

Division 2: mandible is retruded and one or more maxillary incisors are retruded.

Class III: Mesiocclusion
Molar relationship: buccal groove of the mandibular first permanent molar is mesial to the mesiobuccal cusp of the maxillary first permanent molar by at least the width of a premolar.

Note tendencies and classify both right and left sides of the mouth.
Electronic Health Record - Tx History

512193
McKitrick Patient
Manlin Account For Comc
Account Balance = 0.00
Houston, TX
77030
(713) 111-1111

Date  Provider  User  Code   Site  Sys  Seq  Description
Jun 9/11  D.McKitrick  NOTE  0

D: DHx: Clinical findings are consistent with a preliminary dental hygiene diagnosis of gingivitis (for example pending radiographic interpretation). The diagnosis will be finalized and recorded in the patient record when the radiographs are available and have been interpreted by dental faculty. Comprehensive exam (or Periodic exam if indicated) and plaque control orientation.
H: Reviewed medical history with patient. No contraindications to treatment. Vitalis: BP=128/80; P=85; R=13
O: O’Leary score 43%. Gingival description form completed. Prophy class 2, peri type slight. Patient informed of the importance of oral health, discussed gingivitis. Taught Bass method and shown the use of a Praxabrush.
T: Performed extra and intra oral exam. Dental and peri charted entire mouth. The treatment was discussed with the patient and consent form signed by patient on 8/9/11. Patient informed it will take 3 appointments to complete treatment. Scaled Q1 & Q4 with hand instruments to completion (if quads were completed). Post Qp instructions. Rx non-aspirin analgesic PRN for discomfort and warm salt water rinses due to moderate bleeding.
E: Patient tolerated procedure well. Patient acknowledged need for oral hygiene, especially in the lower anterior.
N: Re-evaluate Q1 & Q4 for residual calculus. Start scaling Q2 & Q3.

***THIS IS AN EXAMPLE OF A SUBSEQUENT APPOINTMENT. DO NOT DOUBLE SPACE.***
Approval: Darla McKitrick.

Jun 9/11  D.McKitrick  NOTE  0

D: Gingivitis. Adult prophylaxis and plaque control orientation.
H: Reviewed medical history with patient. Patient states no changes in medical history since last visit. (Make changes on form if there are any) Vitalis: BP=128/80; P=85; R=13
T: Reviewed extra and intra oral exam; no changes. Evaluated Q1 & Q2 for residual calculus. Scaled Q2 and Q3 with hand instruments to completion (if quads were completed). Polished and flossed. (If fluoride is on the treatment plan - "Administered neutral sodium fluoride for 4 mins." or "Administered fluoride varnish").
E: Patient tolerated procedure well. Patient acknowledged need for oral hygiene, especially in the lower anterior.
N: Patient informed of need for 6 mos. recare. Referred to Blue Practice for restorative treatment. (or private DCS if patient has one).

***THIS IS AN EXAMPLE OF A SUBSEQUENT APPOINTMENT. DO NOT DOUBLE SPACE.***
Approval: Darla McKitrick.

Jun 9/11  D.McKitrick  D.McKitrick  DB013  P  0
Approval: Darla McKitrick.

Jun 9/11  D.McKitrick  D.McKitrick  DC150  P  0
Approval: Darla McKitrick.

Jun 9/11  D.McKitrick  D.McKitrick  D0210  P  0
Approval: Darla McKitrick.

Jun 9/11  D.McKitrick  D.McKitrick  D1110  P  0
Approval: Darla McKitrick.

Jun 9/11  D.McKitrick  D.McKitrick  D1204  P  0
Approval: Darla McKitrick.

Jun 9/11  D.McKitrick  D.McKitrick  D1330  P  0
Approval: Darla McKitrick.

Case Complete (Exit Interview)
Comprehensive oral evaluation
Introral x-rays - compit series
Prophylaxis - adult
Flouride w/o prophyl - adult
Oral hygiene instructions
Electronic Health Record - Tx History

512207
McKittrick Patient
Manikin Account For Comps
Account Balance = 0.00
Houston, TX
77030
(713) 111-1111

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***THIS IS AN EXAMPLE OF AN SCALING/ROOT PLANING APPOINTMENT. DO NOT DOUBLE SPACE.***
Approval: Daria McKittrick,

Jun 14/11 DMcKittrick DMcKittrick NOTE 0
D: Moderate periodontitis; Reviewed medical history with patient. Patient states no changes in medical history since last visit. (Make changes on form if there are any)
H: Reviewed medical history with patient. Patient states no changes in medical history since last visit. (Make changes on form if there are any)
O: O'Leary score 20%. Although OH improved, plaque still present on buccal of maxillary posterior teeth. Gingival tissues exhibit slight to moderate resolution from previous appt. Reinforced modified Bass and flossing techniques. Reviewed use of floss threaders for fixed bridges and Rx electric toothbrush due to dexterity problems.
T: Reviewed extra and intra oral exam; no new changes. Local anesthesia administered by Dr. ???; 3.6 ml (2 carpules) of lidocaine 2% 1:100 epi. SRP UR/LR with blended instrumentation to completion (if completed). Post Op instructions: Rx non-aspirin analgesic for discomfort and warm salt water rinses due to moderate bleeding.
E: Patient tolerated procedure well. Patient acknowledged need for improved oral hygiene.
N: Re-evaluation of all quads for residual calculus. Deplaque.

***THIS IS AN EXAMPLE OF AN SCALING/ROOT PLANING APPOINTMENT. DO NOT DOUBLE SPACE.***
Approval: Daria McKittrick,
**FLUORIDE APPLICATION: TRAY TECHNIQUE**

The hygienist may use a tray technique for administering the gel like acidulated phosphate or neutral sodium fluoride. An APF (acidulated phosphate) gel will **not** be given to any patient with composite, veneer, or porcelain crown restorations, as the APF will etch these materials. After the completed prophylaxis, a fluoride tray and fluoride gel can be obtained from the dental hygiene dispensary. See clinic procedure checklist. **Not given to children under 6.**

**FLUORIDE APPLICATION: VARNISH TECHNIQUE**

A fluoride varnish may be administered to patients of any age. These products are safe for all restorative material and also for children under six. See clinic procedure checklist.

**SUPPLEMENTAL FLUORIDE**

The most common use of a fluoride gel is for caries protection. Below are listed special cases and their optimum usage:

- **Orthodontic patients** - once a day, preferably at night before going to bed.
- **Radiation therapy patients (head and neck area)** - once a day, preferably at night before going to bed to prevent caries due to decreased salivary flow.
- **Rampant caries** - once a day to twice a day, preferably at night before going to bed, depending upon the patient.
- **Preventive** - (child or adult) once a day for best results preferably at night before going to bed.
- **Cementum hypersensitivity** - use of fluoride gel for controlling root hypersensitivity. Some of the causes of tooth sensitivity result from recession or periodontal surgery exposing cementum.

If you feel supplemental fluoride would be beneficial, consult your instructor. Complete a requisition form including your instructor’s signature and obtain from the first floor dispensary.
RECALL / RECALL SYSTEM

The recall recare system is a source of patients for the students in both the first year and second year classes. Specific information is required on the Patient Number Form. Please be sure that the patient information is correct so that the patient can be contacted at the time of the next recall, although this cannot be guaranteed.

Purpose for a Recall System

1. Students are given an opportunity to observe any changes in the patient’s oral health and to determine if they have been able to motivate the patient to make changes in oral health habits.
2. The procedure will simulate the use of recall systems in a dental practice.
3. The Patient Number Form will be turned in to the Clinic Coordinator at the end of the second year.

Procedure for Placing Patients on the Recall System

1. An entry will be made on the Patient Number Form after every patient is completed in our clinic.
2. The student will keep the Patient Number Form for his/her own use during the school year. Patients may be recalled during the months noted on the form.
3. At the end of the year, the Patient Number Form will be turned in to the Clinic Coordinator.
4. Patients must be made aware that the School of Dentistry should not replace their private practice dentist for their basic dental needs.

APPOINTMENT PROCEDURE

Before initial check-in - The student is expected to:

- Sign name on clinic assignment sheet. **(No signature–clinic absence)**
- Sign in to request DDS to do radiographic interpretation, periodic exam, or local anesthesia
- Check cubicle and equipment for cleanliness. Follow Infection Control Checklist.
- Assemble all necessary armamentarium.
- Login and open EPR (**Note: Chair side workstations will be set to log out of the EPR after 30 minutes of inactivity**)
- Open digital radiographs and reduce window.
- Proceed to reception room to meet patient and introduce self.
- Bring patient into cubicle; offer to hang coat and/or hat or place purse and/or personal belongings in the closet, Seat patient comfortably.
- Open Medical/Dental History (Full) form in EPR, Interview the patient and make comments on all “yes” responses in the **Full Medical History** form. Have signature pad in cubicle. **DO NOT HAVE PATIENT SIGN UNTIL INSTRUCTOR HAS DONE MEDICAL HISTORY CHECK IN. NOTE: THERE ARE 2 FORMS TO COMPLETE THE MEDICAL/DENTAL HISTORY PLEASE COMPLETE BOTH BUT DO NOT HAVE PATIENT SIGN UNTIL AFTER INSTRUCTOR CHECKS YOU IN**
- Take and record blood pressure, pulse, and respiration in EPR medical history form as baseline.
- ADD NOTE: Record the problem and all vitals in EPR Notes/DHOTEN under the P and H and click on ADD NEW… USE MODIFY from then on to make changes to the note
MEDICAL/DENTAL HISTORY CHECK-IN WITH INSTRUCTOR STUDENT will:

- Notify instructor that she/he is ready for a Medical/Dental History Check-In
- Have EPR Full Medical/Dental History form open in window (in window full view)
- Introduce patient to instructor, stand beside computer and review pertinent findings and medications with instructor
- Instructor will approve medical history and dental history forms using ID badge and instruct you to obtain patient signature, using the signature pads (available in the back of each bay)

**NOTE:** BOTH MEDICAL AND DENTAL HISTORIES MUST BE SIGNED BY PATIENT AND APPROVED BY AN INSTRUCTOR

CONTINUATION OF INITIAL VISIT STUDENT will:

- Offer gauze square to female patients to remove lipstick.
- Place patient napkin and attach with sterilized bib clip.
- Ask patient to remove any removable dental prosthetic; place prosthetic in plastic zip bag.
- Ask patient to rinse with mouthwash.
- Complete Extra and Intra-oral exam using the Clinical Exam (Grad/DH) form (pull down from list of forms) **NOTE:** INSTRUCTOR MUST APPROVE THESE FORMS ON THE DAY THEY ARE COMPLETED USING ID BADGE
- Complete DH Gingival Description form (pull down form list of forms) **NOTE:** INSTRUCTOR MUST APPROVE THESE FORMS ON THE DAY THEY ARE COMPLETED USING ID BADGE
- Lubricate patient’s lips.
- Dental charting and perio charting may be done before the next Beginning check-in (with instructor’s permission) or after check-in and at subsequent appointments when the student is waiting for dental hygiene instructors. **Dental charting must be complete prior to any D.D.S. exam if doing dental charting competency**
- Begin charting while waiting for instructor.

BEGINNING CHECK

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<td>Have clean mirror and clean gauze on bracket tray.</td>
<td>Introduce clean mirror and clean gauze on bracket tray.</td>
</tr>
<tr>
<td>Introduce patient to instructor, stand beside pt. opposite the instructor; adjust operating light</td>
<td>Introduce patient to instructor, stand beside pt. opposite the instructor; adjust operating light</td>
</tr>
<tr>
<td>Open EPR to Clinical Exam (Grad/DH) form</td>
<td>Open EPR to Clinical Exam (Grad/DH) form</td>
</tr>
<tr>
<td>Clarify relevant information.</td>
<td>Ask any pertinent questions.</td>
</tr>
<tr>
<td>Review patient’s x-rays if available.</td>
<td>Have digital radiographs open</td>
</tr>
<tr>
<td>Examine soft tissues</td>
<td>Observe instructor’s examination. <strong>Edit notes in EPR Clinical Exam (Grad/DH) form as directed by instructor</strong></td>
</tr>
<tr>
<td>Examine calcified deposits and perio conditions and classifies patient.</td>
<td>Student will note DH case Classification in DHOTEN after instructor confirmation</td>
</tr>
<tr>
<td>Instructor will assign and initial DH case classification on CEF form (if calibrated both instructors will sign)</td>
<td>Instructor will assign and initial DH case classification on CEF form (if calibrated both instructors will sign)</td>
</tr>
<tr>
<td>Task</td>
<td>Detailed Instructions</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Review gingival description form</td>
<td>Observe instructor’s examination <strong>Edit notes in DH Gingival Description form as directed by instructor</strong></td>
</tr>
</tbody>
</table>
| **NOTE: INSTRUCTOR WILL APPROVE Clinical Exam (Grad/DH) and DH Gingival Description FORM AT THIS VISIT WITH ID BADGE** | **Student will formulate treatment plan and enter proposed treatment plan in EPR**  
**NOTE: INSTRUCTOR WILL APPROVE THE PLANNED PROCEDURES**  
**Student will have patient read and sign treatment plan and consent form**  
**NOTE: INSTRUCTOR WILL CHECK TO SEE THAT “SIGNATURE ON FILE” BOX IS GRAY**  
**Student will enter planned treatment into student scheduler**                                                                                       |
| Advise student on treatment planning.                               | **NOTE: INSTRUCTOR WILL APPROVE WITH ID BADGE WHEN ALL DENTAL CHARTING HAS BEEN COMPLETED**  
**NOTE: INCOMPLETE/COMPLETE PERIO CHART AND/OR O’LEARY PLAQUE SCORE MUST BE APPROVED BY THE INSTRUCTOR FOR THIS VISIT...**  
**Begin treatment discussed with and approved by instructor. Ask CA to clean removable prosthetic.**                                                                 |
| Advise student on individualized patient oral care instructions.     | **NOTE: INCOMPLETE/COMPLETE PERIO CHART AND/OR O’LEARY PLAQUE SCORE MUST BE APPROVED BY THE INSTRUCTOR FOR THIS VISIT...**  
**Begin treatment discussed with and approved by instructor. Ask CA to clean removable prosthetic.**                                                                 |
| Instruct student to:                                                | **NOTE: INCOMPLETE/COMPLETE PERIO CHART AND/OR O’LEARY PLAQUE SCORE MUST BE APPROVED BY THE INSTRUCTOR FOR THIS VISIT...**  
**Begin treatment discussed with and approved by instructor. Ask CA to clean removable prosthetic.**                                                                 |
| - complete dental charting                                           | **NOTE: INCOMPLETE/COMPLETE PERIO CHART AND/OR O’LEARY PLAQUE SCORE MUST BE APPROVED BY THE INSTRUCTOR FOR THIS VISIT...**  
**Begin treatment discussed with and approved by instructor. Ask CA to clean removable prosthetic.**                                                                 |
| - complete O’Leary plaque score                                      | **NOTE: INCOMPLETE/COMPLETE PERIO CHART AND/OR O’LEARY PLAQUE SCORE MUST BE APPROVED BY THE INSTRUCTOR FOR THIS VISIT...**  
**Begin treatment discussed with and approved by instructor. Ask CA to clean removable prosthetic.**                                                                 |
| - complete patient education                                         | **NOTE: INCOMPLETE/COMPLETE PERIO CHART AND/OR O’LEARY PLAQUE SCORE MUST BE APPROVED BY THE INSTRUCTOR FOR THIS VISIT...**  
**Begin treatment discussed with and approved by instructor. Ask CA to clean removable prosthetic.**                                                                 |
| - complete perio charting                                            | **NOTE: INCOMPLETE/COMPLETE PERIO CHART AND/OR O’LEARY PLAQUE SCORE MUST BE APPROVED BY THE INSTRUCTOR FOR THIS VISIT...**  
**Begin treatment discussed with and approved by instructor. Ask CA to clean removable prosthetic.**                                                                 |
| - complete Oral Risk Assessment                                      | **NOTE: INCOMPLETE/COMPLETE PERIO CHART AND/OR O’LEARY PLAQUE SCORE MUST BE APPROVED BY THE INSTRUCTOR FOR THIS VISIT...**  
**Begin treatment discussed with and approved by instructor. Ask CA to clean removable prosthetic.**                                                                 |
| Review perio chart AND/OR                                            | **NOTE: INCOMPLETE/COMPLETE PERIO CHART AND/OR O’LEARY PLAQUE SCORE MUST BE APPROVED BY THE INSTRUCTOR FOR THIS VISIT...**  
**Begin treatment discussed with and approved by instructor. Ask CA to clean removable prosthetic.**                                                                 |
| Review dental chart                                                  | **NOTE: INCOMPLETE/COMPLETE PERIO CHART AND/OR O’LEARY PLAQUE SCORE MUST BE APPROVED BY THE INSTRUCTOR FOR THIS VISIT...**  
**Begin treatment discussed with and approved by instructor. Ask CA to clean removable prosthetic.**                                                                 |
| Make corrections as indicated by instructor in EPR records           | **NOTE: INCOMPLETE/COMPLETE PERIO CHART AND/OR O’LEARY PLAQUE SCORE MUST BE APPROVED BY THE INSTRUCTOR FOR THIS VISIT...**  
**Begin treatment discussed with and approved by instructor. Ask CA to clean removable prosthetic.**                                                                 |
| Compute plaque index (in perio form of EPR)                         | **NOTE: INCOMPLETE/COMPLETE PERIO CHART AND/OR O’LEARY PLAQUE SCORE MUST BE APPROVED BY THE INSTRUCTOR FOR THIS VISIT...**  
**Begin treatment discussed with and approved by instructor. Ask CA to clean removable prosthetic.**                                                                 |
| and note in DHOTEN (use Modify button)                              | **NOTE: INCOMPLETE/COMPLETE PERIO CHART AND/OR O’LEARY PLAQUE SCORE MUST BE APPROVED BY THE INSTRUCTOR FOR THIS VISIT...**  
**Begin treatment discussed with and approved by instructor. Ask CA to clean removable prosthetic.**                                                                 |
| Instructs patient in oral hygiene.                                  | **NOTE: INCOMPLETE/COMPLETE PERIO CHART AND/OR O’LEARY PLAQUE SCORE MUST BE APPROVED BY THE INSTRUCTOR FOR THIS VISIT...**  
**Begin treatment discussed with and approved by instructor. Ask CA to clean removable prosthetic.**                                                                 |
| Take radiographs as prescribed, if they have not yet been taken.    | **NOTE: INCOMPLETE/COMPLETE PERIO CHART AND/OR O’LEARY PLAQUE SCORE MUST BE APPROVED BY THE INSTRUCTOR FOR THIS VISIT...**  
**Begin treatment discussed with and approved by instructor. Ask CA to clean removable prosthetic.**                                                                 |
# TEMPORARY CHECK-OUT

<table>
<thead>
<tr>
<th>INSTRUCTOR</th>
<th>STUDENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straighten bracket tray and clean mouth mirror. Go to Instructor and request “temporary check checkout” from assigned instructor. Have clean mirror and clean gauze on bracket tray. Move to opposite side of patient to observe.</td>
<td></td>
</tr>
<tr>
<td>Examine hard and soft deposits.</td>
<td>Record instructions or errors (On Sticky Note) Complete treatment notes in EPR</td>
</tr>
<tr>
<td>HAVE EPR NOTES/DHOTEN ON SCREEN</td>
<td></td>
</tr>
<tr>
<td><strong>Look in Progress Tab and Convert codes of procedures done that day in clinic (for example, P to I, I to C…Planned to In-Process to Complete)</strong></td>
<td></td>
</tr>
<tr>
<td>NOTE: OHI code needs to be opened and closed to show that it is still in process</td>
<td></td>
</tr>
<tr>
<td>Instructor will approve notes/DHOTEN with ID badge</td>
<td>Re-appoint patient in EPR. Return clean removable prosthetic. Remove patient napkin. Return patient’s purse and/or coat Escort patient to waiting area.</td>
</tr>
<tr>
<td>Instructor will approve codes completed or in progress with ID badge and assign daily grade in EPR. Instructor will make written comment on all grades less than a three. Sign clinic evaluation form</td>
<td></td>
</tr>
</tbody>
</table>

**NOTE AT THIS POINT IN APPOINTMENT PROCEDURE:**

**THE FOLLOWING EPR FORMS SHOULD BE APPROVED BY FACULTY:**

1. Medical History
2. Dental History
3. Clinical Exam(grad/dh)
4. DH Gingival Description
5. Oral Risk Assessment
6. Treatment Plan
7. Dental Chart
8. Perio Chart/Plaque Index
9. Daily Clinic grade/approval of codes for the day
10. EPR Notes/DHOTEN

**IF ALL IS APPROVED THE AQUA ICON WITH THE PATIENT NUMBER WILL TURN GRAY... REMEMBER GRAY IS GOOD!**

**FOR SUBSEQUENT CHECK OUTS:**

**THE FOLLOWING EPR FORMS SHOULD BE APPROVED BY FACULTY:**

1. Perio Chart/Plaque Index
2. Daily Clinic grade/approval of codes for the day
3. EPR Notes/DHOTEN
### SUBSEQUENT APPT. CHECK-IN

<table>
<thead>
<tr>
<th>INSTRUCTOR will:</th>
<th>STUDENT will:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ASSURE THAT PLANNED PROCEDURES FOR THE DAY ARE ENTERED IN THE STUDENTS SCHEDULER</td>
</tr>
<tr>
<td></td>
<td>Question patient regarding changes in medical history since last appointment. Record changes or lack of changes in EPR Notes/DHOTEN</td>
</tr>
<tr>
<td></td>
<td>Take and record vitals and record in EPR Notes/DHOTEN</td>
</tr>
<tr>
<td>Review medical history.</td>
<td>Have medical history window opened and be ready to review patient’s medical history status with instructor</td>
</tr>
<tr>
<td>Assure that planned procedures are entered in the student’s schedule and a signed consent form is attached... if codes are not scheduled instructor will not be able to grade for the day.</td>
<td>Perform abbreviated oral examination. Record changes in EPR Notes/DHOTEN.</td>
</tr>
<tr>
<td><strong>Any changes to planned procedures will be approved by instructor using ID badge and require an additional signed consent form</strong></td>
<td>Go to Instructor and request instructor check-in. Introduce patient to instructor.</td>
</tr>
<tr>
<td>Radiographs taken upon radiology room availability...</td>
<td>Have EPR opened to radiographs or perio chart depending on type of radiographs available</td>
</tr>
<tr>
<td></td>
<td>Have clean mirror and clean gauze on bracket tray</td>
</tr>
<tr>
<td></td>
<td>Stand beside patient opposite of pt. from instructor, adjusts operating light</td>
</tr>
<tr>
<td><strong>NOTE: STUDENTS MUST HAVE RADIOGRAPHS PRIOR TO BEGINNING SRP TREATMENT</strong></td>
<td><strong>INSTRUCTOR will:</strong></td>
</tr>
<tr>
<td></td>
<td>Examine hard and soft tissues.</td>
</tr>
<tr>
<td></td>
<td>Review planned procedures with student.</td>
</tr>
<tr>
<td></td>
<td>Approve Perio/charting/plaque index etc. using ID badge</td>
</tr>
<tr>
<td></td>
<td>Compute plaque index using the Plaque/Bleeding Index unless a perio charting will also be done. In that case, put the plaque index on the perio chart.</td>
</tr>
</tbody>
</table>
Instruct patient in oral hygiene. Begin treatment discussed with and approved by instructor.

### BEFORE FINAL CHECK-OUT

<table>
<thead>
<tr>
<th>INSTRUCTOR will:</th>
<th>STUDENT will:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Complete all scaling or re-evaluation of previously scaled quadrants.</td>
</tr>
<tr>
<td></td>
<td>Complete dental charting. Use radiographs if available. Must have been completed prior to D.D.S. exam if applicable.</td>
</tr>
<tr>
<td></td>
<td>Complete periodontal charting if needed for re-evaluation.</td>
</tr>
<tr>
<td></td>
<td>Complete all polishing (after final scale check or re-evaluation of previously scaled quadrants).</td>
</tr>
<tr>
<td></td>
<td>Complete EPR Notes/DHOTEN</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INSTRUCTOR will:</th>
<th>STUDENT will:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Discuss recare/ maintenance with patient as well as any post op instruction</td>
</tr>
</tbody>
</table>

### FINAL CHECK-OUT

72 hours prior to final appointment, send EPR message to PCC asking to have the record audited.

<table>
<thead>
<tr>
<th>INSTRUCTOR will:</th>
<th>STUDENT will:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Go to Instructor and request a scaling check or polishing check.</td>
</tr>
<tr>
<td></td>
<td>Have clean mirror and clean gauze on bracket tray</td>
</tr>
<tr>
<td></td>
<td>Moves to the opposite side of patient from the instructor with evaluation form to observe</td>
</tr>
<tr>
<td><strong>SCALE CHECK:</strong> Call off any remaining calculus. Check charting. Instructor will sign CEF</td>
<td>Observe instructor; record remaining deposits as instructor indicates (may use sticky notes)</td>
</tr>
<tr>
<td></td>
<td>Correct errors on charting and remove remaining deposits.</td>
</tr>
<tr>
<td></td>
<td>Verify the student's removal of remaining deposits.</td>
</tr>
<tr>
<td><strong>POLISH CHECK:</strong> Check for removal of soft deposits, stain and any remaining deposits recorded during the scale check. Check partials and dentures.</td>
<td>Observe instructor; record remaining plaque as instructor indicates (may use sticky notes)</td>
</tr>
<tr>
<td>If patient is deemed to be plaque free:</td>
<td>Complete <strong>DH Case Complete</strong> form. After record audit, send EPR message to your facilitator regarding case complete</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Approve perio/plaque/bleeding index</td>
<td></td>
</tr>
<tr>
<td>Instructor will do final approval of</td>
<td></td>
</tr>
<tr>
<td>completed procedures using ID badge</td>
<td></td>
</tr>
<tr>
<td>Instructor will approve the case complete</td>
<td></td>
</tr>
<tr>
<td>code only using ID badge</td>
<td></td>
</tr>
<tr>
<td>Instructor will give a clinical grade in EPR and make written comments on all grades less than a three.</td>
<td></td>
</tr>
<tr>
<td>Instructor will approve DHOTEN/ note</td>
<td></td>
</tr>
<tr>
<td>Instructor will sign CEF, If this is patient’s final visit, instructor will take white copy of CEF after student completes recare/appt. number info</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Remove remaining plaque</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rechecks plaque removal.</td>
<td>Complete <strong>DH Case Complete</strong> form. After record audit, send EPR message to your facilitator regarding case complete</td>
</tr>
<tr>
<td>If patient is deemed to be plaque free:</td>
<td></td>
</tr>
<tr>
<td>Approve perio/plaque/bleeding index</td>
<td></td>
</tr>
<tr>
<td>Instructor will do final approval of completed procedures using ID badge</td>
<td></td>
</tr>
<tr>
<td>Instructor will approve the case complete code only using ID badge</td>
<td></td>
</tr>
<tr>
<td>Instructor will give a clinical grade in EPR and make written comment on all grades less than a three.</td>
<td></td>
</tr>
<tr>
<td>Instructor will approve DHOTEN/ note</td>
<td></td>
</tr>
<tr>
<td>Instructor will sign CEF, If this is patient’s final visit, instructor will take white copy of CEF after student completes recare/appt. number info</td>
<td></td>
</tr>
</tbody>
</table>

| Explain fluoride application to patient. |  |
| Apply fluoride. Stay with pt. |  |
| Return clean removable prosthesis to patient. |  |
| Remove patient napkin, return purse, and/or coat. |  |
| Escort patient to waiting room. |  |
AT THE COMPLETION OF THE FINAL APPOINTMENT:
THE FOLLOWING EPR FORMS SHOULD BE APPROVED BY FACULTY:
1. Perio Chart/Plaque Index
2. Daily Clinic grade/approval of codes for the day
3. EPR Notes/DHOTEN
4. ALL codes planned by the DH STUDENT SHOULD BE TO “C” STATUS
5. CASE COMPLETE CODE ONLY!!

NOTE: CASE COMPLETE FORM IS UNAPPROVED SO THE PATIENT NUMBER ICON WILL REMAIN AQUA
PROTOCOL FOR TOPICAL ANESTHETIC

A. Check the medical/dental history for information contraindicating the procedure or requiring further investigation and act accordingly.

B. Obtain topical anesthetic (code no. 01999) from the surgical dispensary. The Requisition Form must be signed by the DDS in our clinic.

C. Explain procedure to patient and provide appropriate individualized patient education. (Encourage patient not to swallow, as this may numb throat area.

D. Select site for application. Dry and isolate the area.

E. Apply a limited amount of topical anesthetic with a cotton pellet or swab.

F. Curettes may be dipped in topical anesthetic when deep scaling.

G. Make complete, accurate, dated entry in EPR DHOTEN.

PROTOCOL FOR ORAQIX

1. Check medical history for information contradicting the procedure or requiring further investigation and act accordingly

2. The DDS in our clinic will sign a Requisition form for Oraqix use. Obtain Oraqix dispenser, blunt-tip applicator and cartridge of Oraqix from dispensary. (1 cartridge will be sufficient for most full mouth applications)

3. Remove the blunt-tip applicator from the plastic blister tray, break the seal and remove plastic cover from the cartridge-penetrating end of the cannula. Keep hands away from the exposed cannula during mounting and removal to prevent accidental injuries.

4. Attach the blunt-tip applicator to the tip of the Dispenser.

5. Reset the internal ratchet mechanism before loading the first cartridge. This is accomplished by pressing the mechanism-reset button towards the back end of the body.

6. The air bubble present in the Oraqix cartridge allows the user to determine if the product is in a liquid or gel form. If the bubble is fixed or moves very slowly, cool the cartridge before use to bring the product back to a liquid form. The cartridge may be loaded into the tip or body of the Dispenser.

7. Carefully assemble the body and tip of the Dispenser with the cartridge in place holding the Dispenser in front of you with the tip facing right, rotate the tip sleeve section away from you until locked in place.

8. The applicator tip may be bent to improve access to the periodontal pockets, using the cap. If a greater bend than 45° is desired, a double-bend technique is recommended Note: Do not bend the applicator tip more than once in the same location. Breakage may be more likely if bent at the hub.

9. Hold the Dispenser vertically and observe the transparent portion of the tip the air bubble in the cartridge will be visible and can be removed by depressing the paddle. This will provide more consistent flow of Oraqix. A backlight may assist with this step.
10. Dispense Oraqix by depressing the paddle. The volume of Oraqix used per tooth is dependent on the periodontal pocket space. Consult the Oraqix® (lidocaine and prilocaine periodontal gel) 2.5%/2.5% package insert for specific dose information.

11. Oraqix is a viscous liquid. Dispensing slowly and evenly works best.

12. When the cartridge is nearly empty, the rubber plunger will be visible in the transparent section of the Dispenser tip.

13. **To reload the Dispenser,** first depress the reset button. You will hear the ratchet "click" back into the reset position.

14. Holding the Dispenser in front of you with the tip facing right, rotate the tip sleeve section toward you to unlock the Dispenser tip.

15. Remove the empty cartridge.

16. Insert a new Oraqix cartridge. A new blunt tip applicator may be used if needed.

17. Reposition the cartridge and tip assembly and lock in place as before.

**At the End of Use**

1. *Carefully remove the blunt tip applicator.*  *Re-capping makes this easier. Although the tip is blunt, use a one-handed technique to prevent accidental exposure to the contaminated cannula. Dispose of in the same manner as a contaminated dental injection needle. Place in the Sharps container in your cubicle*

2. Remove the empty cartridge as described above, *place empty or partially used cartridge in the Sharps container in your cubicle.*

3. If necessary, wash the surface of the Dispenser to remove any debris, blood or saliva that may be present. Return dispenser in 2 parts to dispensary for sterilization

4. Make complete, accurate, dated entry in EPR DHOTEN.
PROTOCOL FOR ARESTIN™ USE IN THE DENTAL HYGIENE CLINIC:

When indicated by the following criteria, Arestin™ may be put into the treatment plan after being approved by attending DDS faculty. The DDS will make a note in the EPR that Arestin™ was ordered, including the site where the Arestin™ is to be placed. The DDS will also need to approve the planned procedure in the treatment plan. The code for Arestin™ is 4381 (Chemotherapy per tooth) and the description in the EPR is chemotherapy per tooth. There is a $0.00 fee for DH students to dispense Arestin™. The DDS must sign a dispensary requisition form for the Arestin™. Arestin™ and applicators may be obtained from the first floor dispensary with the signed requisition.

Indications for use of Arestin™:

Scaling and Root Planing Appointments

- Arestin™ may be placed at the scaling and root planing appointment (4341 or 4342) if there are localized (1-2) sites per quadrant that have probing depths of ≥5mm with bleeding. If there are more than 1-2 sites per quadrant, these areas should be assessed at periodontal reevaluation for possible referral to graduate Periodontics.

Periodontal reevaluation

- After complete periodontal charting, if there are 1-3 residual sites in the mouth with ≥5mm pockets with bleeding, these areas should be recorded as areas needing debridement followed by Arestin™ placement to be done at the periodontal maintenance appointment. You may consider having the periodontal maintenance sooner than the usual 3 month interval.

- If there are more than 1-2 sites per quadrant that still present with ≥5mm pockets with bleeding, a periodontal consultation should be obtained.

Periodontal maintenance

- Areas noted for debridement and Arestin™ placement at reeval will be treated accordingly

- Isolated areas that present at the maintenance appointment with ≥ 5mm and bleeding may also be treated with Arestin following a thorough debridement.

- Isolated areas at any subsequent periodontal maintenance appointments may also be treated with Arestin™ following a thorough debridement.

- If there are numerous new or refractory sites, a periodontal consult should be obtained.
PROTOCOL FOR LOCAL ANESTHETIC

A. Determine the need for local anesthesia.

B. Check medical history for contraindications to local anesthesia, such as first or third trimester pregnancy, allergy to local anesthetics, or other.

C. Check medical history for contraindications to epinephrine, such as cardiac problems, allergy, or idiosyncratic reaction(s) to epinephrine, prohibited by patient’s physician, possible drug interaction with medication(s) they are taking, high blood pressure, or other.

D. Check medical history and ask patient if they are taking any medications, prescription or non-prescription. (Non-prescription cold remedies containing an antihistamine can elevate the patient’s blood pressure).

At this point you should have determined:

1. Are there any contraindications to local anesthesia for this patient?
2. Is epinephrine contraindicated for this patient?

E. Take vital signs:

1. If blood pressure is >140/90 in an otherwise healthy appearing patient, repeat the blood pressure in 10 minutes. If still elevated, consult with your instructor. It may be necessary to send a medical consult to the patient’s physician.

2. If blood pressure is 140/90 or lower:

   a. Consult with attending D.D.S. and request a syringe, needle and carpule(s). There is no charge. The anesthesia ordered must be signed by a dentist on a requisition form Request “2% xylocaine with 1:100,000 epi” or “2% xylocaine with 1:200,000 epi”. *IF EPINEPHRINE IS CONTRAINDICATED, REQUEST “3% Carbocaine” or 4% Citanest Forte.

   *Rule of thumb: request one carpule per quadrant.
   (You may want to check with the dental faculty member about the type of anesthesia.)

   b. Go to the dispensary; get topical anesthesia (if you are working on multiple quadrants remember to get enough for each injection), a syringe, a needle, and the anesthesia. The student will sign a loan record for the needle and syringe.

   *Rule of thumb: If you are working in the maxillary arch only, request a short needle. If you are working in the mandibular arch only, request a long needle. If you are working in both maxillary and mandibular arches, request a long needle.

   c. Consult with the dental faculty member assigned to the dental hygiene clinic. Have the chart ready for review. If dental faculty member is unavailable, consult with your instructor.

   (Remember that the beginning and end of the clinic session are very busy times, therefore, you may need to wait for the dental faculty member to anesthetize your patient. Some dental faculty members may want to assess the patient before ordering the anesthesia).
3. Begin your work. If more anesthesia is needed:
   
a. If you have at least one full carpule of local anesthetic remaining, find the dental faculty member and tell him/her that your patient needs more anesthesia.

b. If you do not have enough local anesthesia remaining from the first injection, repeat the above procedure and then find the dental faculty member.

c. Make complete, accurate, dated entry in EPR DHOTEN as to type and amount of anesthetic delivered and by whom.
REQUISITION FOR MATERIALS

Patient ___________________________ Chart No. __________________

Student ___________________________ ID NO. __________________

Name ___________________________ Operation __________________

Materials:
1. ___________________________ Quantity: __________________
2. ___________________________ Quantity: __________________
3. ___________________________ Quantity: __________________

Date ___________________________ Instructor - Name __________________

Clinic Charge ___________________________ ID NO. __________________

Important — See reverse side.

PSF 030-082 1/85

REQUISITION FOR ANESTHETIC AGENTS

PATIENT ___________________________ CHART NO. _____________

STUDENT ___________________________ I.D. NO. _____________

☐ Lidocaine 2% W/1:100,000 Epinephrine # Carpules __________
☐ Lidocaine 2% W/1:50,000 Epinephrine # Carpules __________
☐ Lidocaine 2% Plain — Latex Free * # Carpules __________
☐ Lidocaine 2% W/1:200,000 Epinephrine — Latex Free * # Carpules __________
☐ Carbocaine (Mepivacaine) 3% Plain # Carpules __________
☐ Carbocaine 2% W/1:20,000 Neocobefrin # Carpules __________
☐ Carbocaine 3% Plain # Carpules __________
☐ Citanest (Prilocaine) 4% Plain # Carpules __________
☐ Citanest Forte 4% W/1:200,000 Epinephrine # Carpules __________
☐ Marcaine (Supravacaine) 0.5% W/1:200,000 Epinephrine # Carpules __________
☐ Septocaine (Articaine) 4% W/1:100,000 Epinephrine # Carpules __________
☐ Other: ___________________________ # Carpules __________
☐ Topical, 2% Benzocaine or Oraqix # Carpules __________

* MUST BE REQUESTED IN ADVANCE

Date: ____________ Faculty Signature/ID#: ___________________________
The following are duties to be performed by the clinic assistants. The supervising faculty member that opened the clinic session will follow up on these procedures to ensure the clinic assistant has completed these tasks before signing this duty sheet.

____1. Report to DH clinic at 8:45 am if assigned to AM rotation or 1:00 PM if assigned to PM rotation and remain on duty until dismissed by the instructor that opened clinic.

____2. The designated CA will obtain the instrument cart from central sterilization. If a particular student is not assigned to clinic that session, sterile instruments will be placed in the designated cabinets in Bay F12.

____3. Restock all forms in Bay F12. Replace all PDR’s from the clinic area into cabinet in F12.

____4. Restock glove, towel and soap dispensers in each bay.

____5. Replenish mouth rinse and cups.

____6. Clean dentures and partials for patients. Supplies and ultrasonic bath are in F 12. Change solution in ultrasonic bath every Monday morning.

____7. Verify that the phase contrast microscope has been turned off and cover placed back on. Discard slides and slip covers into the biohazard sharps container. If saline is low in bottle, take to 1st floor dispensary and have them refill with isotonic solution.

____8. At the close of clinic, verify all units have been raised to the highest position and unit has been left in proper order and turned OFF. Place rheostats on the base of the dental chair.

____9. Verify that all Cavijets and Dual Select systems have been returned to the storage area in Bay F.

____10. The designated CA will return the instrument cart with contaminated instruments, covered with plastic, to central sterilization. Items must be counted (Cassettes and white/clear bagged items) separately and recorded on slip of paper (in central sterilization.)

____11. Mark “NA” next to the duties that do not apply. Have this rotation sheet signed by the instructor that opened clinic and place it in the “in” box.

Revised 07/11
The following are duties to be performed by students assigned to be dispensary assistants. Assistants are not dismissed until lab is completely over and all duties have been satisfactorily completed. Both names of assistants should be written on this form and duties should be checked off as they are completed. Upon completion this form is to be signed by and turned in to the faculty who opened the lab session (check the sheet in F11 for this).

___1. Obtain instrument cart at 1:00 p.m. from central sterilization (door at the end of hallway nearest elevator)

___2. Take cart to dental hygiene clinic at 1:00 p.m. and help distribute instruments to students from the cart.

___3. If a particular student is not in clinic this session, that student's sterile instruments are placed in the DH 1 cabinet in Bay G.

___4. At the close of lab cover the instrument cart (containing contaminated instruments) with plastic and return the cart to central sterilization (basement door across from the lockers near the cafeteria. A tally of items on the cart will be made at central sterilization.

___5. Remain in clinic at the end of the session until all duties have been performed or until dismissed by the supervising faculty member.

___6. At the close of the lab session make sure all units have been raised to the highest position, left in proper order and turned off. Report any infractions to the Preclinic coordinator.
This rotation is designed to provide feedback to students and during performance of various clinical procedures. The Peer Evaluator must be in clinic on time and stay until dismissed by the assigned faculty.

**Instructions:**

Peer review consists of watching a classmate perform a procedure and providing immediate feedback on her/his performance. You must watch 5 procedures each with different students. Observe students performing these 2 procedures: **New Patient Medical History & ELO**. Select other procedures to be observed. Use Section D in your DH Handbook to check how well the procedure is performed. When the procedure is complete, have the student sign next to the procedure you observed from the list below. Please be tactful when giving constructive criticism. Turn the completed and signed Peer Evaluation Rotation sheet in to the Clinic Coordinator.

When evaluating your peers consider the following:
- The procedure was performed with complete accuracy (no errors).
- Suggestions for improvement.

Other acceptable procedure to observe:
- Disclosing/O’Leary plaque score
- Patient Education
- Scaling
- Polishing

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F2011
COMPETENCY EVALUATION

Each underlined number designates a critical step in the procedure. Omission or incorrect performance of the step is considered a critical error.

A breach in aseptic technique and/or professionalism will constitute a critical error in any and all associated procedures.

All competencies must be performed on English speaking patients, unless prior instructor approval has been given for the competency to be attempted on a non-English speaking patient.

Evaluation performance levels are defined as:

5 = during this observation, your performance of the procedure surpasses that of entry-level competency in judgment and skill. No critical or non-critical* errors occur at this level of performance. (Refer to Handbook, Competency Sheet and Course Syllabus to identify Competency Demonstrations that may have allowable non-critical errors for a level 5 evaluation.)

4 = during this observation, your performance of the procedure is at entry-level competency in judgment and skill. No critical errors occur at this level of skill performance. (Refer to Handbook, Competency Sheet and Course Syllabus for allowable non-critical errors.)

1 = during this observation, your performance of the procedure is below entry-level competency in judgment and/or skill. Critical and/or non-critical errors occur at this level of performance. This evaluation indicates that you need more practice in order to become competent in performing this procedure.
Aseptic Technique/Infection Control
Air Polishing
Amalgam Finishing and Polishing Technique
Calculus Detection
Chemotherapeutic Agents
Cleaning Removable Prostheses
Curets
Dental Charting
Desensitizing
Disclosing Procedure
Ethics and Professionalism
Explorers
Extra / Intraoral Examination
Flossing
Fluoride Application
Implant Patients
Instrument Sharpening
Medical and Dental History
Nutritional Counseling
Periodontal Charting
Periodontal Probe
Phase-Contrast Microscope
Pit and Fissure Sealant Application
Polish and Floss
Polishing – Seating Positions
Scaling and Root Planing
Sickle Scalers
Tobacco Cessation Counseling
Tooth brushing/Dentifrice
Treatment Plan
Ultrasonic Scalers
Vital Signs
ASEPTIC TECHNIQUE / INFECTION CONTROL

All procedural steps are critical

The student is expected to:

Unit Preparation
Turn on PC and log in to EPR patient record.

1. Remove extraneous items from floor and field of contamination.
2. Remove jewelry and put on utility gloves.
3. Clean unit, dental and operator chair bases, foot controls, and cubicle area with germicidal wipe.
4. Clean with germicidal wipe: Clean dental unit, chair and counter top, PC keyboard, and box to remove blood and debris. Dry with paper towels. DO NOT TOUCH OR CLEAN MONITOR SCREEN.
5. Disinfect germicidal wipe. Wipe the following with germicidal wipe and let dry. **Dental unit to include:**
   - saliva ejector and high volume evacuator (including controls and cord)
   - light handles, switch and arm
   - bracket tray, grip bar
   - air/water syringe and cord
   - hand piece adaptor and cord
   - dental chair, headrest control and arm release button
   - operator chair
   - counter tops and drawer pulls
   - x-ray view box and buttons (only if x-rays are not digital)
6. TURN DENTAL UNIT OFF AND BLEED AIR OUT OF A/W SYRINGE. REMOVE WATER BOTTLE AND REFILL BY DOING THE FOLLOWING:
   - pull up on top coupling and unscrew bottle from dental unit
   - empty any water in the bottle at the sink
   - run water from sink faucet for 30 seconds or until clear. Rinse bottle with tap water
   - add 1 tablet of Citrisil to empty water bottle. AVOID TOUCHING THE TABLET
   - fill bottle with tap water to “Fill Line”. Water will turn blue.
   - wait 60 seconds for tablet to fully dissolve and reattach bottle to unit
7. Wipe any remaining wet disinfected areas with paper towels.
8. Remove utility gloves; wash hands for one – 15 second washings.
9. Flush dental unit water lines for 30 seconds (without A/W syringe tip or handpiece attached.
10. Apply barriers to the following:
    - headrest
    - light handles and switch
    - bracket tray, bar grip
- air/water syringe
- high volume evacuator and saliva ejector
- view box buttons (only if x-rays are not digital)
- PC keyboard and mouse
- Backrest of operator stool and lever to raise/lower the stool
- Pens or pencils

11. Place a patient napkin on the right desk area. Place the following on the napkin.
   - Cocoa butter on gauze square with cotton applicator for lubricating patient’s lips.
   - Sterile gauze squares for cleaning instrument tips during the appointment (remove debris as you work to avoid it from drying. Dried debris is hard to remove during sterilization procedures).
   - Disclosing solution swab
   - Cup with mouth rinse (Patient is to rinse 30 seconds prior to treatment.)

12. Place an unopened cassette bag on the bracket tray (to be opened when the patient is seated).

13. Assemble other needed items such as patient education supplies; place in the appropriate areas.

14. Mount radiographs on view box, if available (only if x-rays are not digital)

15. Place a cotton tip applicator near the PC for use as a stylus.

**Operator Preparation**

1. Put on clinic gown
2. Put on glasses and mask. Fit face mask under glasses and tie securely.
3. Wash hands for 15 seconds, dry, and remove cassette from the autoclave bag. Place top in secure place. (The bag is not opened until after the patient is seated)
4. Put on gloves.

**Unit Clean-up**

1. Remove gown, gloves & mask and wash hands for 15 seconds and dismiss patient.
2. Put on gown, glasses, mask, and utility gloves.
3. Carefully remove gross debris from instrument tips with gauze squares or instrument brush (should be minimal if removing debris as you scale).
4. Dispose of “medical waste” in the biohazard bag (if needed).
5. Flush water lines for 30 seconds (with air/water syringe tip or hand piece attached)
6. Remove barriers and dispose of non-medical waste in trash can.
7. WIPE CLEAN unit area with germicidal wipe as directed under “Unit Preparation”, #6. Leave wet.
8. Instrument cassette sterilization:
   - Place instruments in correct order in cassette (cassette rails need to be secure).
Place in sterilization bags small items that will slip through openings.
- \textbf{DO NOT} place paper or gauze in cassettes.
- Place top on cassette and secure latches.
- Place closed cassette in sterilization cart.

9. Instrument sterilization using autoclave bags:
   - Wrap groups of instruments in paper towels using gauze to cover instrument tips and protect mirror face.
   - Fold ends of towels over to protect instrument tips.
   - Label instruments bags with permanent pen indicating student name, DHI or II, contents, and date.
   - Seal bags.

10. Clean counter tops and sink with non-abrasive cleanser.
11. Fill a paper cup half full of iodophor solution and flush the saliva ejector.
12. With utility gloves on, wash glasses and utility gloves with antimicrobial soap, rinse and dry. Place utility gloves and glasses in plastic box or bag.
13. Wash hands.
14. Put on clean gloves and dispose of biohazard bag (if used) at "contaminated" window of dispensary. \textbf{DO NOT PUT BIOHAZARD BAG IN CUBICLE TRASH CAN EVEN IF UNUSED.}
15. Remove and dispose of gloves in trash container across from biohazard box.
16. Remove and dispose of gown and mask in cubicle wastebasket.
17. Wash hands again.

\textbf{Infection Control}

\textit{All procedural steps are critical.}
1. Practice standard precautions.
2. Follow good principles of personal hygiene on a daily basis.
3. Follow proper hand washing guidelines.
5. Wear approved clinic attire.
6. Do not wear jewelry when in clinic except as specified.
7. Keep hair securely pinned up and pulled back away from face.
8. Practice proper disinfecting protocol.
10. Use appropriate barrier techniques, i.e. gloves, mask, protective eyewear.
11. Remove gloves when leaving the cubicle.
12. Wear heavy duty, vinyl utility gloves when cleaning cubicle.
13. Follow environmental surface asepsis, i.e. wipe clean/wipe again.
14. Provide a needle cap holder when a needle and syringe are present.
15. Manage and dispose of hazardous waste properly (red biohazard bag), in biohazard bin located at the check-in area of the dispensary.
16. \textbf{Keep forms and documents on the left counter area.} (this is not considered a "contaminated" area).
17. \textbf{PROFESSIONALISM}

\textbf{COMPLIANCE WITH ALL STANDARDS IN THE INFECTION CONTROL SECTION OF THE SCHOOL OF DENTISTRY CLINIC MANUAL IS MANDATORY.}
AIR POLISHING

The student is expected to:

1. Thoroughly review medical/dental history for information that contraindicates proceeding or will otherwise influence the procedure. (Do not use on patients who have a severe respiratory illness. Other contraindications include: patients with acute necrotizing ulcerative gingivitis or patients known or suspected of having Hepatitis B, AIDS, tuberculosis, or an HIV positive diagnosis, renal disease, metabolic disorders, patients on diuretics and known infectious diseases).

2. Explain procedure and rationale to patient, providing individualized patient education.

Assemble armamentarium:

- air polisher unit
- air polishing nozzle
- plastic drape for patient
- protective eye glasses for patient and operator
- paper towels for patient
- face mask and shield for operator
- mouth mirror
- sodium bicarbonate or aluminum trihydroxide powder used on patients with sodium restricted diets
- saliva ejector
- pre procedural rinse (essential oil or chlorhexidine-based antimicrobial)
- lubricant for patient’s lips with a non-petroleum product (i.e., cocoa butter)

3. Wrap hand piece, unit, and bar grips.

4. Connect **BLUE** water line to water outlet.

5. Connect **YELLOW** air line to air outlet.

6. Fill powder chamber with either sodium bicarbonate or aluminum trihydroxide **BEFORE** unit is turned on. (If the need for more powder is desired during treatment, turn the unit off to relieve pressure in the powder chamber.)

7. Plug in unit and turn on.

8. Flush lines for two (2) minutes prior to nozzle attachment. (Push the **PURGE** button on the Cavijet unit to perform this function.)

9. Make sure suction is ready to use.

10. Have patient use a pre procedural rinse before using the air polisher.

11. Drape patient with plastic apron and provide with paper towels and safety glasses.

12. Put on gloves, mask, eyeglasses and protective gown and use appropriate aseptic technique.

13. Adjust patient position to the proper angle.

14. Utilize foot pedal in first position for delivery of water for rinsing the teeth and tongue.

15. Utilize foot pedal in the second position for delivery of water and air polishing powder for the prophylaxis of the teeth. (When foot is removed from pedal, a continuous bleeding of air flows through hand piece.)
16. Change powder flow rate by rotating the adjustable pointer to H for heavy stain, and L for light stain (clockwise or counterclockwise) respectively.

17. Lubricate patient’s lips with a non-petroleum lubricant.

18. Check cleaning spray. This spray can be contained by “cupping” rather than retracting the patient lips.

19. Place 2 X 2 gauze square on the patient’s lip near the working area.

20. Direct tip of the hand piece nozzle approximately 3 – 4 mm from the tooth surface being cleaned; use direct vision and external fulcrums where possible, use a mirror for illumination as needed.

21. Center the spray on the middle one-third of the tooth and use a constant circular motion.

22. Aim nozzle toward the enamel area but not in the sulcus.

23. Direct hand piece nozzle at an angulation of 60 degrees on anteriors and 80 degrees for posteriors. The hand piece nozzle is held at 90 degrees when used on occlusal surfaces.

24. Polish 1-2 teeth for 1-2 seconds with the spray (second position on foot switch) and then rinse the area with water only (first position on foot switch).

25. Use your hand to cup the patient’s cheek to contain the aerosol spray.

26. Use quick, constant sweeping motions of the hand piece in areas of soft tissue.

27. Avoid use of air polisher on amalgam, porcelain, composite or highly polished metal restorations.

28. Avoid prolonged use of air polishing on cementum, dentin, or soft tissue.

29. Use suction continuously.

30. Check for patient comfort both verbally and visually.

31. Evaluate patient to determine that all enamel surfaces are stain and plaque free.

32. Assess procedures and outcomes and determine ways to improve performance.

33. At the conclusion of the procedure use the Purge button to flush lines for two (2) minutes.

34. Clean and disinfect cubicle and air polishing unit.

35. Return air polishing unit neatly into the storage container and return to supply closet in Bay F.

36. PROFESSIONALISM

37. INFECTION CONTROL
AMALGAM FINISHING AND POLISHING TECHNIQUE

The student is expected to:

1. **Apply General Considerations**
   
   a. Use articulating paper check occlusion before starting the procedure to note any heavy markings. Functional anatomy must not be disturbed. Not every amalgam will need finishing and polishing steps.

   b. Heat produced during polishing not only causes potential pulp damage and discomfort but also a deterioration of the properties of the amalgam attributed to mercury being drawn to the surface.

   c. When using stones or finishing burs, work from enamel to restoration and avoid over-reducing amalgam at the margins.

2. **Demonstrate correct technique**

   The following is based on the assumption that adequate carving and matrix application have resulted in a desired restoration which simply needs to be smoothed and polished.

3. **Determine which restorations need to be finished and or polished according to the service-ability criteria.** Indicate the exact sequence to be used and confirm with instructor.

   Inform the patient of the procedure and why it is being done.

4. **Assemble armamentarium:**

   - Slow speed hand piece (latch and friction)
   - Articulating paper
   - Finishing and polishing bur b lock:
     - Brownie polishing point
     - Greenie polishing point
     - Super Greenies polishing point

5. **Remove tarnish and corrosion with a light touch of the white stone.** Use the white stone sparingly.

6. **Follow the white stone with the following polishing points in the order listed:**

   a. Finishing bur(s)
   b. Brownie polishing point
   c. Greenie polishing point
   d. Super Greenies polishing point
   d. Obtain an instructor check

7. **Make complete, accurate, dated chart entry in EPR.**

8. **PROFESSIONALISM**

9. **INFECTION CONTROL**
CALCULUS DETECTION

The student is expected to detect and accurately record:

1. Areas of granular calculus and detectable areas of moderate to large pieces of calculus (granular, red; moderate to large, blue).

2. Areas of calculus with no tissue trauma.

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CHEMOTHERAPEUTIC AGENTS

1. Review medical history for any contraindications for the use of a chemotherapeutic agent. Arestin should not be used in a patient who has a known sensitivity to minocycline or tetracyclines. Arestin should also not be used in pregnant or nursing patients.

2. Select the appropriate chemotherapeutic agent (Arestin is currently available from the dispensary).

3. Explain the rationale to the patient.

4. Have requisition signed by DDS for Arestin. One cartridge is needed for each site to be treated.

5. Arestin will be placed after completion of SRP, or at periodontal maintenance as advised by your instructor.

6. Insert the Arestin cartridge into the handle while exerting slight pressure.

7. Twist until you feel and hear the cartridge “lock” into place.

8. Should you need to manipulate the cartridge tip to reach difficult areas, gently bend the tip, leaving the blue cap on.

9. Place the cartridge tip into the periodontal pocket, parallel to the long axis of the tooth. Be sure not to force the tip into the base of the pocket.

10. Gently press the thumb ring to express Arestin powder while withdrawing the cartridge tip away from the base of the pocket.

11. Once delivery is complete, retract the ring and remove the Arestin cartridge and discard.

12. Patients should be instructed to delay brushing the treated area for 12 hours after treatment with Arestin and to abstain from using interproximal cleaning devices around the treated area for 10 days. Patients should also avoid foods that could traumatize the gingiva.

13. PROFESSIONALISM

14. INFECTION CONTROL
CLEANING REMOVABLE PROSTHESSES

The student is expected to:

1. Assemble the armamentarium. Gloves should be worn when handling prostheses.

2. Explain procedure to the patient and provide appropriate individualized patient education.

3. Have the patient remove their prosthesis:
   - Give patient a paper towel.
   - Provide a private environment for removal.
   - Respect patient’s wishes not to talk or be seen without prosthesis.

4. Examine the prosthesis and patient. Seek consultation regarding ill-fitting prostheses, ulcerations, inflammation, and cracked or broken prostheses.

5. Take partials/denture(s) to cubicle F-11 and follow instructions there. Put patient’s name on outside of baggie with sharpie pen. Place prosthesis in a zip-lock bag and add enough of the cleaning agent to completely cover it. Place the baggie into the ultrasonic bath for a length of time that removes the stain and/or calculus.

6. Use a denture brush to remove any remaining debris from the prosthesis. Brush over a sink lined with paper towels or filled with water to prevent breakage. Be careful not to bend clasps. Rinse the prosthesis and keep it stored in water in a secure place until the end of the appointment.

7. Check prosthesis:
   - No calculus or stain visible
   - Outer surfaces smooth in appearance and to patient’s tongue
   - Absence of all polishing and cleaning agents

8. Assess procedures and outcomes and determine ways to improve performance.

9. Clean up work area and armamentarium.

10. PROFESSIONALISM

11. INFECTION CONTROL
CURETS

The student is expected to:

1. Grasp
   a. Hold with index finger and thumb pads
   b. Stabilize with pad of middle finger
   c. Maintain contacts between index, middle, and third fingers
   d. Place index finger and thumb pads at junction of handle and shank
   e. Maintain handle between second knuckle and “V” of thumb and forefinger
   f. Rotate instrument handle when adapting to tooth surface
   g. Use light pressure for exploratory stroke

2. Fulcrum
   a. Establish on stable tooth, finger, vestibule on gauze, or prescribed extra oral
   b. Establish on embrasure area, occlusal or incisal surface
   c. Position as close to the working area as possible
   d. Use constant, equal pressure
   e. Pivot on finger pad for adaptation
   f. Move hand (up down, side-side) when pivoting

3. Stroke
   a. Select correct working end
   b. Insert the toe with the blade closed
   c. Open the blade to 60°-80° for working strokes
   d. Move in direction toe faces
   e. Hold side of toe and cutting edge against tooth during: exploratory stroke, and working stroke
   f. Use short, overlapping strokes
   g. Roll instrument between thumb and forefinger on line angle to adapt side of toe to tooth

4. Student actions
   a. Maintain terminal shank handle as close to parallel with long axis of tooth as possible.
   b. Use oblique, vertical and/or horizontal strokes.
   c. Have no independent finger motion.
   d. Apply pressure to remove calculus.

5. Technique
   a. Use systematic sequence for scaling individual teeth or quadrants.
   b. Adapt instrument appropriately:
      - anterior instruments from midline to proximal surface
      - posterior instruments from distal line angle to proximal surface
   c. Position patient for efficient access to areas.
   d. Assume operator position as needed for field of operation.

6. PROFESSIONALISM

7. INFECTION CONTROL
DENTAL CHARTING

The student is expected to complete the procedure without the assistance of any other student:

1. Open EPR to patient record; open "Chart Add " folder; open MiPacs for radiographs
2. Use mirror and EX 5 explorer
3. Place patient and operator in correct position
4. Use light, mirror, compressed air and radiographs to aid examination
5. Make recording on the proper teeth
6. Use cotton tipped applicator as stylus for recording.
7. Indicate missing teeth (right click on missing tooth # and make selection)
8. Identify existing conditions; click “Findings”, “Existing Rest/Pro…”, Make selection; click on tooth on odontogram; click icon on right with 2 teeth to add to odontogram
9. Identify suspicious carious areas and other conditions; click “Findings”, “Conditions”, Make selection; click on tooth on odontogram; click icon on right with 2 teeth to add to odontogram
10. Make tooth note as appropriate of if description is not available

12. PROFESSIONALISM

13. INFECTION CONTROL

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DESENSITIZING

The student is expected to:

1. Check medical/dental history for information contraindicating the procedure or requiring further investigation, and act accordingly.

2. Select the appropriate agent and assemble the armamentarium:
   - Topical Fluoride Varnish
     - fluoride varnish
     - cotton rolls
     - gauze square
     - benda brush
     - saliva ejector
   - Dentin desensitizer (Colgate Pro-Relief)
     - saliva ejector
     - mouth mirror
     - prophyl cup
     - slow speed handpiece

3. Explain procedure to patient and provide individualized patient education:
   - Patient plaque control is the most important issue to convey to help improve hypersensitivity. Discuss trigger foods.

4. Apply Dentin Desensitizer (Colgate Pro-Relief)
   a. Obtain material in the back closet of Bay F.
   b. This agent can be applied prior to scaling and/or as a final polishing step.
   c. Dry (with gauze square) and isolate area.
   d. Place agent on a prophyl cup. Using a slow speed handpiece slowly polish the desensitizing agent to the areas of sensitivity.
   e. Re-apply to sensitive area if needed. If you are using fluoride varnish, please apply the Pro-Relief first then the varnish.

5. Apply Dentin Desensitizer (Colgate Pro-Relief)
   a. Obtain material in the back closet of Bay F.
   b. Dry (with gauze square) and isolate area.
   c. Place agent on a prophyl cup. Using a slow speed handpiece slowly polish the desensitizing agent to the areas of sensitivity.
   d. Re-apply to sensitive area if needed.

6. If hypersensitivity persists, these procedures may be repeated or another method of treatment can be attempted.

7. Make complete and accurate entry in progress notes.

8. Assess procedures and outcomes and determine ways to improve performance.

9. PROFESSIONALISM

10. INFECTION CONTROL
DISCLOSING PROCEDURE

1. Thoroughly review medical/dental history for information that contraindicates proceeding or will otherwise influence the procedure.

2. Discuss the purpose and procedure of disclosing.

3. Assemble the armamentarium: disclosing solution, cotton tip applicator, mouth mirror and a hand mirror.

4. Remove excess saliva with saliva ejector. Apply the solution to the crowns of the teeth.

5. Ask patient to disperse liquid with tongue; do not use water.

6. Advise patient to expectorate or use suction.

7. Guide the patient in discovering the deposits.

8. Explain the terms plaque, material alba, and food debris. Utilize the phase-contrast microscope.

9. Record the plaque index in the patient’s dental record.

10. PROFESSIONALISM

11. INFECTION CONTROL
ETHICS AND PROFESSIONALISM / CORE VALUES

ALL STEPS ARE CRITICAL

The following are some factors that will be considered under professionalism. The student is expected to demonstrate ethical, professional conduct and judgment. Representative examples are given but will not necessarily be limited to these examples. Examples of positive professional conduct include:

1. Maintain patient confidentiality.
2. Place the patient’s welfare first when planning and implementing patient care.
3. Concern for the patient’s welfare, safety and comfort.
4. Provide treatment in accordance with the treatment plan after checking in with supervising faculty.
5. Discuss review of medical history with faculty prior to instrumentation.
6. Acknowledge medical history alert.
7. Adhere to medical history alert, if applicable.
8. Abide by clinic policies and regulations.
9. Accept suggestions for improvement and evaluation in a mature manner.
10. Maintain physical, mental and emotional composure/attitude in all situations.
11. Maintain respect, concern and be cooperative toward fellow classmates, dispensary/records personnel and faculty.
12. Demonstrate sound clinical judgment commensurate with level of experience.
13. Maintain honesty with faculty members, patients, and colleagues.
14. Show greater concern with quality treatment for patients rather than a quest for grades.
15. Demonstrate adequate and appropriate communication.
EXPLORERS

The student is expected to:

1. Grasp (use modified pen grasp).
   a. Hold with index finger and thumb pads.
   b. Stabilize with pad of middle finger.
   c. Maintain contacts between index, middle, and third fingers.
   d. Place index finger and thumb pads at junction of handle and shank.
   e. Maintain handle between second knuckle and “V” of thumb and forefinger.
   f. Rotate tip between thumb and forefinger when adapting to keep flush side of tip on tooth surface.
   g. Use light pressure.

2. Fulcrum
   a. Establish on stable tooth, finger, and vestibule on gauze or prescribed extra oral.
   b. Establish on embrasure area, occlusal, or incisal surface.
   c. Position close to work area, if possible.
   d. Use constant, equal pressure.
   e. Pivot on fingertip for adaptation.
   f. Move hand (up-down, side-side) when pivoting.

3. Stroke
   a. Make no independent finger motion.
   b. Select correct working end.
   c. Insert smallest portion of tip.
   d. Insert tip at oblique angle to epithelial attachment.
   e. Insert with tip contacting tooth.
   f. Maintain side of tip on tooth.
   g. Keep terminal shank parallel with long axis of tooth.
   h. Maintain maximum contact of working end with tooth (1-2 mm).
   i. Move tip obliquely or vertically to epithelial attachment.
   j. Move explorer in direction tip is pointed.
   k. Use short, overlapping strokes
   l. Use overlapping strokes.
   m. Cover area from epithelial attachment to margin of gingiva (circumferentially).

4. Technique
   a. Use systematic sequence.
   b. Use correct explorer tip for each surface.
   c. Choose the explorer type recommended for specific area or needs.
   d. Use mouth mirror for tissue retraction as needed.
   e. Use mouth mirror for indirect vision.

5. Patient-operator positioning
   a. Assume operator position required for field of operation.
   b. Position patient for efficient access to field of operation.

6. PROFESSIONALISM

7. INFECTION CONTROL
EXTRA / INTRAORAL EXAMINATION

The student is expected to:

1. Apply methods and materials
   a. Wash hands
   b. Set up bracket tray and equipment
   c. Assemble gauze squares, mouth mirror, and gloves for the operator.
   d. Explain the purpose and routine order of the examination to the patient.
   e. Ask patient to rinse with mouth rinse. Pour remaining contents of cup into sink.
   f. Ask patient to hold safety glasses (if not wearing corrective glasses)
   g. Open cassette, wash hands and put on mask, glasses and gloves.

2. Ask patient to remove corrective glasses if wearing them.

3. Complete Extra oral Exam
   a. Observe from front, noting symmetry of face and neck.
   b. Have patient move head from side to side to detect masses or restricted mobility.
   c. Inspect color and texture of skin.
   d. Inspect eyes and eyelids (opened and closed).
   e. Palpate occipital nodes bilaterally. Ask patient if nodes are painful.
   f. Palpate pre & post-auricular nodes bilaterally.
   g. Palpate TMJ bilaterally. Ask patient if opening mouth causes discomfort.
   h. Palpate parotid gland bilaterally.
   i. Palpate bimanually the sub mental and submandibular nodes along angle of mandible and under chin.
   k. Palpate thyro...turn head to side.
   j. Palpate parotid gland bilaterally.
   l. Palpate bidigitally along sternocleidomastoid muscles for cervical lymph nodes. Turn head to side.
   m. Palpate thyroid gland with index finger and thumb. Ask patient to swallow while palpating.
   n. Remove gloves and discard.

4. Complete intra-oral exam
   a. Ask patient to wear corrective glasses or safety glasses.
   b. Put on fresh gloves
   c. Observe lips opened and closed. Dry lips and labial mucosa. Recheck.
   d. Palpate lips bidigitally.
   e. Observe and palpate maxillary and mandibular mucobuccal fold.
   f. Palpate gingiva.
   g. Retract cheeks to observe buccal mucosa. Dry and recheck.
   h. Manipulate duct opening of parotid gland, noting saliva.
   i. Palpate each cheek bidigitally or bimanually.
   j. Observe tongue: Wrap with gauze to inspect.
   k. Palpate entire tongue bidigitally.
   l. Observe ventral surface of tongue, floor of mouth and lingual frenum. Dry and check salivary flow from submandibular gland.
   m. Palpate floor of mouth bimanually.
   n. Observe and palpate hard and soft palates.
   o. Inspect oral pharynx and tonsillar region. Depress tongue with mouth mirror.
   p. Ask patient to close together on posterior teeth and check occlusion.

5. Observe deviations from normal and record accurately on the clinical edam (Grad) form in EPR

6. Follow routine order of inspection.
7. PROFESSIONALISM

8. INFECTION CONTROL

CLINIC I  Process only, findings not evaluated for competency grade.

Extra oral exam:
   Evaluation of “5” = no critical errors
   Evaluation of “4” = 1 critical error
   Evaluation of “1” = 2 or more errors

Intraoral exam:
   Evaluation of “5” = 0-1 critical errors
   Evaluation of “4” = 2 critical errors
   Evaluation of “1” = 3 or more errors

CLINIC II  Notations of Head and Neck Exam findings must include normal structures or conditions, such as Fordyce granules, ventral/sublingual varicosities, chapped lips and any abnormal conditions. All findings must be identified and/or described thoroughly.

Evaluation of “5” = no critical errors and no errors in identification or description of findings.

Evaluation of “4” = no critical errors and all normal and abnormal findings have been noted with allowance of one of the findings being incorrectly described or identified.

Evaluation of “1” = two or more errors in the description of the findings.

CLINIC III  Must maintain competency

CLINIC IV  Must maintain competency
FLOSSING

The student is expected to:

1. Select appropriate length of material (12-18 inches)

2. Wind material around the middle or fore fingers of each hand.* (Variations are acceptable)

3. Secure floss/tape with the index finger and thumb of each hand, with a length of ¾ to 1 inch between each hand.

4. Introduce 1 inch of floss interproximally through the contact point with a see-saw motion.

5. Wrap the floss around the tooth in a “C” shape.

6. Slide the floss up and down the tooth surface, while holding the material firmly against the proximal surface.

7. Carry the floss below the gingival margin.

8. Perform the procedure on the adjacent tooth in the inter-proximal space by moving from the sulcus to the contact, avoiding the papillary tissue.

9. Remove the floss by holding the material against one tooth and using a see-saw motion through the contact.

10. On the maxilla, the floss is stretched over the thumbs, which guide the floss. Place one thumb on the lingual, and one thumb on the facial side with approximately 1-inch of floss between the thumbs.

11. On the mandible, the floss is stretched over the index fingers which guide the floss. Place one thumb or index finger on the buccal, and one thumb or index finger on the lingual side with approximately 1-inch between the fingers.

12. Reposition and repeat motions, winding used floss around the take-up finger to permit access to a fresh span.

13. Follow definite sequence.

14. Adapt to a patient’s ability and preferences, if not harmful. Recommend flossing aids as appropriate such as holders, super – floss, etc.

15. PROFESSIONALISM

16. INFECTION CONTROL

*Wind most of the floss around the finger of the least dominant hand. The finger of the other hand will serve as a take-up reel for the used floss.
FLUORIDE APPLICATION

The student is expected to:

1. Explain the benefits of fluoride, describe the application procedure, and obtain the consent of the patient or parent if minor. All UTSD patients are treated unless they object. Make notations in the EPR if the patient refuses fluoride. Fluoride should not be given to patients under six years old.

2. Assemble all necessary supplies.

3. Seat the patient in an upright position for the trays. Ask the patient to tilt his/her chin down.

**TRAY TECHNIQUE**

1. Select the appropriate size tray and check fit in the patient’s mouth. Dry surfaces of tray wetted with saliva.

2. Dispense gel or foam into tray. Fill the tray 1/3 full if using gel.

3. Dry the teeth with an air syringe using the following pattern:
   - Mandibular arch – Dry buccal, occlusal, and then lingual surfaces.
   - Maxillary arch – Dry palatal, occlusal, and then buccal surfaces.

4. Retract the buccal and labial mucosa away from the dried teeth with the fingers of one hand until the hinged trays are inserted into position.

5. Ask the patient to close his/her mouth and bite the teeth together gently to distribute gel inter-proximally.

6. Insert the saliva ejector.

7. Begin timing the procedure. Keep trays in place for four (4) minutes.

8. Stay with the patient and monitor their comfort for the full 4 minutes.

9. Remove the trays after the time has elapsed.

10. Remove excess fluoride with a saliva ejector or high-speed evacuator.

11. Allow the patient to expectorate for 30-60 seconds.

12. Give instructions not to eat, drink, or rinse for 30 minutes.


14. **PROFESSIONALISM**

15. **INFECTION CONTROL**

**VARNISH TECHNIQUE**

Varnish – available in the dispensary

1. Dry teeth with air or gauze

2. Mix the varnish with the applicator brush

3. Apply a very thin coat of varnish with a bend-a-brush

4. Rinse immediately to set the varnish

5. Advise the patient not to eat crunchy foods or brush for 4-12 hours.

*Contraindications

1. Ask patient if allergic to collophonium resin or active ingredient in the varnish being used.

2. Do not apply on bleeding gingiva.
IMPLANT PATIENTS

The student is expected to:

1. Review patient assessment date to determine contraindications to treatment or other factors that will influence the procedure.

2. Assemble the appropriate armamentarium:
   - mirror - metal mouth mirror is fine; just avoid hitting or scraping implant(s).
   - plastic probe
   - plastic scaler
   - super floss
   - dental floss
   - auxiliary aids – whatever is appropriate “nylon coated” proxabrush, end tuft brush
   - gauze – helps to “shoeshine” implant(s)
   - tin oxide or fine (pink) proxyt – to polish implant(s)

   *Check out plastic implant instruments from the 1st Floor dispensary.

3. Use correct patient and operator positioning.

4. Explain the procedure to patient and present appropriate patient education and psychological support (i.e., home care instructions, why procedure is being done, post-operative instructions, etc.).

5. Review the patient assessment data and treatment plan assessment procedures to decide which area to scale, and consider the following variables:
   - ability to complete the area
   - patient comfort and acceptance
   - need for tissue conditioning
   - patient needs
   - location

6. Use appropriate type of instruments according to the nature and location of the deposits. (Metal instruments can be used on natural teeth, and plastic instruments must be used on implants.)

7. Correctly grasp instrument, establish fulcrum, position cutting edge and activate instrument according to the basic principles of instrumentation. **

8. Completely scale each tooth and/or implant(s) so that:
   - all surfaces are calculus free
   - gingiva is not bleeding profusely or lacerated

9. Polish teeth and/or implants with appropriate polishing agents to remove plaque. (Implants will be polished with tin oxide or fine (pink) proxy.)

10. Use appropriate auxiliary aids for complete plaque removal.

11. Allow patient to rinse thoroughly with water.

12. Observe the patient for signs of discomfort and use pain-control techniques as needed to ensure comfort.

13. Evaluate the procedure and final product to determine that criteria were met and identify ways in which performance could be improved.

14. Make complete, accurate, dated chart entry in EPR.

15. Clean up treatment area and armamentarium.

16. PROFESSIONALISM

17. INFECTION CONTROL

**Refer to Periodontal Instrumentation by Nield-Gehrig.
INSTRUMENT SHARPENING
(Hu-Friedy Technique)

The student is expected to:

1. Assemble armamentarium.

2. Evaluate sharpness continually while using instruments in the clinical situation; if necessary, obtain another sharp instrument or sharpen the instruments during the procedure.

3. Explain the procedure and provide pertinent, individual education to patient when sharpening instruments in the clinical situation.

4. Sharpen instrument utilizing basic sharpening procedures (refer to Hu-Friedy’s "It’s About Time To Get on The Cutting Edge"):
   - remove any debris from instrument.
   - evaluate instrument before sharpening to determine if proper contour is present.
   - establish correct angle between stone and cutting edge.
   - maintain correct angle between stone and cutting edge.
   - utilize proper grasp and stroke.
   - work on stable work surface with maximum illumination.

5. Test for sharpness before determining if procedure is complete.

6. Evaluate instrument before the end of sharpening procedure for changes in contour or design features.

7. Use procedures to ensure patient safety and comfort and maximize operator efficiency and effectiveness.

8. Evaluate the procedure and final product to determine ways to improve performance.

9. PROFESSIONALISM

10. INFECTION CONTROL
Right-handers

It's About Time To Get on The Cutting Edge

Sickle Scalers &
Universal Curettes

Gracey Curettes

Take Time for Tips & Toes

**Sickle Scalers & Universal Curettes**

1. Position instrument vertically with blade to be sharpened at 6:00.
2. Stabilize entire length of instrument with a firm grasp.
3. Balance upper shank with index finger or thumb.
4. Point tip or toe of blade toward you to sharpen right cutting edge and away from you to sharpen opposite cutting edge.
5. Hold terminal shank at 12:00.
6. Place side of stone against right lateral surface.
7. Tilt top of stone toward, **not beyond**, 1:00.
8. Move stone up and down in three distinct sections of the blade: heel third, middle third, anterior third.
9. For curettes, rotate the instrument blade toward 3:00.
10. Aim the stone at 2:00.
11. Use continuous and overlapping up-and-down motions to "round" the toe.

**Gracey Curettes**

1. Position instrument vertically with blade to be sharpened at 6:00.
2. Check the blade identification number:
   - Aim the toe of all ODD-numbered Graceys toward you.
   - Direct the toe of all EVEN-numbered Graceys away from you.
3. Stabilize entire length of instrument with a firm grasp.
4. Counterbalance top shank with index finger or thumb.
5. Tilt terminal shank toward 11:00.
6. Hold stone against right lateral surface and tilt toward 1:00.
7. Move stone up and down in three distinct sections of the blade: heel third, middle third and anterior third.
8. Repeat steps #9, 10, and 11 to "round" the toe.
**Left-handers**

It’s About Time To Get on The Cutting Edge

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>12</td>
<td>Position instrument vertically with blade to be sharpened at 6:00</td>
</tr>
<tr>
<td>13</td>
<td>Stabilize entire length of instrument with a firm grasp.</td>
</tr>
<tr>
<td>14</td>
<td>Balance upper shank with index finger or thumb.</td>
</tr>
<tr>
<td>15</td>
<td>Point tip or toe of blade toward you to sharpen left cutting edge and away from you to sharpen opposite cutting edge.</td>
</tr>
<tr>
<td>16</td>
<td>Hold terminal shank at 12:00.</td>
</tr>
<tr>
<td>17</td>
<td>Place side of stone against left lateral surface.</td>
</tr>
<tr>
<td>18</td>
<td>Tilt top of stone toward, <strong>not beyond</strong>, 11:00.</td>
</tr>
<tr>
<td>19</td>
<td>Move stone up and down in three distinct sections of the blade: heel third, middle third, anterior third.</td>
</tr>
<tr>
<td>20</td>
<td>For curettes, rotate the instrument blade toward 9:00.</td>
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<tr>
<td>21</td>
<td>Aim the stone at 10:00.</td>
</tr>
<tr>
<td>22</td>
<td>Use continuous and overlapping up-and-down motions to &quot;round&quot; the toe.</td>
</tr>
</tbody>
</table>

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**Sickle Scalers & Universal Curettes**

- **Position instrument vertically with blade to be sharpened at 6:00.**
- **Stabilize entire length of instrument with a firm grasp.**
- **Balance upper shank with index finger or thumb.**
- **Point tip or toe of blade toward you to sharpen left cutting edge and away from you to sharpen opposite cutting edge.**
- **Hold terminal shank at 12:00.**
- **Place side of stone against left lateral surface.**
- **Tilt top of stone toward, **not beyond**, 11:00.**
- **Move stone up and down in three distinct sections of the blade: heel third, middle third, anterior third.**
- **For curettes, rotate the instrument blade toward 9:00.**
- **Aim the stone at 10:00.**
- **Use continuous and overlapping up-and-down motions to "round" the toe.**

**Gracey Curettes**

- **Position instrument vertically with blade to be sharpened at 6:00.**
- **Check the blade identification number:**
  - **Aim the toe of all EVEN-numbered Graceys toward you.**
  - **Direct the toe of all ODD-numbered Graceys away from you.**
- **Stabilize entire length of instrument with a firm grasp.**
- **Counterbalance top shank with index finger or thumb.**
- **Tilt terminal shank toward 1:00.**
- **Hold stone against right lateral surface and tilt toward 11:00.**
- **Move stone up and down in three distinct sections of the blade: heel third, middle third and anterior third.**
- **Repeat steps #9, 10, and 11 to "round" the toe.**
MEDICAL AND DENTAL HISTORY COMPETENCY

The student will complete a medical/dental history on all patients. The type of data collected will dictate proper clinical procedure. The medical history will be reviewed, and updated if necessary, at the beginning of each consecutive appointment.

1. Assemble armamentarium prior to seating patient.

2. Take blood pressure, pulse, respiration before starting the competency. Make "P" and "H" notes (of the DHOTEN) in the Treatment History tab of the EPR. Document vital signs in the EPR before reviewing medical history with instructor. Take and record temperature if needed.

3. Review with the patient the Patient Information, needed for record keeping:
   a. name, home address, telephone numbers, emergency contact
   b. If any information has changed, send an EPR message stating changes to your PCC

4. For the DH1 competency: Review the following categories in front of instructor: Baseline Data, General, HEENT, and Cardiovascular

5. Review/question each category of medical conditions listed. Make notations for affirmative answers in "comments" at the end of each category; double click and use text box and date when the condition was diagnosed.

6. Note in the Treatment History if previously taken medication has been discontinued. New medications should be added into the Medical History. Look up all medications (OTC and herbal included) and be knowledgeable about indications for use and contraindications; drug class and therapeutic category; warnings, precautions and adverse reactions to treatments; drug interactions and dental considerations.

7. Assess need for medical consultation and/or antibiotic premedication or any medical alert (right click on medical alert and highlight) Note…some medications won’t automatically be posted as an alert even if listed on the medical history.

8. Review the Dental History page (paying particular attention to any affirmative answers).

9. Make appropriate notations in Treatment History DHOTEN not included under the “H” section.

10. Have instructor review medical and dental history prior to having the patient sign both medical and dental history on the signature pad and before starting the Clinical Exam, exploring, probing, OHI, etc.

11. Communication with patient; good eye contact, pronounces conditions correctly, explains unfamiliar conditions to patient.

12. PROFESSIONALISM
**Clinic I**

Evaluation will be as follows: (Process only)

Evaluation of “5” = 1 critical error OR 2 non-critical errors

Evaluation of “4” = 1 critical error AND 1-2 non-critical errors

Evaluation of “1” = more than 1 critical error OR more than 2 non-critical errors

**Clinic II**

(Product only)

Evaluation of “5” = 0 errors

Evaluation of “4” = 1-2 non-critical errors

Evaluation of “1” = 1 critical error OR 3 or more non-critical errors

**Clinic III**

(Product only)

Evaluation of “5” = 0 errors

Evaluation of “4” = 1-2 non-critical errors

Evaluation of “1” = 1 critical error OR 3 or more non-critical errors

**Clinic IV**

(Product only)

No Allowable errors.
NUTRITIONAL COUNSELING

The student is expected to:

1. Review medical/dental history for information to determine if diet survey is indicated.
2. Explain to the patient all the procedures and rationale for 24 hour dietary recall.
3. Complete 24 hour food diary with patient at initial appointment.
4. Analyze the frequency of foods eaten according to their exposures to fermentable carbohydrates. (Analysis must be completed prior to counseling the patient, but not at the same appointment that the food diary is completed).
5. Calculate the exposures according to the directions on the 24 hour dietary recall sheet.
6. Discuss the results with the patient.
7. Analyze the frequency of foods eaten according to my Pyramid and make appropriate recommendations. Go to http://www.choosemyplate.gov/ to individualize your nutritional counseling.
8. Calculate patient’s nutritional score and make recommendations to the patient.
9. Assist patient in setting nutritional goals.
10. Make complete and accurate, entry in the treatment notes into the EPR including all nutritional recommendation & calculations.

11. PROFESSIONALISM
PERIODONTAL CHARTING

The student is expected to:

1. Assemble mirror, Hu-Friedy PCPUNC probe, and Naber’s probe
2. Place patient and operator in correct position
3. Use light and mirror to aid in examination
4. Chart periodontal conditions of patients 18 years or older unless indicated by patient’s condition.
5. Document in EPR the following:
   a. Probe depths (PD)
      1) Record six number readings per tooth within 1mm of instructor’s measurement.
   b. Bleeding on probing (BOP)
   c. Free gingival margin - CEJ (FGM-CEJ)
      1) The measurement must be within 1mm of instructor’s measurement
   d. Tooth mobility
   e. Furcation involvement
   f. Note areas where there is inadequate attached gingival (make a tooth note in the EPR)

6. PROFESSIONALISM

7. INFECTION CONTROL

<table>
<thead>
<tr>
<th>Clinical Practice</th>
<th>Allowable Errors to earn a “1”</th>
<th>Allowable Errors to earn a “4”</th>
<th>Allowable errors to earn a “5”</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>4</td>
<td>3</td>
<td>1</td>
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<tr>
<td>II</td>
<td>3</td>
<td>2</td>
<td>1</td>
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<tr>
<td>III *</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>IV *</td>
<td>4</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

* Indicates advanced to moderate periodontal involvement.
PERIODONTAL PROBE

The student will be able to:

1. Grasp (modified pen grasp)
   a. Hold with index finger and thumb pads.
   b. Stabilize with pad of middle finger.
   c. Maintain contacts between index, middle, and third fingers.
   d. Place index finger and thumb pads at junction of handle and shank.
   e. Maintain handle between second knuckle and “V” of thumb and forefinger.
   f. Rotate instrument handle between thumb and forefinger when adapting to tooth surface, keeping tip parallel and in contact with tooth surface.
   g. Use light pressure.

2. Fulcrum
   a. Establish on stable tooth, finger, prescribed extra oral, or vestibule on gauze.
   b. Establish on embrasure area, occlusal, or incisal surface.
   c. Position close to work area.
   d. Use constant, equal pressure.
   e. Pivot on finger pad for adaptation.
   f. Move hand (up-down, side-side) when pivoting.

3. Stroke
   a. Make minimal independent finger motion.
   b. Maintain side of tip on tooth and slide tip gently under the gingival margin.
   c. Place working end parallel (or as parallel as possible) to surface being probed.
   d. Cover entire col area.
   e. Use 1 mm walking stroke.
   f. Walk around entire sulcus.
   g. Remain in sulcus during consecutive strokes.
   h. Overlap strokes on reinsertion.
   i. Insert to epithelial attachment with light pressure.

4. Technique
   a. Use systematic sequence.
   b. Use mouth mirror for indirect vision.
   c. Maintain correct patient/operator position.
   d. Read probe markings correctly.

5. PROFESSIONALISM

6. INFECTION CONTROL
PHASE-CONTRAST MICROSCOPE

All steps must be prepared prior to patient viewing.

The student is expected to:

**PREPARE THE EQUIPMENT**
1. Remove the dust cover.
2. Turn on the computer.
3. Hit “ok” button in dialog box. Push button. Double click on “Motic Images Plus 2.0” icon. Go to the “file” tab, select “capture window”. Expand it.
4. Turn on the microscope. (Green switch is on the back of the microscope base)
5. Move the light intensity control (rheostat) to the brightness position. (Rheostat is located on the lower right side of microscope base). Red display lights will appear.

**PREPARE THE SLIDE (Chair side)**
6. Explain the procedure to the patient and obtain consent.
7. Assemble the armamentarium:
   - glass slide
   - cover slip
   - sterile water in dropper dispensing bottle
   - scalers/curettes
8. Place one drop of water on the slide for each site to be examined.

**OBTAIN THE SAMPLE**
9. Make a clinical assessment of the mouth to determine the most advanced and severely diseased sites: deep crevices, adjacent to crowns, areas of malalignment.
10. Use a sterile instrument to obtain a sample from the most apical portion of the gingival crevice selected. (Avoid including any calculus).
11. Use a second instrument to dislodge the sample into the drop of water. (Do not break up the sample).
12. Place a single cover slip over the sample.
13. Use an instrument to gently compress the cover slip.
14. Evaluate the sample. A thin sample free of calculus is essential.
15. Blot excess water with a tissue or paper towel.

**MOUNT THE SLIDE**
16. Place the prepared slide, cover slip up, onto the microscope stage.

**CENTER THE SPECIMEN OVER THE LIGHT**
17. Use the knobs under the stage to move the field: larger upper knob moves the slide front-to-back; smaller lower knob moves the slide left-to-right.

**SELECT THE OBJECTIVE**
18. Rotate the lens turret until the 40X objective clicks into place above the specimen.

**SET THE CONDENSER**
19. Rotate the condenser wheel (in front, under the stage) until 40 appears in the window.

**RAISE THE STAGE**
20. Observe the distance between the objective and the cover slip of the slide.
21. Use the large outer knobs on either side of the microscope stand to raise the stage until the lens of the objective appears about to touch the cover slip.
**ADJUST THE FINE FOCUS**
22. Look through the microscope lenses.
23. Use the small fine focus knob (located outside of knob to raise the stage) to bring the specimen into sharp focus.

**POSITION THE FOCUS LOCK**
24. Rotate the focus lock (located between the left-hand coarse focus knob and microscope stand) up and toward you until it is tight.

**ASSUME THE PROPER SCANNING POSITION**
25. Let your left hand adjust the fine focus knob while your right hand moves the specimen on the stage, using the stage controls.

**IDENTIFY THE ORGANISMS VISIBLE: CLASSIFY AS TO STATE OF HEALTH**
26. Locate the microcosm of the healthy crevice:
   - Some cocci
   - Some filamentous organisms
   - WBC’s, 6/field or fewer
   - Low count vibrios

27. Locate the microcosm of marginal gingivitis:
   - Cocci (TMC)
   - Filamentous organisms
   - WBC’s 0 – 12/field
   - Spirochetes
   - Spinning and/or gliding rods
   - Amoeba
   - Trichomonads

28. Locate the microcosm of destructive periodontitis:
   - Cocci (TNC)
   - Filamentous organisms
   - WBC’s, few to TMC and vibrios.
   - Vibrios
   -Spirochetal pumps
   - Spirochetal brush forms
   - Gliding, palisading rods
   - Amoeba
   - Trichomonads

29. Communicate information to patient.

30. Turn off computer, camera, and microscope (end of clinic) or power down the light (during clinic)

31. Replace dust cover on unit.

32. Place slide in the bio-hazardous sharp container.

33. Make the notation in EPR.

34. PROFESSIONALISM

35. INFECTION CONTROL
PIT AND FISSURE SEALANT APPLICATION

The student is expected to:

1. Review medical/dental history, general assessment, and oral inspection prior to treatment for information contraindicating treatment.

2. Explain procedure to patient and/or parent.

3. Assemble armamentarium:
   - mouth mirror
   - explorer
   - articulating paper
   - articulating paper holder
   - cotton pellets or small sponges
   - cotton pliers
   - etching material
   - sealant material
   - cotton roll holders or rubber dam
   - cotton rolls
   - pumice
   - prophy cups and brushes
   - UV curing light
   - protective eyeglasses for operator and patient
   - floss
   - finishing burs or stones
   - fluoride


5. Place protective eyeglasses on patient.

6. Maintain field:
   a. Position light for maximum illumination.
   b. Evaluate teeth scheduled for sealants
   c. Isolate teeth required
   d. Remove saliva and debris routinely to provide adequate vision and patient comfort.
   e. Replace “wet cotton rolls”

7. Follow the instructions of the desired sealant material:
   a. Evaluate teeth scheduled for sealants.
   b. A fluoride polishing agent cannot be used prior to sealant application; polish with pumice.

8. Thoroughly rinse the tooth surface.

9. Isolate the tooth surface using cotton rolls and cotton roll holder and protect from any contamination.

10. Dry the tooth surface with compressed air from 10-20 seconds.
VISIBLE LIGHT APPLICATION (ULTRADENT)

1. Etching procedure:
   a. Apply etchant to the entire occlusal surface for 15 – 20 seconds for permanent teeth, and 15 – 20 seconds for deciduous teeth.
   b. Apply etchant with a continuous, gentle dabbing motion.
   c. Cover the entire occlusal surface with the etchant, including the inclined planes up to the tips of cusp tips.
   d. At least 2 – 3 mm of surrounding enamel should be etched around buccal and lingual pits and grooves.
   e. When etching more than one tooth, add 5 seconds etching time to the basic 60 seconds for each tooth for a maximum of four teeth in one quadrant.
   f. Rinse the tooth surface thoroughly with an oil free spray of water.
   g. Dry the tooth surface with compressed air for 10 – 20 seconds.
   h. The surface of the tooth should have a dull, whitish appearance, indicating complete etching.
   i. The tooth should be isolated from the tongue, saliva, and tissue fluids.

2. Priming procedure:
   a. Apply PrimaDry and leave 5 seconds.
   b. Dry by gently blowing area with moisture-free and oil-free air.
   c. Do not rinse.

3. Sealant application:
   a. Apply sealant to the etched surface.
   b. Confine the sealant to the etched surfaces.
   c. Have patient close eyes while visible light is on.
   d. Place end of curing light tip (wand) 1-2 mm above the tooth surface.
   e. Cure for the desired amount of time for sealant material: according to manufacturer
   f. Check surface of the sealant with explorer.
   g. Rinse with water or rub with a wet cotton roll to remove unpolymerized resin.
   h. Check occlusion with articulating paper.
   i. Floss between teeth after sealant placement.
   j. Have supervising instructor check placement of sealant.
   l. Make complete, accurate, dated chart entry in EPR.
SELF-CURE SEALANT (3M OR DELTON)

1. Etching procedure:
   a. Apply the etching liquid to the entire occlusal surface for: 1) 60 seconds for permanent teeth; 2) 60 seconds for deciduous teeth.
   b. Apply the etching liquid with a continuous dabbing action.
   c. Rinse the tooth surface with an oil free spray of water.
   d. Dry the tooth surface with compressed air for 10-20 seconds.

2. Sealant application
   a. Mix the resin sealant components (follow manufacturer’s instructions).
   b. Apply the sealant to all etched surfaces; allow polymerizing for three (3) minutes.
   c. Rinse with water or rub with a cotton pellet to remove unpolymerized resin.
   d. Check occlusion with articulating paper.
   e. Floss between teeth after sealant placement.
   f. Have supervising instructor check placement of sealant.
   g. Give fluoride treatment.
   h. Make complete, accurate, dated chart entry in EPR.

11. PROFESSIONALISM

12. INFECTION CONTROL
POLISH AND FLOSS

The student is expected to:

1. Assemble the armamentarium.
   a. check odontogram for types of restorations
   b. select correct abrasive agents

2. Check the medical/dental history for information contraindicating the procedure.


4. Explain the procedure to patient.

5. Discuss technique to be used with instructor.

6. Place eyeglasses on patient.

7. Inspect teeth for contraindications to polishing and select teeth to be polished.

8. Disclose the patient’s mouth and discuss areas of plaque with the patient.

9. Use abrasive agents in order of most abrasive to least abrasive changing cups between abrasives.

10. Establish a fulcrum.

11. Use intermediate pressure & maintain slow, constant speed with the prophy angle.

12. Flare the cup into the crevicular and proximal areas.

13. Adapt edge of cup to tooth contour.

14. Adapt occlusal brushes to pits and fissures.

15. Use auxiliary polishing aids as needed.

16. Use caution in retracting corners of the mouth or other soft tissue areas.

17. Wipe cup clear of saliva and debris as needed to avoid splatter.

18. Floss all interproximal areas. (Refer to flossing procedure checklist).

19. Re-disclose and check with mirror and air. Remove plaque as necessary.

20. Clean removable dentures or other removable appliances and return to patient.

21. Evaluate the procedure and final product to determine ways to improve performance.

22. Clean up treatment area and armamentarium.

23. **PROFESSIONALISM**

24. **INFECTION CONTROL**
EVALUATION

Clinical Practice I (Process and product)

5 = 1 critical errors and/or 1 plaque or stain error
4 = 1 critical errors and/or 2 plaque or stain error
1 = 1 critical errors and/or 3 or more plaque or stain error

Clinical Practice II (Product only- any technique except the prophy cup)

5 = 0 – 1 error per case
4 = 2 errors per case
1 = 3 or more errors per case

Clinical Practice III

Use rationale for plaque/stain removal technique according to syllabus guidelines. Maintain competency with critical errors being #4, 5 & 6

Clinical Practice IV

Use rationale for plaque/stain removal technique according to syllabus guidelines. Maintain competency with critical errors being #4, 5 & 6
## POLISHING – SEATING POSITIONS

<table>
<thead>
<tr>
<th>Operator Position</th>
<th>Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>FRONT</td>
<td>Max. Right Facial to Midline</td>
</tr>
<tr>
<td></td>
<td>Max. Left Lingual to Canine</td>
</tr>
<tr>
<td>BEHIND</td>
<td>Max. Left Facial to Midline</td>
</tr>
<tr>
<td></td>
<td>Max. Anterior Lingual</td>
</tr>
<tr>
<td></td>
<td>Max. Right Lingual-Posterior</td>
</tr>
<tr>
<td>BEHIND</td>
<td>Mand. Left Facial to Midline</td>
</tr>
<tr>
<td></td>
<td>Mand. Anterior Lingual-</td>
</tr>
<tr>
<td></td>
<td>(Behind and Front)</td>
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<tr>
<td>FRONT</td>
<td>Mand. Right Facial to Midline</td>
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<tr>
<td></td>
<td>Mand. Left Lingual-Posterior</td>
</tr>
<tr>
<td></td>
<td>Mand. Right Lingual-Posterior</td>
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</tbody>
</table>
SCALING AND ROOT PLANING

The student is expected to:

1. Review patient assessment date to determine contraindications to treatment or other factors that will influence the procedure.
2. Assemble the appropriate armamentarium.
3. Use an aseptic technique.
4. Use correct patient and operator positioning.
5. Explain the procedure to patient and present appropriate patient education and psychological support (i.e., home care instructions, why procedure is being done, postoperative instructions, etc.).
6. Evaluate the patient's pain and anxiety levels. You may use Corah's Dental Anxiety scale to aid in this evaluation. Use appropriate pain management techniques (topical or qix, and/or local anesthesia supervising DDS will administer).
7. Review the patient assessment data and treatment plan assessment procedures to decide which area to scale, and consider the following variables:
   - Ability to complete the area. Since partial calculus removal on a tooth is undesirable, select an area of the mouth that can be scaled and root planed to completion in the time available at this appointment.
   - Patient comfort and acceptance. To make the first scaling appointment less complicated and to help orient the patient to treatment, you may want to select either the sextant with the fewest teeth or the sextant with the least severe periodontal disease.
   - Need for tissue conditioning. Tissue conditioning is accomplished by initiating a daily program of plaque removal and warm salt water rinsing. The goals of such a program are: 1) gingival healing, 2) a lowered bacterial accumulation, and 3) establishing plaque control behaviors by the patient.
   - Patient needs. When the patient indicates an area of discomfort, that area may be completed first.
   - Location. When two quadrants are to be treated as the same appointment, select a maxillary and mandibular quadrant on the same side of the mouth.
8. Formulate a plan as to the sequence of instruments to be used.
9. Use appropriate type, sharp, correctly contoured instruments according to the nature and location of the deposits.
10. Correctly grasp instrument, establish fulcrum, position cutting edge and activate instrument according to the basic principles of instrumentation.
11. Completely scale each tooth so that:
   - All surfaces are calculus free
   - There is no undue tissue trauma.
12. Allow the patient to rinse thoroughly with water. Irrigate with an antimicrobial mouth rinse when indicated.
13. Evaluate the procedure and final product to determine that criteria were met and identify ways in which performance could be improved.
14. Make complete, accurate, dated chart entry into the EPR record.
15. Clean up treatment area and armamentarium.
16. PROFESSIONALISM
17. INFECTION CONTROL
CLINIC I
1 ALLOWABLE CALCULUS/TISSUE TRAUMA ERROR EARNS A “5”
2 ALLOWABLE CALCULUS/TISSUE TRAUMA ERRORS EARNS A “4”
3 ALLOWABLE CALCULUS/TISSUE TRAUMA ERRORS EARNS A “1”

CLINIC II*
1 ALLOWABLE CALCULUS/TISSUE TRAUMA ERROR EARNS A “5”
2 ALLOWABLE CALCULUS/TISSUE TRAUMA ERRORS EARNS A “4”
3 ALLOWABLE CALCULUS/TISSUE TRAUMA ERRORS EARNS A “1”

CLINIC III*
1 ALLOWABLE CALCULUS/TISSUE TRAUMA ERROR EARNS A “5”
2 ALLOWABLE CALCULUS/TISSUE TRAUMA ERRORS EARNS A “4”
3 ALLOWABLE CALCULUS/TISSUE TRAUMA ERRORS EARNS A “1”

CLINIC IV
Refer to competency sheet for total Patient Care Competency

* INDICATES TIME ON MORE DIFFICULT CASES
SICKLE SCALERS

The student is expected to:

1. Grasp (modified pen grasp)
   a. Hold with index finger and thumb pads.
   b. Stabilize with pad of middle finger.
   c. Maintain contacts between index, middle, and third fingers.
   d. Place index finger and thumb pads at junction of handle and shank.
   e. Maintain handle between second knuckle and “V” of thumb and forefinger.
   f. Rotate handle when adapting to tooth surface.
   g. Use light pressure for exploratory stroke.

2. Fulcrum
   a. Establish on stable tooth, finger, vestibule on gauze, or prescribed extra oral.
   b. Establish on embrasure area, occlusal or incisal surface.
   c. Position as close to working area as possible.
   d. Use constant, equal pressure.
   e. Pivot on finger pad for adaptation.
   f. Move hand (up-down, side-side) when pivoting.

3. Stroke
   a. Select correct working end.
   b. Insert tip with blade closed.
   c. Move in direction tip faces.
   d. Maintain tip and cutting edge flush with tooth during: insertion; exploratory stroke; and working stroke.
   e. Use short, overlapping strokes
   f. Roll instrument between thumb and forefinger on line angle to adapt tip to tooth.

4. Student actions
   a. Hold handle as close to parallel with long axis of tooth as possible.
   b. Use with oblique or vertical stroke.
   c. Have no independent finger motion
   d. Apply pressure to remove calculus

5. Technique
   a. Use systematic sequence for scaling individual teeth or quadrants.
   b. Adapt instruments:
      1) Adapt anterior instruments from midline to proximal surface.
      2) Adapt posterior instruments from line angle to proximal surface.
   c. Position patient for efficient access to areas.
   d. Assume operator position as needed for field of operation.

6. PROFESSIONALISM

7. INFECTION CONTROL
TOBACCO CESSATION COUNSELING

The student is expected to:

1. Ask every patient about tobacco use to identify all tobacco users. Determine if they have contemplated quitting.

2. Advise the tobacco user to quit by personalizing the message while utilizing active listening, sensitivity and empathy.

3. Assess the patient’s willingness to quit. Assess the patient’s level of addiction by administering the Faegerstrom’s Questionnaire.

4. Assist the patient with a quit plan; set a quit date and make a note in the chart. Discuss nicotine replacement or pharmacological therapies. Refer to a Tobacco Dependence counselor if more assistance is needed.

5. Follow-up with a phone call in one week. Follow-up at the next appointment with either encouragement or praise for quitting.

6. PROFESSIONALISM
TOOTHBRUSHING / DENTIFRICE

The student is expected to:

1. Assess patient needs: medical history, oral exam, gingival description, case classification.

2. Determine oral hygiene regimen and nutritional habits.

3. Question as to when dental home care procedures were last performed.

4. Disclose patient.

5. Complete and record the plaque index.

6. Provide brushing instructions:
   a. Allow patient to brush in the usual way.
   b. Request patient to identify remaining plaque deposits. (They should be seated upright in the dental chair with the light and hand mirror angled to aid their visualization).
   c. Suggest alteration in brushing technique if appropriate.
   d. Demonstrate brushing in the patient’s mouth. Make modifications as necessary and incorporate aspects of other techniques as appropriate.
   e. Request the patient to perform in his/her own mouth. Give constructive feedback and reinforcement.
   f. Demonstrate tongue brushing. Have patient: 1) extend the tongue; 2) Place the brush as far posteriorly as possible; 3) Sweep the brush anteriorly, displacing the tongue as little as possible.

Brushing Instructions For:

(1) Facial and Lingual Surfaces (Follow a definite sequence)
   a. Grasp the toothbrush in order to maintain control during all movements.
   b. Point the bristles apically at a 45º angle to the long axis of the tooth.
   c. Place the bristles at the gingival margin. The first row of bristles will be close to the crevice. The adjacent row will touch the gingival margin.
   d. Press lightly. The bristles will contour themselves into the crevice and inter-proximal area.
   e. Apply 10 short back-and-forth vibratory or circular strokes. Do not lift the brush or use a scrubbing motion.
   f. Relax the bristle pressure and move the brush to the next segment, overlapping at least one tooth.

(2) Anterior Lingual Surfaces
   a. Insert the brush vertically.
   b. Place the bristles of the toe of the brush at the crevicular area and vibrate.
   c. Pull the bristles over the tooth surface toward the incisal edge.

(3) Occlusal Surfaces
   a. Scrub by moving the bristles back and forth.

7. PROFESSIONALISM

8. INFECTION CONTROL
**TREATMENT PLAN**

The student is expected to:

1. Complete all patient records and diagnostic aids, assessing all information which will influence dental hygiene treatment. Forms and procedures include medical and dental history, extra/intraoral exam, gingival description, dental charting, periodontal charting, and oral risk assessment.

2. Using all patient assessment data, determine a dental hygiene diagnosis. In periodontally involved cases, the dental hygiene diagnosis should include type, extent, and severity of periodontal disease.

3. Based on dental hygiene diagnosis and other assessment data, prepare a comprehensive treatment plan for patient care, including dental hygiene therapeutic services and other preventive services as determined from assessment data.

4. Enter a sequential treatment plan into the EPR.

5. Discuss comprehensive treatment plan with the instructor and have him/her approve it.

6. Discuss the comprehensive treatment plan with the patient, have patient sign the treatment plan consent and make entry in progress notes that the treatment plan has been discussed with the patient, approved and consent form signed.

7. Make complete, accurate, chart entry in the EPR.

8. **PROFESSIONALISM**
ULTRASONIC SCALERS

The student is expected to:

1. Review medical/dental history, vital signs, chart, and patient assessment form for data that contraindicates proceeding with treatment or will otherwise influence the procedure.

2. Explain procedure and rational to patient, providing individualized patient education.

3. Have patient use a pre procedural rinse before using the ultrasonic scaler.

4. Assemble armamentarium:
   - ultrasonic scaling unit
   - plastic drape
   - pre procedural rinse
   - glasses for patient
   - paper towels
   - face mask & shield
   - mouth mirror
   - saliva ejector
   - ultrasonic scaler inserts

5. Make sure that the ultrasonic unit is securely plugged in and turn on the unit.

6. Make sure suction is ready to use.

7. “Bleed” ultrasonic water line for two minutes.

8. Check ultrasonic insert for damage. If a loaned tip is damaged, return to dispensary for replacement. If your own tip is damaged, borrow a replacement from the dispensary until you can replace your own.

9. Fill the ultrasonic hand piece with water and insert appropriate insert.

10. Adjust the insert to an “in-phase” setting.

11. Drape patient with plastic apron and provide with tissues and safety glasses.

12. Put on gloves, mask, and protective eyewear or face shield.

13. Use the appropriate insert for the calculus and/or plaque that is present in the patient's mouth.

14. Adjust ultrasonic unit to correct power setting and water flow for the tip that you are using.

15. Use correct hand piece cord management.

16. Adjust patient position to the proper angle.

17. Correctly grasp hand piece and insert.

18. Apply instrument to the teeth using correct angulations.

19. Keep working end in constant motion.

21. Use light, overlapping strokes.

22. Scale the teeth utilizing a system that minimizes trauma to both teeth and gingival tissue, changing ultrasonic inserts as necessary, and filling the hand piece with water before inserting another ultrasonic insert.

23. Use suction continuously.

24. Check for patient comfort both verbally and visually.

25. Give pre-and post-operative instructions.


27. Clean and disinfect cubicle and ultrasonic unit.

28. Rinse and dry ultrasonic insert, turn into dispensary or wrap in bag and place on cart for sterilization.

29. Make complete, accurate, dated chart entry in EPR.

30. PROFESSIONALISM

31. INFECTION CONTROL
VITAL SIGNS

The student is expected to:

1. Explain all procedures and rationale to the patient.

2. Take Blood Pressure:
   a. Have the patient seat upright, roll up sleeve, flex arm slightly and rest on the arm of the chair at heart level.
   b. Disinfect ear pieces to stethoscope.
   c. Put sphygmomanometer cuff one inch above the elbow with compression bag over the brachial artery.
   d. Place manometer where it can be easily read.
   e. Palpate the radial artery and inflate the cuff until the pulse disappears, continue to inflate another 20-30 mm Hg. The cuff should be deflated slowly at 2-3 mm HG per second until the radial pulse reappears. The point at which the pulse disappears and then reappears on deflation is called palpatory systolic pressure. Release all pressure in the cuff.
   f. Place stethoscope over the brachial artery slightly below the cuff and inflate cuff to 20-30 mm Hg. above the previously determined palpatory systolic pressure.
   g. Release the pressure at a rate of 2-3 mm Hg./second.
   h. Listen for systolic number & note. Listen for diastolic number & note.
   i. Record and date systolic over diastolic pressure, e.g. 120/80 in progress notes.
   j. Recognize abnormally high readings.
   k. Repeat procedure if reading is not within the normal range.
   l. Tactfully advise the patient about the reading. For a patient with blood pressure significantly above normal (> 210 – systolic and > 120 - diastolic) advise the faculty and have the Dispensary RN recheck the readings.

3. Take the Pulse.
   a. Palpate for 60 seconds a readily available artery –usually either the radial or brachial artery. Press the fleshy portion of the index and middle fingers onto the patient’s skin gently enough to feel the pulsation but not so firmly that the pressure occludes the artery. Use carotid artery, if radial pulse is not able to be detected.
   b. Evaluate and record the rate, e.g. 60/min. in progress notes of patient chart.
   c. Advise the faculty if reading exceeds 80 beats per minute.

4. Measure Respiration
   a. Observe the patient’s chest unobtrusively by keeping the fingers on the patient’s pulse as if continuing to take the pulse. Observe the rise and fall of the chest for a minimum of 30 seconds (ideally for one minute).
   b. Measure the rate of respiration and record it accurately, e.g. 14/min. in progress notes.
   c. Advise the faculty if readings diminish to 12 per minute or exceed 28 per minute.

5. Take Temperature if needed or indicated – Temp-a-Dot (found at surgical dispensary)
   a. Peel back wrapper to expose handle end of thermometer.
   b. Remove thermometer taking care not to touch that part which is placed in patient’s mouth.
   c. Place thermometer under tongue as far back as possible into either heat pocket.
   d. Have patient press tongue down on the thermometer, keeping mouth closed.
   e. Keep thermometer in mouth for one minute.
   f. After removal, allow ten seconds before reading the temperature. (The last blue dot indicates temperature).
   g. Record temperature in progress notes of patient chart.

6. Evaluate the patient’s vital signs and correlate them with other physical and medical history findings to determine the treatment plan.

7. PROFESSIONALISM