DENTAL PROGRAMS CLINIC MANUAL

July 1, 2017 - June 30, 2018
Subject to Change

NEW MEXICO STATE UNIVERSITY
3400 S. ESPINA STREET, LAS CRUCES, NM
88003
Table of Contents

Contents

Section 1: INTRODUCTION ........................................................................................................... 11

Dental Faculty and Staff .................................................................................................................. 11
Doña Ana Community College Dental Programs Advisory Committee .................................... 11
Dental Assisting and Dental Hygiene Programs as Professional Partners .................................... 12
Doña Ana Community College (DACC) Mission, Vision, and Values ......................................... 13
Dental Hygiene Program .................................................................................................................. 14

DH Program Vision: ..................................................................................................................... 15
DH Program Goals: ....................................................................................................................... 15
Commission on Dental Accreditation ............................................................................................ 18

The DACC Dental Hygiene Curriculum ......................................................................................... 18

SECTION 2. ACADEMIC & PROFESSIONAL STANDARDS ................................................................. 22

American Dental Education Association (ADEA) Competencies for Entry into the Allied Dental Professions ........................................................................................................................................... 22
CORE COMPETENCIES (C) ........................................................................................................ 24
Professionalism ........................................................................................................................... 29
Advancement, Retention, and Graduation ....................................................................................... 31

Consequences for Non-Compliance of Standards of Conduct ......................................................... 32

Academic Discipline Process-General Cases ................................................................................ 35
Appeal Process ............................................................................................................................ 36
Non-Academic Misconduct ........................................................................................................... 37
Clinical/ Patient Care Area ............................................................................................................. 39
Process following initial observation, removal, and forensic testing ........................................... 40
Professional Activities (ADHA and SADHA) ............................................................................... 40

Insurance Coverage .................................................................................................................. 43

SECTION 3. PERSONAL SAFETY .................................................................................................. 46

SECTION 4. EMERGENCY MANAGEMENT PLAN ..................................................................... 51

Emergency Management ........................................................................................................... 51
Emergency Procedures ............................................................................................................... 58

SECTION 5. HAZARD COMMUNICATION PROGRAM ................................................................. 61

• Blue is for HEALTH ............................................................................................................... 75
Combustible liquids ...................................................................................................................... 76
Highly toxic ............................................................................................................................................ 76

SECTION 6. HEALTH INFORMATION PRIVACY AND ACCOUNTABILITY ACT (HIPAA) ................... 79

SECTION 7. CLINIC BUSINESS OPERATIONS ........................................................................... 86

SECTION 8. CLINIC PROCEDURES .......................................................................................... 100

SECTION 9. INFECTION CONTROL ......................................................................................... 122

DACC Dental Hygiene Program Infectious Disease Standards: ................................................... 122

Basic Infection Control Standards and Procedures ................................................................. 122

Non-Discrimination .................................................................................................................. 123

Immunizations ............................................................................................................................. 123

Hepatitis B Vaccine ...................................................................................................................... 124

Tuberculosis (TB) Test .................................................................................................................... 124

Physical Exam Requirements ....................................................................................................... 124

Admission of Students with Blood borne Infectious Diseases (HIV/AIDS, HBV, HCV) .......... 124

Screening for HIV Infection .......................................................................................................... 124

Medical Care .................................................................................................................................. 124

Management of Personnel with Blood-borne Infections ............................................................. 124

Confidentiality ............................................................................................................................... 125

Standard Precautions ................................................................................................................... 127

Infection Control Standards ......................................................................................................... 128

Blood-borne Pathogens Exposure Control Plan ........................................................................ 129

Implementing Infection Control by DACC Dental Program ........................................................ 131

Work Area Restrictions .................................................................................................................. 131

Labels and Signs ............................................................................................................................. 131

Specimens ...................................................................................................................................... 131

House Keeping ............................................................................................................................... 131

Broken Glass .................................................................................................................................. 132

Vacuum lines and saliva injectors ................................................................................................. 132

Water bottles .................................................................................................................................. 132

Contaminated equipment ............................................................................................................... 132

Trash-Regular VS Regulated/Biohazard ....................................................................................... 132

Lead Foil .......................................................................................................................................... 133

Film Processor Chemicals .............................................................................................................. 133

Sharps .............................................................................................................................................. 133

Laundry Procedures ....................................................................................................................... 134

Operator Preparation ..................................................................................................................... 134

General Guidelines for Exposures to Communicable Diseases .................................................... 137

Post-Exposure to Blood-borne Pathogens: Evaluation & Follow-up ........................................... 137

Blood-borne Pathogen Training .................................................................................................... 138
Study Models ...................................................................................................................................... 185
Vitality Tests ....................................................................................................................................... 185
Specialized Equipment ........................................................................................................................ 186
Screening Patients & Procedures ........................................................................................................ 186

SECTION 11. RADIOGRAPHY ............................................................................................................ 188

Radiographs ............................................................................................................................................ 188
Protocol for Radiographs and Exams .................................................................................................... 188
Patient Refusal of Radiographs ........................................................................................................... 189
Survey Selection .................................................................................................................................. 189
Retakes ................................................................................................................................................ 189
Selecting Radiographic Method (3 options) ........................................................................................ 189
Exposure Settings ................................................................................................................................ 192
Exposure Records ................................................................................................................................ 193
Evaluation of Radiographs .................................................................................................................. 194
Supervision of Radiography ................................................................................................................ 195
Dosimetry Badges ............................................................................................................................... 195

Pregnant Students/Providers .................................................................................................................. 195
Pregnant clinicians will also wear a fetal monitoring badge and a special lead apron to protect the
developing embryo/fetus when exposing radiographs. ......................................................................... 195

Pregnant Patients .................................................................................................................................... 195
Radiographs will be postponed on pregnant patients. If radiographs are necessary and can not be postoned the patient will be referred to the community. .................................................................. 195

Infection Control for Radiography ........................................................................................................ 199

Requirements for Proficiency in Radiology ............................................................................................. 202

SECTION 12. DENTAL HYGIENE THERAPY .......................................................................................... 206

Tobacco Education ................................................................................................................................. 206
Nutritional Counseling .......................................................................................................................... 206
Other Education .................................................................................................................................. 206

Preventive Procedures ............................................................................................................................ 206
Fluoride Therapy .................................................................................................................................. 207
Sealants ................................................................................................................................................ 209
Other Preventive Measures .................................................................................................................... 210

Dental Hygiene Therapy .......................................................................................................................... 210
Scaling/Root Planning (NSPT) .............................................................................................................. 211
Coronal Polish .................................................................................................................................... 211
Desensitization .................................................................................................................................... 212
Appliance Care .................................................................................................................................... 212

**Adjunctive Dental Hygiene Services** .................................................................................................... 213

Antimicrobial Applications .................................................................................................................. 213
Margination ......................................................................................................................................... 213
Implant Care ........................................................................................................................................ 214
Mouth Guards ..................................................................................................................................... 216
Polishing Restorations .......................................................................................................................... 216
Tooth Whitening ................................................................................................................................... 216
Post-Operative Care ............................................................................................................................ 217
Suture Removal ................................................................................................................................... 217
Prescriptions/Dispensing Drugs .......................................................................................................... 217
Prescription (Rx) Writing Protocol ...................................................................................................... 217
Re-Evaluation and Re-care Maintenance ............................................................................................ 218

**SECTION 13. PAIN CONTROL & ANXIETY MANAGEMENT** ................................................................ 220

Local Anesthetic .................................................................................................................................. 220
Monitoring .......................................................................................................................................... 222
Stress Reduction .................................................................................................................................. 222
Topical Anesthetics ............................................................................................................................... 222
Complications ...................................................................................................................................... 223
Documentation ................................................................................................................................... 232

Nitrous Oxide/Oxygen Sedation ........................................................................................................... 233
Patient Selection .................................................................................................................................... 233
Monitoring .......................................................................................................................................... 233
Documentation ................................................................................................................................... 233
Preparing the N2O + O2 Unit ................................................................................................................ 234

**SECTION 14. STUDENT EVALUATION** .......................................................................................... 236

Time Required for Study and Self Reflection ...................................................................................... 238
Evaluation/Grading: General Information .......................................................................................... 238
Classroom Evaluation .......................................................................................................................... 239
Competency Based Evaluation ............................................................................................................. 239
Clinical Competencies .......................................................................................................................... 241
Standards for Clinical Performance ..................................................................................................... 241
Clinical Skill Evaluations (CSE’s) ........................................................................................................ 241
Increasing Competency Levels ............................................................................................................ 242
Clinical Curriculum Map ...................................................................................................................... 242
Mock Boards ....................................................................................................................................... 246
Rotations .............................................................................................................................................. 247
Office Assistant ................................................................................................................................... 248
Sterilization Duty ................................................................................................................................. 248
Radiology Duty .................................................................................................................................... 248
External Rotations ............................................................................................................................... 248
Chart Audits ........................................................................................................................................ 249
Patient Satisfaction Survey .................................................................................................................. 249
Student Progress Report ...................................................................................................................... 249
Graduation Requirements .................................................................................................................... 250
CASE LOAD .......................................................................................................................................... 250

SECTION 15. EQUIPMENT AND SUPPLIES .......................................................................................... 252

Equipment Sign-out ............................................................................................................................ 253
Unit Cleanup ....................................................................................................................................... 255
Disposable Supplies ............................................................................................................................. 255
Equipment Problems ........................................................................................................................... 257
Cavitron Jet Combination .................................................................................................................... 258
Piezo .................................................................................................................................................... 258
Hand-piece Maintenance ..................................................................................................................... 258
Clinic Computers: ................................................................................................................................ 259
Intra-Oral Cameras .............................................................................................................................. 259
Clinic Music System ............................................................................................................................. 260
Autoclaves ........................................................................................................................................... 260
Midmark M-9 Auto Clave .................................................................................................................... 260
Ultrasonic Cleaners ............................................................................................................................. 262
Radiography & Darkroom Equipment ................................................................................................ 262
Laundry ............................................................................................................................................... 262
Nitrous Oxide/Oxygen Units ............................................................................................................... 263
Eye-wash Stations .............................................................................................................................. 263
Dental Laboratory Equipment ........................................................................................................... 263
Diagnostic Equipment ......................................................................................................................... 263
End of Day Clinic Shut Down ............................................................................................................... 264

APPENDICES ................................................................................................................................... 264

Appendix A, Acknowledgement Pages ................................................................................................... 265
Appendix B, Disciplinary Action and Drug Screening Forms ................................................................. 265
Appendix C, Immunizations and Exposure Incident Form ..................................................................... 265
Appendix D, Equipment and Repairs .................................................................................................... 265
Appendix E, Instructor Help Request in Clinic and Chart Audit ............................................................ 265
Appendix F, Radiology............................................................................................................................. 265
Appendix G, Emergency and Incident Forms ................................................................. 265
Appendix H, Foliotek Instructions .............................................................................. 265
Appendix I, Eaglesoft Instructions ............................................................................ 265
Section 1: INTRODUCTION

This Manual provides a written description of important policies and procedures related to the Doña Community College (DACC) Dental Hygiene Program's educational curriculum and its clinical services.

It is a "working document" that is revised and updated as needed, using input from faculty, staff, students, advisory committee members, college administrators, community members, accrediting agencies, and local and state agencies. The Manual is subject to change, and should be used in conjunction with other written materials, such as the DACC Catalog-Student Handbook, course syllabi, other documents, as well as verbal directions provided by Program faculty and staff.

Your responsibility, as the users of this document, is to put these policies and procedures into effect, and to make recommendations for change. Constructive change will enhance the Dental Hygiene Program, its clinical and community services, and the personal and physical environment of the Program and the College.

There are several separate, but related, documents with which you should be familiar, since together they comprise the total documentation of the Program standards. They include:

- This Manual
- Emergencies File
- Equipment Manuals and Maintenance Logs
- Sterilization and Radiographic Certificates and Logs
- Safety Data Sheets
- DACC Catalog- Student Handbook
- The College Catalog-Student Handbook
- All DH course syllabi

Dental Faculty and Staff

Full Time Faculty- Dental Hygiene
Doña Ana Community College Dental Programs Advisory Committee

The Dental Hygiene Program has an advisory committee, which is made up of local dental professionals, as well as public members and students. The committee serves to provide a mutual exchange of information for improving the program, recruiting qualified students, and meeting employment needs of the community.

The objective of the DACC Dental Hygiene Program is to prepare the dental hygiene
student for a career in the practice of dental hygiene.

Future dental hygienists will be prepared to serve the public, and will do so by adhering to the highest standards of professional conduct and behavior. No person shall be excluded from participating in, denied the benefits of, or be subject to discrimination as a result of any program or activity conducted by the Dental Program. Discrimination is prohibited by applicable laws, including, but not limited to: race, color, nationality; religion; disability; age; gender or sexual orientation.

**Dental Assisting and Dental Hygiene Programs as Professional Partners**

The Dental Assisting and Dental Hygiene Programs will share the educational facilities. Faculty will work to develop a variety of opportunities for students in both Programs to work and learn together. It is important for everyone to develop an understanding of both professions, and learn about their potential contributions to the overall practice of dentistry.

The goal is to develop a true sense of teamwork, based on mutual respect for the unique and common characteristics of each profession, and the special attributes of every individual involved. This will help students’ transition to clinical practice, where the importance of each profession, and each professional, can be truly appreciated.

It is expected that students and faculty will develop a collegial and supportive environment for learning and working. Effective communication and teamwork are essential. One factor that will help the community recognize the importance of both professions will be to always refer to the DACC clinical facility as “the Dental Clinic” – not “the Dental Hygiene clinic” or “the Dental Assisting Clinic”.

Faculty will work to develop opportunities outside of the professional educational curricula where students from both programs may participate. For example, students will work together at health fairs, community service projects or in fund raising activities that may be used to support professional development. If you have ideas about how to help bond the two programs, please contribute your suggestions.

**Creating the Ideal Atmosphere**

To help maintain a calm, professional atmosphere, everyone is reminded that the DACC clinic and its related facilities (laboratories, reception areas, business office space and the Program classrooms) are, in fact, all classrooms; disruptions are to be minimized. Everyone participating in the clinic/ laboratory/business area and/or classroom is expected to present a professional appearance and demeanor.

Only faculty, staff, patients and students who are participating in either the Dental Hygiene or Dental Assisting Programs are allowed to be in the clinic, lab, sterilization room, dark room, locker room, or business office. This means that children, other family members and friends may visit briefly, but will not be allowed to remain in these areas for any extended amount of time. Visiting individuals must be supervised, and anyone creating disturbances will be asked to leave.
Doña Ana Community College (DACC) Mission, Vision, and Values

**Mission:** DACC is a responsive and accessible learning–centered community college that provides educational opportunities to a diverse community of learners in support of workforce and economic development.

**Vision:** DACC will be a premier learning college that is grounded in academic excellence and committed to fostering lifelong learning and active, responsible citizenship within the community.

**Values:** As a learning-centered community college, DACC is committed to the following core values.

**Education**

- offers lifelong learning opportunities
- fosters dynamic learning environments designed to meet the needs of our students
- guarantees equality of rights and access
- ensures integrity and honesty in the learning environment
- provides comprehensive assessment of learning

**Students who will be:**

- respected for their diversity
- provided with a safe and supportive learning environment
- challenged to become critical and independent thinkers
- expected to take an active role in their learning process

**Leaders and Employees who:**

- practice tolerance and inclusiveness in decision-making and shared governance with external stakeholders
- encourage and support professional growth
- demonstrate high ethics and integrity
- encourage collaborative interaction among faculty and staff
- practice responsible fiscal management and personal accountability
- ensure equal opportunities for a diverse faculty and staff

**Communities that:**

- build partnerships, including educational alliances
- strengthen industry partnerships to provide workforce development
services and programs in support of economic development

● develop and adapt instructional programs in response to changing economic needs

DACC Strategic Priorities
1. Improve Student Success
2. Inclusive Student and Academic Support Services
3. Academic Curriculum Development and Redesign
4. Workforce for the Future
5. Institutional Efficiency, Effectiveness, and Resource Management

DACC Goals
DACC’s student learning outcomes include four (4) major goals for student achievement:

1. Communicate effectively
2. Identify ethical behavior
3. Problem solve effectively
4. Demonstrate appropriate technical skills

Dental Hygiene Program
The program values, vision, mission, goals and objectives reflect those established by Doña Ana Community College, and help operationalize DACC’s strategic priorities.

Program Philosophy Statement:
The Doña Ana Community College Dental Hygiene Program is committed to developing oral health professionals who become valued members of the dental profession. The following are the values and core beliefs that support the program philosophy:

DACC Dental Hygiene Values, Mission and Vision:

1. Responsibility- Demonstrate self-responsibility for the DACC dental hygiene mission including:

   • Professional and academic honesty
   • Lifelong learning
   • Positive, pleasant learning environment
2. **Critical Thinking and Creativity**: Employ critical thinking to identify, assess, analyze, and creatively address/resolve situations/problems.

3. **Interpersonal Relationships**: Encourage optimal health and personal development, including:
   - Integrity, trust, empathy, and respect
   - Effective communication
   - Appreciation of diversity
   - Collaborative work

4. **Leadership**: Develop and model leadership skills in a variety of settings, including:
   - Management skills—self and systems
   - Positive community contributions
   - Professional development/advancement

**DH Program Vision**:  
The Program will develop and implement a premier educational program incorporating creative, scholarly activity, outstanding service and continuing professional development for students, faculty, staff and the community we serve.

**DH Program Goals**:  
Goals have been established to help define the intended learning outcomes of the DACC Dental Hygiene Program:

**Goal 1**: Effectively communicate with individuals and groups from diverse populations verbally, non-verbally and in writing.

**Goal 2**: Use computers and other resources to locate information related to the practice of dental hygiene and to present information to others.

**Goal 3**: Apply ethical standards of conduct to personal life, professional roles, and assuming responsibility for self-assessment and lifelong learning.

**Goal 4**: Promote patient health and wellness using critical thinking and problem solving in the provision of evidence-based practice.

**Goal 5**: Provide relevant, individualized, quality education, preventive strategies and therapeutic services that will enhance both oral and systemic health.

**Goal 6**: Promote the prevention of diseases and conditions affecting oral and general health.

**Note**: The chart on the following page defines the specific DH program learning outcomes in
four (4) areas: teaching, patient care, research, and service, as well as demonstrates the alignment between the DH program goals and DACC’s student learning outcomes.
<table>
<thead>
<tr>
<th>Relevant DACC General Education Student Learning Outcomes</th>
<th>Program Goals</th>
<th>Learning Outcomes for Teaching</th>
<th>Learning Outcomes for Patient Care</th>
<th>Learning Outcomes Related to Research</th>
<th>Learning Outcomes Related to Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicate Effectively</td>
<td>Goal 1: Effectively communicate with individuals and groups from diverse populations verbally, non-verbally and in writing.</td>
<td>The student will provide accurate, consistent and complete documentation for assessment, diagnosis, planning, implementation and evaluation of dental hygiene services.</td>
<td>The student will respect the goals, values, beliefs and preferences of clients while promoting optimal oral and general health.</td>
<td>The student will work effectively as a team member, and take a leadership role in encouraging interdisciplinary health care.</td>
<td>The student will consult with professional colleagues using appropriate medical/dental terminology.</td>
</tr>
<tr>
<td>Identify ethical behavior</td>
<td>Goal 2: Use computers, and other resources to locate information related to the practice of dental hygiene and to present information to others.</td>
<td>The student will utilize appropriate computational skills to help perform dental hygiene services.</td>
<td>The student will present educational information to clients and professional colleagues utilizing a variety of appropriate audio-visual aids and technology.</td>
<td>The student will demonstrate skill in using computers, written and graphic resources to research evidence based, health related information.</td>
<td>The student will participate in community events and maintain a link to providing services to all groups of diverse individuals.</td>
</tr>
<tr>
<td>Identify ethical behavior</td>
<td>Goal 3: Apply ethical standards of conduct to personal life professional roles and assuming responsibility for self-assessment and lifelong learning.</td>
<td>The student will apply ethical principles as outlined in the professional code of ethics of the American Dental Hygienists Association to his/her personal life and to the practice of dental hygiene.</td>
<td>The student will provide the highest ethical services to all patients.</td>
<td>The student will develop multiple strategies to continue his/her education, to stay current with contemporary practices and to further personal and professional development.</td>
<td>The student will identify ethical community service projects and will continually work to improve the overall health of the community.</td>
</tr>
</tbody>
</table>
Problem solve effectively

| Goal 4: Promote patient health and wellness using critical thinking and problem solving in the provision of evidence-based practice. | The student will critically analyze research and apply it to dental hygiene practice. | The student will use critical thinking, problem-solving, and ethical decision-making in the assessment, diagnosis, planning, implementation and evaluation of dental hygiene services. | The student will critically analyze research and apply it to dental hygiene practice. | The student will recognize emergency situations and respond effectively. |

Demonstrate appropriate technical skills

| Goal 5: Provide relevant, individualized, quality education, preventive strategies and therapeutic services that will enhance both oral and systemic health. | The student will provide care to all patients using an individualized approach that is humane, empathetic and caring and ensures the confidentiality of client information. | The student will differentiate between normal and non-normal structures of the head, neck, and oral cavity. | The student will assume responsibility for dental hygiene actions and care based on accepted scientific theories and research as well as the accepted standard of care | The student will consult with other professionals as needed to help ensure healthcare is comprehensive. |

Goal 6: Promote the prevention of diseases and conditions affecting oral and general health.

| The student will develop an understanding of civic responsibility by participating with instructor in local and state dental hygiene events. | Students will stay abreast of advances in dental hygiene and ethically incorporate appropriate technology for the health and well-being of patients | The student will support and recognize current research and communicate with other professionals for the best overall health outcome for patients. | The student will work with individuals and communities to improve oral and general health |

**Commission on Dental Accreditation**

**Information Accreditation Status**
The Dental Hygiene Program is accredited through the Commission on Dental Accreditation of the American Dental Association.

Accreditation is a complex process that helps ensure the quality of education provided by all programs across the nation. Graduation from an accredited program is a requirement for licensure in all but one state in the U.S. For further information about the accreditation process, and the way in which to contact the commission, please see the DH Program Director.

**The DACC Dental Hygiene Curriculum**
The DACC Dental Hygiene Curriculum is designed to integrate the knowledge, attitudes and skills necessary
to become competent for entry into the profession. The Program is sequenced to provide maximum integration of basic science, dental hygiene theory and clinical skills. Therefore, it is important that students progress through the curriculum as it is designed.

<table>
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<tr>
<th>Program Prerequisites</th>
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<tbody>
<tr>
<td>Course Number</td>
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<tr>
<td>ENGL 111G</td>
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<tr>
<td>MATH 120</td>
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<td>BIOL 225</td>
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<tr>
<td>BIOL 226</td>
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<tr>
<td>CHEM 210</td>
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<tr>
<td>BIOL 221+L</td>
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<tr>
<td>HNDS 251 or AHS 225</td>
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<tr>
<td>COMM 253G or 265G</td>
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<tr>
<td>PSY 201G</td>
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<td>SOC 101G</td>
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Total Prerequisite 34
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<th>Course Number</th>
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<th>Credit Hours</th>
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<th>Lecture</th>
<th>Lab</th>
<th>Clinic</th>
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**Semester 5**

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**Overall Prerequisite + Technical Requirements**

95

**Signature Pages Required:**

Students, faculty, and staff are required to read this manual, and sign the acknowledgement forms which state that they have read, understand and, will abide by the policies and procedures described herein. After signing, the forms shall be turned into the Dental Hygiene Program Director.

- Recognition and Acceptance of Program Policies and Procedures
- Confidentiality Statement and Acknowledgement of HIPAA Training
- Acknowledgement of Infection Control and Ionizing Radiation Training
- Acknowledgement of Hazardous Communication and Management, and Emergency Management Training
SECTION 2. ACADEMIC & PROFESSIONAL STANDARDS

American Dental Education Association (ADEA) Competencies for Entry into the Allied Dental Professions

“Competencies describe the knowledge, skills, and attitudes expected of the graduate, establish benchmarks for outcomes assessment, and guide the development of relevant curriculum content.”


Dental hygienists must complete an accredited educational program and qualify for licensure in all states or jurisdictions in which they plan to practice. Dental Hygienists practice in collaboration with other dental and other health care professionals in a variety of settings.

Competencies for Entry into the Profession of Dental Hygiene were approved by the ADEA House of Delegates in 2010. The competencies are divided into five general domains:

Domains

1. Core Competencies (C) reflect the ethics, values, skills, and knowledge integral to all aspects of each of the allied dental professions. These core competencies are foundational to the specific roles of each allied dental professional.

2. Health Promotion and Disease Prevention (HP) are a key component of health care. Changes within the health care environment require the allied dental professional to have a general knowledge of wellness, health determinants, and characteristics of various patient communities.

3. Community Involvement (CM). Allied dental professionals must appreciate their roles as health professionals at the local, state, and national levels. While the scope of these roles will vary depending on the discipline, the allied dental professional must be prepared to influence others to facilitate access to care and services.

4. Patient Care (PC). Allied dental professionals have different roles regarding patient care. These are reflected in the competencies presented for each discipline. The roles of the allied dental disciplines in patient care are ever changing, yet central to the maintenance of health. Allied dental graduates must use their skills following a defined process of care in the provision of patient care services and treatment modalities. Allied dental personnel must be appropriately educated in an accredited program and credentialed for the patient care services they provide; these requirements vary by individual jurisdiction.
5. Professional Growth and Development (PGD) reflect opportunities that may increase patients’ access to the oral health care system or may offer ways to influence the profession and the changing health care environment. The allied dental professional must possess transferable skills (e.g., in communication, problem-solving, and critical thinking) to take advantage of these opportunities.
### CORE COMPETENCIES (C)

**Standard 2-24c**

**COMPETENCY CROSSWALK BY COURSE, SEMESTER AND TEACHING LEVEL**

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<td>A complete definition of all competencies can be found in the Dental Hygiene Clinic Manual</td>
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#### C. CORE COMPETENCIES

1. **Apply professional code of ethics**
   - 3
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2. **Adhere to laws, regulations, recommendations**
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3. **Promote patient health and wellness/critical thinking**
   - 2
   - 3
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   - 1
   - 1
   - 2
   - 3
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   - 2
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4. **Assume response based on scientific theory & research**
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5. **Self-assessment for life-long learning**
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6. **Provide quality assurance mechanisms for health services.**
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7. **Communicate effectively with diverse groups orally/writing**
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8. **Provide accurate, consistent, documentation of all DH ser.**
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9. **Provide human, private, empathetic, care to all**
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10. **Develop an understand. of basic skills that apply to all DH serv.**
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11. Advance the profession through affiliations with professional organizations
12. Critically analyze research and apply to DH practice

<table>
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<tr>
<th>HP HEALTH PROMOTION AND DISEASE PREVENTION</th>
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<tbody>
<tr>
<td>1. Promote values of health to public outside the profession</td>
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<tr>
<td>2. Communication with diverse population groups</td>
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<tr>
<td>3. Respect goals, values, beliefs, privacy of patient</td>
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<tr>
<td>4. Identify risk factors and develop intervention strategies</td>
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<td>5. Evaluate factors or strategies to promote pt. adherence</td>
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<td>6. Evaluate &amp; utilize methods for health and safety</td>
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<table>
<thead>
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<th>CM COMMUNITY INVOLVEMENT</th>
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<tbody>
<tr>
<td>1. Assess oral needs, quality and availability of resources/serv.</td>
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<tr>
<td>2. Assess, plan, implement, evaluate oral health promotion</td>
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<tr>
<td>3. Provide screening, referral, educational services</td>
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<td>4. Provide comm. oral health services in a variety of settings</td>
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<td>5. Facilitate pt. access to oral health services</td>
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<tr>
<td>6. Evaluate reimbursement mechanisms and their impact on care</td>
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<td>7. Evaluate outcomes of community based programs</td>
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</table>
### PC  PATIENT CARE

1. Assessment - Systematically collect, analyze & record data
   a. Select, obtain, interpret information & note limitations/advs.
   b. Recognize predisposing & etiologic risk factors
   c. Obtain, review & update histories
   d. Recognize health conditions & medications
   e. Identify risks for emergencies & manage emergencies
   f. Perform dental hygiene assessment to assess patient’s needs

2. Diagnosis - Critical decision making based on assessment data
   a. Use assessment findings, etiologic factors & clinical data
   b. Identify pt. needs & findings that impact DH services
   c. Obtain consultations as indicated

3. Planning - Collaborate with pt. health prof. for DH care plan
   a. Correlates assessment to disease findings
   b. Prioritize care plan based on actual/potential problems

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**DH Competency Crosswalk (Cont.)**

(A complete definition of all competencies can be found in the Dental Hygiene Clinic Manual)

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- 3: Core Competency
- 2: Basic Competency
- 1: Essential Competency
- 0: Minimal Competency
c. Establish planned sequence of care based on DH diagnosis

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4. Implementation - Provide spec. tx. to achieve/maintain oral health
   a. Perform DH interventions to prevent and control dental disease
   b. Control pain/anxiety during tx. through accepted techniques
   c. Provide basic life support measures in emergencies
   d. Displays honesty, confidential and cultural sensitivity
   e. Manages environmental health risks with universal precautions

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| 1 | 3 | 0 | 0 | 0 | 2 | 1 | 3 | 0 | 0 | 2 | 3 | 3 | 3 | 0 | 3 | 0 | 2 | 0 | 2 | 3 | 1 | 3 |

5. Evaluation - Evaluate effectiveness of services & modify
   a. Determine outcomes of DH interventions
   b. Evaluate pt. satisfaction with oral health care
   c. Provide subsequent tx. or referrals based on eval. findings
   d. Develop and maintain health maintenance program

|   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
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DH Competency Crosswalk (Cont.)
(A complete definition of all competencies can be found in the Dental Hygiene Clinic Manual)

| Course Prefix | 110 | 112 | 114 | 116 | 117 | 118 | 120 | 122 | 124 | 126 | 134 | 132 | 218 | 219 | 210 | 212 | 214 | 216 | 217 | 220 | 222 | 224 | 226 |
|---------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| PGD PROFESSIONAL GROWTH AND DEVELOPMENT |
| 1. Identify alternative career options and evaluate DH opportunities | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 3 |
| 2. Develop management & marketing strategies for non-trad. settings | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 2 |
| 3. Access professional and social networks | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 2 |
| 4. Conduct literature review and research for DH prof. growth | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 1 | 0 | 0 | 1 | 0 | 1 | 0 | 3 |
| Teaching Level |
| 3 | Most Emphasis |
| 2 | Some Emphasis |
| 1 | Little Emphasis |
| 0 | No Emphasis |
Professionalism
Students entering the Dental Hygiene Program at Doña Ana Community College have been accepted into an academic program that leads to a distinguished profession. Students must satisfy the requirement of scholarship, academic integrity, health, and conduct as outlined in this communication, as well as in the DACC College Catalog, which includes the Student Handbook.

Assuming the role of a health care professional requires certain ethical and behavioral responsibilities. These responsibilities include, but are not limited to:

- Demonstrating academic and professional integrity.
- Providing optimal oral hygiene care by fully utilizing the resources provided by the academic learning environment.
- Accepting the role of professional educator, patient advocate and community service provider.
- Mentoring and working as a colleague with other health care professionals.
- Recognizing the importance of the learning process as a life-long skill.
- Membership in the American Dental Hygienists' Association and participation in local and state association activities.

Professional Integrity/Conduct
Students are required to perform in a professional manner in all student roles. Specifically, the student is expected to:

- Carry out assignments delegated by those in authority.
- Recognize the limitations of his/her training or experience and to function within those boundaries.
- Maintain the confidentiality of records and communications about clients;
- Be punctual and maintain a cooperative, helpful attitude.
- Adhere to the Code of Ethics established by the Dental Hygiene professional organization.
- Maintain strict standards of infection control and radiation safety as outlined in this manual.
- Know and follow all safety procedures, emergency protocols, program/clinic standards, guidelines and procedures.
- Be flexible in order to meet the challenges of change in immediate circumstance as well as change in greater society.
- Comply with the dress and personal appearance code established by the Program.
Students are accountable for their behavior and performance. Program faculty reserves the right to warn the student about unprofessional conduct, and will document any transgressions in writing. Violations will be subject to review by the Program Director and a faculty panel. Violations may result in deduction in Professionalism points and/or sanctions for non-compliance with the program’s protocols. Please refer to our section on Consequences for Non-Compliance of Standards of Conduct and if needed, refer to the Health Sciences Student Handbook for more information.

Violations include, but are not limited to:

- Mishandling of documentation
- Falsifying information
- Altering patients’ records
- HIPAA violation
  - Communicating patient PHI to others who should not have access without patient approval
  - Taking patients’ information out of the clinic
  - Any other mishandling of Protected Health Information (PHI) as outlined by NMSU HIPAA training
  - All students, faculty and staff must complete HIPAA training no later than September first each year. The training is provided through www. trainingcentral.nmsu.edu
  - Faculty and staff can find this training on their training central page
  - Students must go to the website, select:
    - not an NMSU employee
    - I am affiliated with NMSU (student, retiree, or affiliate)
    - Complete the sign in form, the access requested is for undergraduate students, Department of Dental Hygiene, DACC main campus.
    - Upon completion of the training, print your certificate and bring a copy to program director to be placed in your files.

Violations in these areas will be reported to the Program Director immediately.

- The instructor, faculty or staff person who witnessed the violation will notify the student of the violation.
  - Instructors and staff will report the violation to the clinical coordinator
  - The clinical coordinator will evaluate the violation; if the violation meets the above criteria, it will be escalated to the Program Director.
  - The clinical coordinator and the Program Director will determine the sanction to the violation as follows:
• A first time violation. Students will receive professionalism deductions up to 10 points of the overall grade. In addition, the student will need to complete additional training related to the violation in question. Successful completion of the training must be presented to the Program Director within 30 days or by graduation, whichever comes first.

• Second violation will result in referral for processing of academic misconduct or other misconduct as outlined in the DACC manual.

• Professionalism
  o Acting disrespectfully towards instructors and faculty
  o Unprofessional behavior with patients and others
  o Not complying with clinical and educational protocols
  o Any other unprofessional behavior as outlined in this clinic manual or the DACC student manual.

• The sanctions for unprofessional behavior:
  o **First time offense**- The student will receive a warning in pre-clinic only. For other clinical courses, the student will receive a 2-point deduction.
  o **Second time offense**- The student will receive up to 5 point deductions from their professionalism grade.
  o **Third time offense**- The student will receive 10 points off from their professionalism grade.
  o **Above three offenses**- The student will be referred to Program Director and will receive a zero in professionalism. Additional sanctions may be imposed at the discretion of the Program Director.
  o A notice of Violation of Academic Honesty may be given to a student at any time during any violation if deemed necessary by the clinical coordinator.

• Academic Misconduct in didactic courses will be handled according to the DACC student manual and policies. See Academic Misconduct section below.

• Students have the opportunity to appeal to the Dean of Health Sciences any decisions taken by the Program Director within 72 hours of receiving notice in writing.

**Advancement, Retention, and Graduation**

Students are expected to advance through the Dental Hygiene curriculum by meeting all requirements of all courses as listed in course syllabi. To be eligible for graduation from Doña Ana Community College Dental Hygiene Program, a student is expected to maintain a **minimum grade of C, equivalent to a 75%, or higher in all dental hygiene courses. In addition to the 75%, in clinical courses, the student is expected to complete ALL clinical requirements by the end of the semester in course.** If the student does not maintain the minimum grade/score, the Program for the remainder of the semester will place him on academic probation. Students who are unable to achieve a 75%, and complete ALL clinical requirements by the end of that semester (this includes any remediation period) may be face consequences for non-compliance of the program’s protocols. Please refer to our section on Consequences for Non-Compliance of Standards of Conduct and if needed, refer to the Health Sciences Student Handbook for more information.
Grounds for Non-Compliance include:

- Failing to maintain a “C” grade at 75 % or higher in each dental hygiene course.
- Unable to fulfill ALL clinical requirements within the allowed time frame, including remediation.
- Committing violations of academic integrity and/or ethical standards.
  - Presenting to class, clinic, lab or any other school related activity under the influence of alcohol or any other illicit substance.

Consequences for Non-Compliance of Standards of Conduct

Corrective Action up to Involuntary Dismissal from Program

Students are expected to meet performance standards and comply with other academic requirements for each of the Health Sciences Programs, and consequence for non-compliance will be commensurate with the severity of the violation (e.g. not every violation would warrant dismissal from the program), and that as appropriate, and provided patient safety or departmental operations are not placed at risk, some type of warning or progressive discipline will be provided.

Involuntary Dismissal from a Program

Violation of standards of conduct pertaining to any of the DACC Health Services academic programs or failure to abide by specific program requirements may result in the student being dismissed from a program, after notice and an opportunity for the student to provide the student’s position relative to the proposal dismissal.

DACC recognizes that involuntary dismissal from an academic program is a serious event with significant consequences for the student. As a result, DACC has developed the following procedures by which allegations will be investigated, facts will be determined and the administrative consequence (e.g. dismissal from the program) will be clearly communicated to the student, with an opportunity for an informal fact finding hearing and right to appeal to an objective third party not involved in the underlying decision.

Students charged with violations may continue to attend classes pending the final outcome of all steps in the process, including the appeal if any, EXCEPT WHEN continuing student participation creates a risk of harm to patients or would disrupt the learning process of others; in these situations, an interim academic suspension may be imposed pending the outcome of the hearing.

STEP 1: Allegations are Received and Investigated: Often infractions are brought to the attention of faculty or administrators by other students or by patients participating in the programs. Allegations will be fairly and timely investigated by the faculty member or program coordinator. The investigation must include an interview with the student to notify them about the allegations and the investigation, to obtain their side of the story, and to allow them to provide relevant evidence. The investigative process and all factual findings will be documented, including whether witness testimony taken was found to be credible etc.

STEP 2: Notice of Intent to Dismiss Student from Program is provided: If the consequence proposed as a result of a violation of the academic program standards or other requirements is involuntary dismissal, the student will
be notified, provided a copy of the investigative documentation, and offered an opportunity to withdraw from the program in lieu of dismissal or the opportunity to contest the findings or the sanction at an informal administrative hearing.

STEP 3: INFORMAL ADMINISTRATIVE HEARING: The Division Dean or designee or equal rank or higher will serve as the hearing officer for the informal hearing. The parties will be given the opportunity to present their position relative to the facts alleged and those documented after investigation. If either party wishes to call a witness to testify, they may do so, and must give the other party and the hearing officer at least five working days advance notice so that arrangements may be made for the witnesses to attend, for sufficient time to be scheduled, and to allow the other party to choose to call live witnesses rather than rely on the documentation. Each party will be permitted to ask questions of the other party and of any witness who may provide testimony. The hearing officer may ask questions of any party or of any witness. The student charged may have a representative attend with them who will not activity participate or interfere in the process. Within ten working days from the close of the hearing, the Division Dean or designee will issue a written Determination outlining findings of fact and determining whether the proposed sanction will be upheld, reversed or modified. The proposed sanction shall not be increased in severity.

STEP 4: APPEAL PROCESS: Students who receive a Determination that they are to be dismissed from a program may seek an on-the-record-review from the next level of administration or designee in the case of unavailability or conflict of interest. To appeal, within ten working days from the date of receipt of the Determination, the student must submit a Notice of Appeal indicating the basis for the appeal, and attach the Determination appealed from. The student must send a copy of the appeal to the other party and to the faculty member or program director as appropriate. The other party may submit a position statement responding to the basis for the appeal within five working days from receipt of the appeal notice. Typically, the DACC Associate Vice President for Academic Affairs serves as the appeal officer. The appeal will be decided based on the record from the informal hearing, the appeal documentation, and any position statement provided by the other party to the appeal. An appeal may reverse or modify the Determination for substantial procedural error or if the Determination is not supported by a preponderance of the evidence. The appeal officer will issue a Final Decision within fifteen working days from the date the Notice of Appeal was received. The Decision shall be sent to all parties, the informal hearing officer, and the faculty member/program director as appropriate.

Student may continue to attend class pending completion of all procedural steps, including the appeal, unless patient safety considerations dictate otherwise.

**Tutors and Extra Credit**
If a student is unable to progress through the clinical experience at an acceptable rate to complete all requirements within the prescribed time frame, he/she may be required to hire, at their own expense, a Program-approved tutor, and/or participate in developmental clinical experiences to meet the requirements for advancement. Students who are unwilling to participate in a tutorial or additional clinical experience will risk an extension of their clinical experience or successful completion of clinical requirements. Please see our section of “Consequences for Non-Compliance of Standards of Conduct”.

Students having academic difficulty are encouraged to take advantage of the campus Academic Readiness Center (ARC) for tutoring and/or courses in reading comprehension, note taking, critical thinking, test taking, listening skills, etc. Dental hygiene students are also encouraged to study together and to take advantage of faculty’s willingness to provide out of class tutoring.
DACC DH Program Course Retakes and Readmission Procedure

The curriculum for the Dental Hygiene Program is designed with each successive semester of Dental Hygiene courses requiring the previous semester’s Dental Hygiene courses as pre-requisites. It is, therefore, not possible to allow a student to continue in the program if they have not passed all clinical and laboratory competency exams and didactic courses. If there are extenuating circumstances, such as a prolonged illness or accident, it may be possible for the Program to work with the student to approve extra tutoring (at the student’s expense) in order to let the students proceed. In this case a special “Educational Contract” will be written outlining the requirements for fulfilling the outstanding requirements.

In the event that a student does not successfully complete a Dental Hygiene course due to academic failure, the student may appeal to the Program Director. If after careful assessment, the Program Director confirms the failing grade, the student can contest through the DACC grade appeals process described in the current catalog/student handbook. Please see our section on “Consequences for Non-Compliance of Standards of Conduct” and refer to the Health Sciences Student Handbook for this policy as well.

The student’s readmission into the Program will require approval under the following conditions:

(1) The student must petition, in writing, to the Dental Hygiene Program Director for readmission to the Program.

(2) If readmission is requested and granted for the first semester of the Program, the student must compete with all other applicants for entry into the Program.

(3) All petitions for readmission into the Program will be evaluated individually with consideration of a variety of factors; including (but not limited to) an analysis of why the student failed the course(s); a justification of why the student should be re-admitted or allowed to repeat a course; what actions the student has taken, or will take, to improve his/her academic performance in the Program; number of courses failed; professional attitude; and clinical aptitude.

(4) The Dental Hygiene Program Director and faculty will review the petition, with justifications, and they will make the decision to accept or deny the readmission request.

(5) Readmission into the Program may require a student to repeat a course(s). Dental Hygiene courses may be repeated only once.

(6) In the event that more readmission petitions are submitted than there are spaces available in the Program at the readmission point, the Director and faculty will prioritize the petitions for readmission to determine which petitioner(s) will receive the open space(s).

(7) The Director and faculty are not obligated to allow all petitioners to reenter the Program, even if sufficient space exists for all petitioners; some petitioners may be denied readmission into the Program.

(8) In the event that a petition for readmission to the Program is denied, the Director will provide a written response to the student to indicate the reason(s) that his/her petition was denied.

(9) Petitions for readmission to the Program and grade appeals for Dental Hygiene courses must be submitted in writing to the Dental Hygiene Program Director within 10 calendar days of the last official day of the semester (including the summer term). This timeline will allow for decisions to be made speedily, and not delay the student’s enrollment in the next semester. Grade appeals submitted after this deadline, but before the College deadline for grade appeals, will be reviewed in accordance with College guidelines.
However, enrollment in Dental Hygiene courses for the next term may be denied after classes have already begun.

**Board Examinations & Licensing**
The Dental Hygiene Program has an obligation to withhold recommending a graduate to take a board examination to qualify for licensure if a student is considered to be an unsafe or unethical practitioner. Graduation from an accredited dental hygiene program, including DACC, does not guarantee a graduate will perform at a passing level in a stressful examination environment. However, it should be noted that the DACC Program meets or exceeds all requirements for an accredited Program, and faculty are committed to providing a high level of education. Faculties are also committed to providing a supportive environment where students can learn effectively.

Students are responsible for finding an appropriate patient for clinical board examinations and are responsible for all costs related to the board examination and licensing process.

**Program Expenses**
Potential dental hygiene students are advised of approximate cost of tuition, instrument kits, board exams and other expenses that they will incur in their professional education prior to entry into the Program. Therefore, students are expected to be prepared to meet those expenses on time.

It should be noted that because of the challenging nature of the Program, students may not be able to work while maintaining the established academic standards and clinical/service schedules.

**Academic Integrity**
DACC takes an extremely serious view of violations of academic integrity. As members of the academic community, DACC's administration, faculty, staff, and students are dedicated to promoting an atmosphere of honesty and are committed to maintaining the academic integrity essential to the educational process. Inherent in this commitment is the belief that academic dishonesty in all forms violates the basic principles of integrity and impedes learning. Students are therefore responsible for conducting themselves in an academically honest manner.

**Academic Misconduct**
All academic misconduct will be reported and dealt with in accordance with the DACC Student Code of Conduct; a “Notice of Violation of Academic Honesty” form may be filled out. Any student found guilty of academic misconduct shall be subject to disciplinary action. The following summarizes policies from the DACC Catalog/Student Handbook and will be used to guide the process:

**Academic Misconduct-Defined**
Academic misconduct includes, but is not limited to, the following actions:

A. Cheating or knowingly assisting another student in committing an act of cheating or other forms of academic dishonesty;

B. Plagiarism is using another person’s work without acknowledgment in a citation that gives credit to the source. This is true no matter where the material comes from, including internet, other student’s work, unpublished materials, or oral sources. Intentional and unintentional instances of plagiarism are considered instances of academic misconduct. It is the responsibility of the student submitting the work in question to know, understand, and comply with this policy. If no citation is given, even when paraphrasing, plagiarism has occurred.

**Academic Discipline Process-General Cases**
Depending upon the nature of the academic misconduct the following procedures will be followed:

**Course or Departmental Level**
For incidents that occur at the course or academic department level, the faculty member or Department Chair must inform the student of the alleged offense within ten (10) working days of its discovery, and after an investigation and/or conference, will take one of the following actions:

1. The allegation may be dismissed as unfounded;
2. The allegation may be dismissed for lack of preponderance of evidence;
3. The student may admit guilt and a sanction will be imposed; or
4. The Hearing Officer will determine guilt based on preponderance of the evidence, and a sanction will be imposed.
5. The Hearing Officer will report the decision to the student and to the next chain of command

Other Academic Misconduct
Incidents involving academic misconduct not at the course level may include but is not limited to:

1. Unauthorized possession of examinations, reserve library materials, laboratory materials, or other course-related materials;
2. Unauthorized changing of grades on an examination, in an instructor’s grade book, or on a grade report; or unauthorized access to academic computer records;
3. Nondisclosure or misrepresentation in filling out applications or other DACC/NMSU records in, or for, academic departments or colleges
4. In these instances, the Vice President for Academic Affairs, or a designee, will serve as the Hearing Officer and will follow the same process as outlined above.

Appeal Process
All possible levels of appeal should be exhausted before a case reaches the Vice President for Academic Affairs. The student must always be told the next level of appeal.

A. A student who wishes to appeal an instructor’s decision may do so by writing to the course department chair or director (Division Dean, if instructor is also Department Chair or Director) within 72 hours. The appropriate hearing officer will consider both sides of the case and report the decision to the student, the course instructor, the Campus Academic Officer (where applicable), and the Campus Conduct Officer within ten (10) working days. If extenuating circumstances prevent either party from meeting this time frame, all parties involved will formulate an alternate schedule.

B. Either party may appeal a Department Chair’s decision to the Campus Academic Officer. However, a request for a formal hearing need not necessarily be granted. The following points will apply in all cases of appeal:

1. The appeal must be made in writing to the appropriate appellate person or body within the specified period of time.
2. The appeal must include the name of the individual making the appeal, the action that is being appealed, the date the action took place, and the grounds for appeal. Appeals must be made on the basis of one or more of the following grounds:
   a. Procedural or prejudicial error was committed.
   b. The finding of facts contained in the decision included inaccurate information.
c. Specific evidence presented at the hearing is objectionable. Reason for the objection must be stated, i.e., why evidence should not be considered.

d. Evidence not offered during the hearing is now available. Reason why the evidence not offered during the hearing must be stated.

e. The sanction imposed is excessive or inappropriate. Reasons for believing this must be stated.

Persons and/or groups involved in Academic Discipline Cases
Individual students and faculty members are responsible for identifying instances of academic dishonesty. Faculty members then recommend penalties to the Program Director and/or the Division Dean in keeping with the severity of the violation.

If warranted, the Vice President of Academic Affairs shall convene the Academic Appeals Board to solicit its recommendation before making a decision. The highest level of appeal for academic misconduct is the Vice President for Academic affairs whose decision is final.

Academic Appeals Board Procedures
If a decision is made to seek a recommendation from the Academic Appeals Board, the Vice President for Academic Affairs, or a designee, shall assemble case materials for the Board that will normally meet within three (3) weeks. The Vice President for Academic Affairs, or a designee, will inform all parties of procedures to be followed.

Non-Academic Misconduct
Students who engage in disruptive activities in an academic setting (e.g., classrooms, academic offices buildings or grounds) are subject to administrative and disciplinary action in accordance with the DACC Catalog/Student Handbook and as specified in this clinical manual/student handbook.

Attire
Students represent DACC and the Dental Hygiene Program wherever they are. They will be expected to wear appropriate attire when in any assigned classroom, clinical or public setting.

Attendance
The student admitted into the College community has freely accepted the obligation of class attendance. Program attendance and professional conduct standards are outlined in each dental hygiene course syllabus.

In compliance with College policy, instructors will notify the Office of Student Services of the continual absence of a student so that students with non-academic problems may be assisted.

The Dental Hygiene Program has adopted the following guidelines concerning absences from lectures and scheduled clinical and laboratory assignments:

1. Excused absences from lectures and clinical laboratory must be made up in accordance with arrangements approved by the faculty member. It is the responsibility of the student to take the initiative in arranging make-up work.

2. Absences will be excused in case of temporary incapacitation of the student due to illness or accident, and in cases of emergency in the immediate family, such as severe illness, accident or death. Students should do everything possible to notify the appropriate faculty member and to arrange for make-up clinical work prior to being absent. Students requiring considerable assistance in completing missed class/clinic instruction may need to hire an approved tutor from the Program or
the community.

3. Excessive absence, tardiness or excessive client cancellations in a clinical area or in class as defined in the course syllabus, will be grounds for failure of course work and could result in non-compliance of the program’s protocols. Please see our section on “Consequences for Non-Compliance of Standards of Conduct” and if needed, refer to the Health Sciences Student Handbook for more information.

4. In order for students to meet minimum patient requirements and comply with accreditation standards, students who have missed more than 6 clinical hours per semester (regardless of absence or patient cancellation) will be required to make up the missed clinic time in remediation, and will receive 1% point off of total clinical grade per additional absence.

**Impaired Person Standards**

Dental Hygiene students, faculty and staff must perform their clinical activities safely and responsibly. Safe and responsible performance of professional duties is evidenced by accuracy, reliability, and accountability.

a. Students, staff and faculty have a responsibility to notify their immediate supervisors if they are taking any medication that may have an adverse effect upon their performance.

b. Everyone has a legal and ethical responsibility to report persons who are suspected substance abusers. Appropriate referrals will be made.

c. Anyone under the influence of drugs, alcohol or otherwise impaired will not be allowed to participate in any type of Program activity. Attending courses and/or school activities while impaired is not acceptable and could result in violation and non-compliance to the student code of conduct outlined in this clinic manual. Please see our section on Consequences for Non-Compliance of Standards of Conduct. Students can also refer to the Health Sciences Student Handbook for more information.

Doña Ana Community College enforces a policy regarding substance use. Please see the current DACC Student Handbook for details on alcohol and drug policies. In addition, the protocols of the Dental Hygiene Program require additional procedures for dealing with suspected impairment of students.

The Dental Hygiene Program must be certain that students, faculty and staff are not under the negative influence of any substance (regardless of whether the use of the substance is legal or illegal). Substances having the potential to impair, or that actually do impair, judgment could have a deleterious effect on patient care, classroom learning, and laboratory practice. Impairment or possible impairment due to the legal or illegal use of substances resulting in poor decision making may place the safety of students, patients, faculty and the general public at an unacceptable risk.

The intent of this Program standard is not only to protect patient safety, but also to promote a healthy learning environment, as well as learning behaviors free of unwarranted disruptions.

In order to properly address the Program’s standard on the issue of impairment and protect the rights of the student, the following procedures are adopted for handling incidences of suspected impairment.

**Legal use of a substance under the directions of a physician or other health care professional with prescriptive authority which may or does impair:**

If a student is using a substance under the direction of a physician, which either does or may impair his/her judgment, the student should provide the Dental Hygiene Program Director with a letter from his/her physician (or other prescriber) indicating that a substance has been prescribed.
The reason for the prescription should not necessarily be identified, nor will it be requested by the Director or faculty. The Dental Hygiene Program Director may at her/his discretion prohibit a student from participating in a setting where critical judgment may be required as long as the student is using his/her prescription. The Director will issue the student a letter stating the reasons for the decision made.

Students who are legitimately and legally using substances, which either do or may impair judgment while under a physician’s or other health care professional’s direction are NOT subject to disciplinary action if the student complies with the requirements of the preceding paragraph. This Program standard does not negate any requirement that the student must fulfill to complete the course of study. Thus, the student remains responsible for completing all the requirements of the course or Program.

**Suspicion that a student is under the influence of a substance that impairs or could impair judgment:**

**Clinical/ Patient Care Area**

If an instructor in the clinical area has reasonable suspicions that a student is under the influence of a substance that is either impairing or has the potential to impair the student's judgment the following steps should be followed.

- The student will be excused from the patient care setting without delay.
- The student will be informed that they were excused from the setting pursuant to the "Impaired Student" standards.
- The student will be asked if he/she has an explanation for the behavior observed: the student is not required to provide an explanation
- The student’s behavior will be documented using the Behavior Observation Form
- Upon removal from the patient care setting, the student will be placed on probation and will remain on probation until all issues are resolved. This is considered probation due to a safety issue.

However, if the student indicates that he/she is using a substance under the direction of a physician or other prescriber, and can provide a physician or other prescriber statement in support, such a statement will be considered in determining the appropriate course of action.

The Behavior Observation Form will be completed for any type of inappropriate or unusual behavior as listed on the form. The instructor will check all that apply. The category marked “Other” can include, but is not limited to:

- Any type of inappropriate behavior that suggests that a student is under the influence of a substance that impairs or could impair the student's judgment.
- The Behavior Observation Form should be fully completed unless the student refuses, or is unable to execute completion of the document (in which case the instructor should note the reasons given by the student for not completing the form)
- Witnesses to the behavior should be documented on the form with a witness signature.
- Any actions taken, along with time and signature of the faculty should be documented. The Program Director will be notified as soon as possible. If the Director is unavailable, notifications should be made to the Division Dean.
- The student is referred to a qualified and licensed drug testing facility for a drug screen as soon as
possible following removal from the classroom, laboratory or clinical site. Within two hours of the incident, the student shall secure safe transportation to a licensed testing facility for drug screening at the student’s expense.

- A forensic type blood and urine drug screening, with the proper chain of custody by a licensed laboratory will be required. Faculty will provide the student with the referral form.
- If the results are positive, the student may request a retest of the same sample by another properly licensed laboratory. The preceding requirements regarding custody and licensure apply to a retest.
- Results of the test and contents of the Behavior Observation Form shall remain confidential, and may be released only as permitted by law.

**Process following initial observation, removal, and forensic testing**

A meeting involving the student and the Program Director, and/or the Division Dean will occur within three (3) working days of the incident.

- The faculty will arrange for the meeting time and date with the Director and/or Dean.
- The student will not be allowed to return to any setting until he/she has attended this meeting.
- During the meeting the student will have opportunity to present information and discuss the incident.
- Documentation of the content of the meeting shall be signed and dated by the Director, and/or the Dean, and the student.
- If a student refuses to sign, the Director and/or Dean will so indicate on the notes, along with the reason for refusal.

Following the meeting any of the following actions may occur:

- Initiating a behavioral action plan
- Referral to counseling/treatment
- Probation or Leave
- Suspension
- Other actions at the discretion of faculty, Director or Dean

- See section on Consequences for Non-Compliance of Standards of Conduct outlined in this manual and if needed, refer to the Health Sciences Student Handbook for more information.

**Professional Activities (ADHA and SADHA)**

**Student Membership in ADHA**

During the years that students are in the Dental Hygiene Program, each will be a student member of the ADHA.
Membership provides access to professional journals and other resources. The Student American Dental Hygienists Association (SADHA) is an official student club at DACC, and conforms to all policies and procedures required of college student clubs. This includes following college policies for fundraisers and group travel, among other things. Details of these policies will be shared at SADHA meetings as needed. SADHA provides opportunities to develop leadership and organizational skills, and to participate in community service. As part of the responsibilities of a student club, SADHA will elect club officers annually, as well as a senator who participates in DACC student government.

The SADHA club will have regular meetings at a time when both classes may attend; all DH students are expected to participate. As fundraisers and community service projects are developed, it is recognized that not all students will be able to participate in all phases of every project. Committees will be developed and participation will be divided among the group. If someone elects not to participate by providing a fair amount of support over time, that individual will not reap the benefits of fundraisers and group travel.

As part of leadership development, students will attend the New Mexico Dental Hygiene Association’s Annual Scientific Session held in Albuquerque in the early part of the school year. Students are also encouraged to attend the National ADHA Center for Life Long Learning Annual Session held in June of each year in different cities around the country.

Upon licensure as a dental hygienist, graduates are encouraged to become active members of ADHA. This continuing membership provides a wealth of resources to individuals, and helps the organization continue its work to advance the art and science of the profession at both state and national levels.

All students are required to maintain their student membership in the American Dental Hygienists' Association (ADHA). This provides access to professional journals and many important professional resources. The fee is the student’s responsibility. A copy of ADHA membership card must be given to the faculty acting as clinical coordinator for both 1st and 2nd year students.

It is part of the professional profile to participate in continuing education and professional association activities. Therefore, students should be prepared to attend professional activities outside of class time. Students will be notified in advance of these activities (See Section 4 Legal and Ethical Responsibilities of Dental Hygienist).

**Internships and Practicum**

Internships, practicum and off campus rotations are available to the student at the discretion of the affiliated medical/dental facility and dental hygiene faculty. Students are may be required to participate in a practicum in their senior year. Some sites may require an orientation, background checks, and drug testing before students are allowed to attend. Students are responsible for all costs incurred related to these off campus rotations.

**Community Service**

The Program is committed to the concept that health professionals have a responsibility to work to improve the health and wellness of the communities in which they practice. Students will be required to participate in community service activities as part of appropriate courses. Students will also be asked to volunteer for other community service projects as part of the dental hygiene curriculum.

**Transportation and Expenses**

Students are required to provide their own transportation, and pay all personal expenses related to clinical, field experiences, community service projects and professional meetings and conferences.

Students may not transport patients via private vehicles in any situation unless the individual is a member of the immediate family.
**Practice Outside of the DACC Jurisdiction**

While enrolled in the Dental Hygiene Program, the student will **not** engage in dental hygiene practice outside the jurisdiction of the DACC Dental Hygiene Program. Students are not to “practice” patient care outside of approved DACC settings; this type of practice is designated for model use only.

**Business Office Guidelines Computer Use**

Students wishing to use a DACC computer to complete course assignments must utilize computers in the library, or those in DACC campus laboratories. The dental hygiene office and clinic computers are for authorized Program activities only.

Students who wish to use clinic/lab or business office computer for authorized activities, must request permission from the Clinical Coordinator supervising the class, or get written permission from the Dental Hygiene Program Director.

**Email**

All students are required to have a New Mexico State University email. This is the official contact for both DACC and NMSU for emergency alerts, as well as for contact related to course information and grades.

**Clinic Phone Use**

A telephone is available in the clinic area, and in the laboratory for use to schedule patient appointments (local calls only). The Business Operations Specialist or a faculty member must approve long distance calls for clinic-related activities.

**Cell Phone Use**

The use of cell phones in class/clinic is strictly prohibited. Please refer to individual course syllabi’s for specific details.

**Copy Machines**

Department copy machines are **not** to be used by students unless explicitly asked by faculty or staff to duplicate Program materials. Copy machines for student’s personal use are only available in the library for a nominal fee.

**Lockers**

Lockers are assigned for students to use for clinical items only (loupes, shoes, BP cuffs, extra scrubs, Cavitrons, etc.) Books and didactic material for other courses are not to be stored in the locker. The student must furnish a combination lock, and the combination must be provided to the Clinic Lab Manager; this avoids having to cut locks in the event that a student forgets the combination. Nothing is to be stuck to, nailed or otherwise permanently attached to lockers.

Students who are not scheduled to be in the clinic will not be permitted in the locker area.

Lockers are the property of DACC, and are subject to random inspection. Patient’s charts, radiographs, or excess dental supplies are never to be stored in the lockers.

**Instrument Kit Expenses**

Students are required to purchase and maintain specific clinical instruments and equipment over the course of the curriculum. Students may make arrangements to pay for instrument kit on a payment plan through the DACC cashier’s office. A Promissory Note must be signed, and copies of the note, along with all receipts, must be given to the Program Director. Students may not substitute items secured from outside the Program. Students will not be allowed to participate in clinics without purchasing the appropriate kits.

Student Instrument kit monies will not be refunded for any circumstances. Once the kit is purchased and in the possession of the student, the kit belongs to the student and the program cannot take it back for return.

**Instrument Storage**

Small pass through storage areas (often referred to as “cubbies”) are provided for storage of sterile instruments. A key will be checked out to each student to use to retrieve instruments from these cupboards from the clinic.
hallway access. The Clinical Manager, who oversees sterilization and storage procedures in the clinic, checks out a master key to the person on sterilization duty. All instruments should be identified by prescribed color-coding system. Engraving is not recommended, as students are not permitted to have any identifying marks on supplies used at Clinical Board Exams.

Each person should take extra care to ensure the safety and security of their individual and fellow classmate’s equipment, as the instruments are very expensive. Extra equipment such as the stethoscope, dental models, etc. should be kept in the student’s locker.

**Patient Clinic Fees**

Fees for clinical services are very minimal, and help offset the operational cost of running the clinic. Students are responsible for submitting daily fee sheets for each patient. **Payments are required the day of service.** Patients who have not paid their fees in full will not be counted toward fulfillment of graduation requirements and the student will be held responsible for any outstanding patient fees. Graduation from the Program will be delayed if there are any unpaid patient fees.

Students are discouraged from paying patient fees. It is better to educate patients about the value of the services rendered; this is good practice for developing this professional responsibility once employed as a dental hygienist.

**Refrigerators/Food & Drink**

The refrigerator in the clinic facility is not to be used by students or faculty; it is for storage of perishable clinical materials. Absolutely no food or drink is permitted in the clinic or lab. Capped water bottles are permitted in the locker room only, and must be removed daily, as they will be discarded.

**Child Care**

The Program realizes that many students have family responsibilities, and that childcare can at times be difficult. However, for safety reasons, children are not allowed in classroom or clinic sessions unless they are receiving dental hygiene treatment. Under no circumstance should children be left unattended in the lab, clinic reception area, classrooms, hallways or cafeteria.

**Insurance Coverage**

**Professional Liability**

All Dental Hygiene students are **required** to have professional liability insurance throughout the time in the Program. This will be available for a nominal fee as a benefit of your student membership in the American Dental Hygienists’ Association. A copy of the liability insurance policy will be kept on file in the Program office.

Students are encouraged to continue their personal professional liability insurance once they graduate and become employed. It is important to note that a dental hygienist can be sued for many things while in practice. The employing dentist’s insurance policy generally will not protect the hygienist against direct litigation.

**Medical Insurance**

It is strongly encouraged but not **required** that all students obtain medical insurance and needle stick insurance. The program is **not** responsible for paying for medical costs related to illness or injury. College students may obtain insurance through private insurance companies, or the New Mexico State University Student Health Center. A copy of the policy with student’s name, policy number and insurer must be provided to the Program Director.

**Auto Insurance**

Students should carry personal liability insurance for operating personal vehicles to and from campus or clinical sites. Doña Ana Community College covers students for personal injury when they are passengers in
College vehicles for official business.

**Health Certifications**

**Physical Exam**
Each student is required to have a physical exam prior to entering the program. This will ensure the student’s ability to fully participate in the rigorous academic and clinical activities of the program. Proof of the exam will be kept in the student’s academic file.

**Vision Certification**
It is required that students file a certificate from an optometrist or ophthalmologist stating that their vision is 20-20, or corrected to 20-20, within 30 days of entering the Program. It is important to note that color blindness may complicate dental hygiene procedures but does not necessarily preclude an individual from entering the Program.

Students will be required to purchase, and wear loupes (magnification) with headlamps while working in the clinic. Loupes enhance vision, improve ergonomics (body mechanics), and are considered a standard of patient care.

**Proof of Immunizations**
Students are required to show proof of current immunization for the following infectious diseases:

- Diphtheria-Pertussis- Tetanus (DPT)
- Hepatitis B: Faculty may decline HBV vaccination by completing the appropriate form. Under special circumstances a student may be allowed to decline HBV vaccinations.
- Measles, Mumps, Rubella
- Varicella (Chickenpox)

The need for immunization against the flu or other diseases should be discussed with a personal health care provider, and must be considered by each student independently.

Students refusing required immunization will need to appeal in writing to the Program Director.

**Tuberculosis (TB) Test**
Each student will have a tuberculin skin test or chest x-ray prior to entering the Program, and on a yearly basis. The skin test should be made prior to entry into the Program, and at any time following suspected contact with TB. If a student already has a history of positive skin test, chest x-rays should be made. The individual’s physician will determine the frequency of radiographic evaluations.

**CPR Certification**
Health Care Provider Cardio-Pulmonary Resuscitation certification with training in the use of an automated defibrillator is required for all students, faculty and staff participating in clinical activities. Both are responsible for maintaining yearly re-certification and must provide the Program with a copy of their certificate. No one will be allowed to work in clinic without current certification.

Students and full-time faculty certificates must be renewed in August of each year to facilitate clinical and board exam scheduling. All course fees will be the responsibility of the individual.

If one is physically or medically unable to perform CPR, that individual must present a document from their physician explaining why the individual cannot be expected to participate in this procedure.

**Other Responsibilities of Students**
All students are responsible for reading and implementing additional Program standards, guidelines, and procedures distributed throughout the curriculum. Students are also responsible for reading the DACC College Catalog/Student Handbook for College policies and procedures. The following are particularly important:

- Student Services
- Academic Regulations
- Code of Conduct
- Discipline Related Policies and Procedures
SECTION 3. PERSONAL SAFETY

Public Safety for DACC Students
Much of this section is taken directly from the DACC Catalogue/Student Handbook. Included here are important policies and procedures that will help keep students and others safe while on campus. Refer to the cited texts for more information.

Designated “Safe Areas” in the Dental Facility
The following areas have been identified as “Safe Areas” if there is threat of violence or other conditions
where evacuation is not possible, or recommended, such as a tornado or other major types of storms.

- The dental lab, Room 80 E, has a phone, only 1 small window in the door, sturdy benches to get under, and a keyless entry, which automatically locks when the door is closed. People can get out, but no one can enter without the code.
- The dental classroom, Room 82, also has a phone, one small window in the door and a keyless entry.
- All the faculty and staff have a key code for entry to their room. Students may not be in the clinic or classrooms without at least one faculty/staff present.

**DACC Sexual Harassment Policy**

To access the complete Sexual Harassment Policy, please refer to Chapter three, Section 3.94 of the New Mexico State University Policy Manual (dated May 6, 2011). Copies of this policy manual may be obtained via the Personnel website at http://www.nmsu.edu/manual/

All employees and students should be aware that the University is prepared to take action to prevent and remedy such behavior, and those individuals who engage in such behavior are subject to disciplinary action. Faculty and staff with actual or apparent authority who engage in sexual harassment or neglect to control the work environment may be held accountable.

Anyone who may have been subjected to sexually offensive behavior or conduct in the classroom or work environment is encouraged to contact the Office of Institutional Equity/EEO Director at 646-3635 or visit the office located in O’Loughlin House on University Ave.

**Personal Information**

Students, as well as faculty and staff, are cautioned not to reveal personal information to any individual who is not involved in the daily running of the Program, such as:

- personal phone numbers
- addresses
- schedules while on campus
- the presence or whereabouts of others

In addition, the Family Educational Rights and Privacy Act (FERPA) requires that information about grades, or other academic activities, not be discussed with anyone other than the student.

When contacting patients to make appointments, students need to use a clinic phone to avoid having the caller identify a personal phone number. Students should identify themselves by their first name, as a dental hygiene student at Doña Ana Community College, and **use the clinic phone number as the contact phone number**.

Be sure to alert the Business Operations Specialist that a call back is expected, by writing a message in the clinic notebook kept at the front desk for that purpose. When a patient calls back to the clinic, a message will be left in the student’s mailbox. Otherwise, a voicemail message should be left with the Business Operations Specialist so that incoming calls can be dealt with appropriately.

**Internet Sites**
Students are sometimes tempted to post personal information, photographs, etc., on social media. If the information is inaccurate, or demonstrates characteristics potential employers may find offensive, it is possible that a person may not be able to get a desired job. These sites are also potential sources of predators. It is recommended that students be very careful about posting anything on these Internet sites. In addition, no patient information or any kind should be posted on social media.

**Computer Safety**
To prevent misuse of your computer, log on using a secure user ID and Password, and always log off when leaving the computer. Do not open suspicious or unknown attachments without consulting with IT. DACC/NMSU IT will never ask you for a credit card number and will never send you a message indicating that your computer has been compromised. If you receive one of this messages contact your computer support staff person immediately and do not call or enter any information on your computer screen until your computer support staff examines the situation.

**Campus Security Service**
Help keep DACC a safe place to learn and work. Security staff is available to all faculty and students at the various DACC locations. Effective December 1, 2015 DACC will have one centralized number to contact security. If you have a security matter, need an escort, or a guard for safety purposes, please call campus security at the following number:

**527-7777 (7777 if you are dialing from a DACC phone).** The Central Campus Security Office is located in Rm DATS-153E

**Other Important Numbers**
New Mexico State University Police: 646-3311

PEP line (for consult regarding exposure to a blood borne pathogen): 1-888-448-4911 Poison Control Center (New Mexico): 1-800 222- 1222

Control Center (New Mexico): 1-800 222- 1222

Dental Hygiene Program Director: 528-7216 Dean of Health and Public Safety: 527-7639

Environmental/Chemical spill: 646-3327
Emergency: 911 (from a campus phone preferably)

**Please note:** the most efficient and effective way to report an emergency while on Campus is to dial 911 from a campus phone (not a personal cell phone). This will show campus police where you are calling from, and is the quickest way to receive help, as emergency responders will automatically be able to locate from where the call is being made. If you dial 911 from a cell phone, you will get the Las Cruces community emergency line.

**Crisis Assistance Resources**
- New Mexico Crisis and Access Line - 855-662-7474
- Suicide Prevention Lifeline - 800-273-8255
- KidTalk (For children and adolescents, managed by La Casa) - 888-589-3636 or 575-636-3636
- Trevor Project Crisis Line (For youth, LGBTQ community) - 866-488-7386
- Veterans Crisis Line - 800-273-8255

**Safety Tips**
As a deterrent to crime, the College recommends that students and others practice sound crime prevention practices such as:
- Lock vehicles in the parking lot. Never leave personal items, such as purses or backpacks unattended or on the seats of the vehicle. Lock valuables out of sight or carry them.
- Lock rooms and offices when unattended.
- Walk in well-lighted areas only.
SECTION 4. EMERGENCY MANAGEMENT PLAN

Emergency Management
Emergencies, disasters, accidents and injuries can occur in any setting and at any time, usually without warning. Being prepared physically and psychologically to handle emergencies is an individual responsibility as well as an organizational one.

The purpose of this Emergency Management Plan is to help prevent emergences from happening and being prepared in the event of an emergency.

YOUR SAFETY IS OF PRIMARY IMPORTANCE!

For questions concerning this Emergency Management Plan contact: The Dental Hygiene Program Director or The Dean of Health and Public Services

The policies, standards, guidelines and procedures contained here have been formulated to be in accordance with DACC, NMSU, and local, state, and federal regulations. No portion of this manual or these procedures shall be construed as superseding these regulations.

Guidelines
Never leave a patient unattended during an emergency. Notify the closest person to contact a faculty member. If the situation appears life threatening, follow the medical emergency procedures. Record all emergencies in the treatment record.

Review the guidelines published by various agencies that regulate the College, University, and those which establish guidelines to protect health care workers and the public. Please see Stericycle, OSHA Compliance Safety Plans located at teacher station.

- DACC and NMSU Emergency Management Plans
- Occupational Safety and Health Administration
  - CFR 1910.1030 bloodborn pathogens
  - CFR 1910.1200 Hazard Communications
- U.S Department of Health and Human Services
  - CDC – MMWR; Dec. 19, 2003/ Vol. 52/No. RR-17 (Guidelines for Infections Control in Dental Health-Care Settings –2003)
    - CDC – MMWR; June 29, 2001/Vol 50/ No RR-11 (Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis)
Prevention & Preparation

Preventing emergency situations from happening is the first and most effective emergency management strategy. Being prepared for emergencies when they do occur is the second step. Preparation will minimize panic and confusion. It also allows for a planned and coordinated response. No matter what the crisis, THINK before you act, then act swiftly to limit your exposure to danger.

The following prevention and preparation strategies shall be followed at all times to ensure the safety of all personnel in the clinic.

- Use “Universal Precautions” when treating patients
- Never treat a stranger – be familiar with your patients medical history
- Use Personal Protective Equipment (P.P.E) when appropriate
- Keep Provider Vaccinations
- Training and Certifications up-to-date
- Follow work practice controls
- Use Engineering Controls when possible
- Know the location of
  - Exits
  - Emergency equipment (Fire Extinguisher, Emergency Cart, spill kit, etc)
  - Communication equipment (Land line phones)
  - This plan

All students, faculty and staff will be required to renew cardiopulmonary resuscitation (CPR) annually. The training must be at “Health Provider” level and include the use of an automated defibrillator.

Emergency Contacts
Medical and Fire Emergency 911
Campus Security Service:
Help keep DACC a safe place to learn and work. Security staff is available to all faculty and students at the various DACC locations. If you have a security matter, need an escort, or a guard for safety purposes, please call campus security at the following numbers: Remember when dialing out, you must first dial 8, then the number.

<table>
<thead>
<tr>
<th>Campus Security (for all DACC Campuses)</th>
<th>527-7777</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Mexico State University Police</td>
<td>646-3311</td>
</tr>
<tr>
<td>PEP line</td>
<td>1-(888) 448-4911</td>
</tr>
<tr>
<td>Poison Control Center (New Mexico) Dental Programs</td>
<td>1-(800) 222-1222</td>
</tr>
<tr>
<td>Dental Hygiene Program Director</td>
<td>528-7216</td>
</tr>
<tr>
<td>Physical Plant DACC Environmental/ Chemical spill</td>
<td>527-7604 (Director) 528-7210 (Assistant Director) 911</td>
</tr>
<tr>
<td>(NMSU Environmental Health &amp; Safety)</td>
<td>646-3327</td>
</tr>
</tbody>
</table>

Clinic Alert System
In the event of an emergency, a quick and organized action can mean the difference between life and death, temporary and permanent disability, or a short or long hospital stay. The following alert system and guidelines help ensure timely and appropriate behavior in the event of an emergency:

1. Never leave the patient to get help.
2. The person who discovers the emergency (first responder) will verbally alert the closest person (second responder).
3. The second responder will appoint the nearest 3 students to: Notify faculty & the supervising dentist
2. Retrieve the emergency equipment, oxygen, and emergency records. Place Pulse oximeter to help evaluate oxygen level.

3. Be on alert to call 911 (if EMS is called – Send someone to the outside door to direct emergency personnel to the scene)

4. Meanwhile, the first responder will begin a primary survey:
   a. Place the patient in the supine position if possible; if still conscious, the patient may prefer a more upright position
   b. Check for responsiveness, airway, breathing, and pulse. If there is no breathing and/or pulse, begin Basic Life Support (CPR) immediately. Think **CAB**.
      - Carotid pulse checked as a way of ensuring circulation, CPR administered if no carotid pulse, and blood pressure checked if carotid pulse present
      - Air passage opened and cleared if necessary
      - Breathing insured (by artificial respiration if necessary)
   c. If there is breathing and pulse, a secondary survey should be started which includes review of medical history, check blood pressure and pulse every 5 minutes.
   d. Administer Oxygen support if any signs of lack of oxygen are noted. (Oxygen flow should be about 10L/min).

5. Faculty member responding
   a. Go immediately to the emergency location.
   b. Assess patient and determine if you need to assume responsibility for emergency treatment. If attending student is managing the patient effectively, allow them to continue while you continue to monitor closely. If necessary, assume responsibility for managing the patient and continue until someone with more training relieves you and you've relayed all pertinent information.
   c. Once the emergency has been diagnosed, ensure the following appropriate treatment is initiated
      - EMS activated by 911
      - Administer oxygen (10L/min)
      - Use of IV line for rapid drug administration (by dentist with Advanced Cardiac Life Support (ACLS) training)
      - Administer Basic Life Support (BLS) (CPR)
   d. Ensure all incident reports are completed
   e. Notify family of patient if necessary
Emergency Equipment
Staff and Students are responsible to know the location of emergency equipment, to include: medical emergency kit, oxygen and back-up supply of oxygen, fire extinguishers, fire exits, fire alarms, fire blankets, spill kits, eyewash stations, first aid kits, and phones.

Locations
Medical Emergency Kit Teaching Station: center clinic (Note: emergency kit including drugs, are in a red rolling cart.)

Oxygen
Clinic central hallway on emergency cart and on Nitrous Unit across from Operatory #1

AED
Clinic central hallway in emergency cart

First Aid Kits (2)
Clinic central hallway in emergency cart
Lab (Delete: Room 80E, Cabinet above computer.

Eyewash stations (3)
Sink in Lab. Room 80 E has 3 stations. E
Sink in the sterilization area. Sink in the dark room. Remember a 15 minute eyewash is recommended.

Biohazard cleanup kits (2)
Clinic central hallway, Teachers station located on shelves. Cabinet above computer.

Mercury spill kit
Lab: room 80 E. located in Cabinet above computer. 2nd kit located at teachers station in clinic central hallway on shelves

Fire Extinguishers (2)
Clinic wall at back exit
Lab: East wall near hallway exit

Fire Alarm
Clinic far west wall back exit Reception area

Fire Blanket
Lab room 80 E: Emergency Kit, in cabinet above computer.

Phones (5)
Administrative office (2)
Sterilization area (1)
Clinic hallway by computer desk (1) Conference/
Staff Room (1) Classroom # 82
Dental lab, Room # 80 E

Medical Emergency Cart
Blood pressure cuff
Flaslight
Stethoscope
McGill Forceps
Disposable airways
EMT Scissors
Cold packs  
Thermometer  
Pulse oximeter  
Electronic Pulp Tester

Crisis management information including Emergency Records and Blood Borne Pathology Information.

The emergency cart will be monitored monthly for outdated drugs and supplies. All equipment must be accounted for. Records will be reviewed by faculty and filled as necessary.

**Emergency Drug Kit**

<table>
<thead>
<tr>
<th>Color</th>
<th>Item Description</th>
<th>USE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yellow</td>
<td>Twinject (auto-injector) 1.1ml epinephrine injection USP 1:1000 (1mg/ml) from which 2 doses of either 0.15mg (0.15 ml) (or) 0.3mg (0.3 ml) each are available.</td>
<td>Allergic Reaction</td>
</tr>
<tr>
<td></td>
<td>Epinephrine injection, USP 1:1000 (1 mg/ml) Ampul 2 vials are available to be used with syringes in Block area of hit</td>
<td>Allergic Reaction</td>
</tr>
<tr>
<td></td>
<td>Diphenhydramine HCl Injection (Benadryl) USP 50 ug/ml. 2 1ml Vials are available</td>
<td>Allergic Reaction</td>
</tr>
<tr>
<td></td>
<td>Albuterol Inhaler PROAIR® HFA (Albuterol Sulfate) Inhalation Aerosol.</td>
<td>Asthma</td>
</tr>
<tr>
<td>Red</td>
<td>Ammonia Inhalants Crush X3 .3ul each.</td>
<td>Respiratory Difficulty</td>
</tr>
<tr>
<td>Orange</td>
<td>ASA 325 g tablets 2 Tabs per pack Nitrolingual Spray pump 400 Mcg per spray, 60 Metered Sprays</td>
<td>Chest Pain</td>
</tr>
<tr>
<td>Blue</td>
<td>Insta-Glucose gel 3 lg</td>
<td>Hypoglycemia</td>
</tr>
<tr>
<td>Black</td>
<td>Syringes X2 CPR Pocket Mask</td>
<td>Admin Meds and CPR</td>
</tr>
</tbody>
</table>
Clinical Emergency Record
A Record of Medical Emergency Care will be kept in a notebook with the Medical Emergency Kit. It will be filled out in duplicate by or at the direction of a staff member during a medical emergency. A copy of the form shall be retained in the patient’s chart. If the patient required activation of the EMS, a copy shall accompany the patient to the hospital.

The purpose of this form is to:
- Provide a legal record
- Provide information to emergency personnel
- Guide procedures during emergency

General Safety Rules/Risk Management
The main objective of safety rules in the laboratory or clinic atmosphere is to prevent an accident from occurring that might cause serious injury to the student or patient. The following instructions are to be followed throughout the Program to keep accidents from occurring or to minimize injury to the student and/or patient.

1. Wear all necessary personal protective equipment (PPE-gloves, mask and safety glasses with non-perforated side shields) when working in the laboratory and all parts of the clinic.

2. Take special precaution to use all proper instrumentation techniques taught so as not to stick or injure oneself with an instrument or other sharps.

3. In the event you do injure yourself, wash with an antiseptic soap and use hand sanitizer. Report the accident immediately to the instructor so that proper medical procedures can be followed and OSHA documentation can be made. Follow the Post- Exposure Prophylaxis for Exposure if from a contaminated source.

4. Read the label before you use any chemical substance in the lab, clinic, dark room or sterilization area. Some chemicals are corrosive, irritating to mucous membranes, poison, irritating to eyes and will irritate the skin. You may need to wear a face mask, gloves and glasses. Consult Safety Data Sheet (SDS) and labels.

5. Wear nitrile gloves when cleaning the dental operatory, traps and instruments and any areas of contamination in the laboratory. Remember these areas contain waste products, which are contaminants.

6. Disposable sharps must be disposed of properly in designated containers and dispose of pharmaceutical waste in designated container located in the sterilization room.

7. Be sure to seal trash bags properly. Hazardous materials must be placed in red biohazard bags and sealed.

8. Never handle any materials that are, or may be, potentially contaminated by tissue, blood or saliva products without utilizing infection control protocol. This includes the disinfection of impressions, dental prosthesis, and similar materials.
9. All laboratory equipment, models, impressions or similar material must be properly disinfected.

10. In the event you burn yourself, immediately run cold water over the wound or apply ice or cold pack if available. Notify instructor, and seek medical attention as needed.

11. In the event you get a chemical in the eye, immediately flush with water or appropriate eye wash solution at the eyewash station for 15 minutes. Notify instructor and seek medical attention.

12. Use caution and common sense; these work best to prevent accidents from occurring.

Always notify an instructor immediately if first aid assistance is required.

Emergency Procedures

General Principles

Most life-threatening office emergencies are caused by the patient’s inability to withstand physical or emotional stress or the patient’s reaction to drugs. Emergencies also can be caused by a complication of preexisting systemic disease. Cardiopulmonary systems can be involved requiring emergency supportive care.

In all emergencies the following must be performed

1. Place the patient in the supine position if possible. If still conscious, the patient may prefer a more upright position.

2. Begin Basic Life Support (BLS) {cardiopulmonary resuscitation (CPR)}

3. The procedure for CPR were changed in fall 2010, instead of ABC’s of CPR, think CAB; “Circulation, Airway, Breathing”

Remember the CAB’s of CPR.

CIRCULATION - :

- Check carotid pulse, if absent, initiate closed chest cardiac massage. One operator. 2 lung inflations after every 30 heart compressions. Two operators: 1 inflation after every 30 compressions (between compressions without pausing).

Continue cardiopulmonary resuscitative measures until patient is revived, you are unable to continue, or instructed to stop by EMS personnel.

AIRWAY - :

- Open the air passage by tilting the head by placing one hand under the neck and the other hand on the forehead to open the airway.

- Use the Jaw Thrust procedure when breathing does not start after airway is opened by usual procedures.

- From the top of the patient’s head grasp angles of the mandible, lift and displace it forward, tilt head back.

- Open lips to allow mouth breathing.
BREATHING -:

- Check to see if patient is breathing (use hand, ear, or mirror held up to nose).
- If not breathing place a pocket CPR mask tightly over the patient’s mouth. At the same time pinch the patient’s nostrils closed. Blow into the mask tubing to inflate the lungs.
- Determine immediately whether or not there is obstruction. Clear by rechecking the patient’s position, remove oblivious foreign matter but do not do a “blind sleep” which could further lodge the obstruction, wiping the mouth, or otherwise attempting to dislodge foreign matter.
- Inflate the lungs by: mouth-to-mouth resuscitation or mouth-to-nose resuscitation 12 times/min for adults. Mouth-to-airway resuscitation 20 times/min for children. Manual resuscitation oxygen unit with - 5 to 10 liters/minute.
- Check to see that chest rises with each inflation.

4. **Activate Emergency Medical System by 911-Remember to call using a landline phone if possible.**

5. Administer Oxygen (10L/min)
SECTION 5. HAZARD COMMUNICATION PROGRAM

Hazard Communication Program

Introduction

DACC is in compliance with the OSHA Hazard Communication Standard, Title 29, Code of Federal Regulations 1910.1200 through (1) compilation of a hazardous chemical list, (2) utilization of Safety Data Sheets (SDS), (3) ensuring that containers are appropriately labeled, and (4) provision of training in hazardous communication procedures and protocols.

The purpose of the Hazard Communication Standard is to provide you with information and training that will help protect you against hazardous substances in the workplace. Under this program, you will be informed of the contents of the Standard, the hazardous properties of substances with which you work or come into contact, and the handling procedures and measures necessary to protect yourself from these substances. This program applies to all work operations in the College where you may be exposed to hazardous substances under normal working conditions or during an emergency situation.

The Hazard Communication/Infection Control Officer for Dental Programs is the Dental Hygiene Program Director. She/he is responsible for the complete program, its review and update as necessary, and compliance with the College Safety Committee Rules on Hazard Management. Faculty, staff, and students must comply with all provisions of the Standard. In addition to its inclusion in this manual, the OSHA Hazard Communication Standard is available in the clinic.

The written Hazard Communication Program includes a list of hazardous chemicals present in the Dental Programs, a description of the labeling system used to warn employees and students against chemical hazards, a file of Safety Data Sheets (SDS) and how to obtain them, and guidelines for the training of employees and students.

Consumer products (products used in the same manner and frequency as they would be at home) and drugs in solid, final form are not included in the program.

N.M.S.U. Environmental Health and Safety phone number. 8-646-3327

Hazardous Chemicals

A hazardous substance is any substance regarded as a physical or health hazard. A physical hazard is any chemical for which there is scientifically valid evidence that it is a combustible liquid or compressed gas, an organic peroxide, or a material that is explosive, flammable, oxidizing, pyrophoric, unstable (reactive), or water-reactive. A health hazard is any chemical or biological substance or agent which is considered to be a carcinogen, a toxic or highly toxic agent, a reproductive toxin, an irritant or corrosive, or an agent which acts on the circulatory system or damages the lungs, skin, eyes, or mucous membranes.

The clinic and laboratories must compile a list of hazardous chemicals used in their areas. This list must be maintained and updated as new products are added to the inventory. A copy of each current chemical list will be kept at the teaching station area in the OSHA Safety Manual.
General Chemical Safety Rules

The main objective of safety rules in the laboratory or clinic is to prevent an accident from occurring that might cause serious injury to the student, patient, or clinical staff. The following instructions are to be followed to keep accidents from occurring or to minimize injury to the student and/or patient.

1. Handle chemicals in accordance with manufacturers’ instruction.
   - Be familiar with Safety Data Sheets (SDS).
   - Read the label before you use any chemical substance in the clinic or lab. Some chemicals are corrosive, irritating to mucous membranes, poison, irritating to eyes and will irritate the skin. You may need to wear a facemask, gloves and glasses. Consult SDS labels and SDS sheets.
   - Avoid all contact with the skin. Do not touch any item with bare hands that has been contaminated by tissue, blood or saliva products.
   - Avoid spills and splashes.
   - Wear nitrile utility gloves when cleaning the dental operatory, cuspidor, traps and instruments.
   - Remember these areas contain waste products, which are contaminants.

2. Do not use a flame near flammable chemicals.

3. Do not eat, smoke, or apply lip balm or makeup in areas where chemicals are used.

4. When appropriate, Wear protective eyewear, mask, gloves and any other personal protective equipment (PPE) as necessary.

5. Minimize chemical vapor in the air. Areas should be well ventilated to minimize inhalation.
   * Keep chemicals in sealed containers.

6. Know the proper cleanup procedures for chemicals in your area.

7. Dispose of all hazardous chemicals in accordance with SDS instructions and applicable local, state and federal regulations.

8. Be familiar with the Hazard Communication Program and all OSHA guidelines.

9. Be sure to seal trash bags properly. Hazardous materials must be placed in red biohazard bags and sealed.

10. In the event you burn yourself, immediately run cold water over the wound or apply ice, if available. Notify instructor, and seek medical attention as needed.

11. In the event you get a chemical in the eye, immediately flush with water for 15 minutes or an appropriate eye wash solution at the eyewash station, notify instructor and seek medical attention.

12. Report all accidents to the clinical instructor who will assist you in getting proper medical attention, and filing an incident report.

13. Use caution and common sense; these work best to prevent accidents from occurring.

Hazardous chemicals can enter the body by absorption through the skin (dermal), the gastrointestinal tract (oral)
and/or the lungs (inhalation). To avoid dermal exposure, observe all protective measures recommended on the label of the chemical you are using. If a label requires protective clothing, use it. To avoid the danger of splashing chemicals, protect your eyes with safety glasses or plastic shields.

**If any chemical gets into the eye, immediately wash the eye under running water for a full 15 minutes.**

All hazardous chemicals must be disposed of properly.

**Handling of Common Products in Dentistry**
The following is a partial listing of known hazardous chemicals used in dentistry and some of the products in which they may be found.

<table>
<thead>
<tr>
<th>CHEMICAL NAME</th>
<th>MAY BE FOUND IN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acid, nitric</td>
<td>pickling solutions; some bleaching solutions</td>
</tr>
<tr>
<td>Acid, phosphoric</td>
<td>etching agents; phosphate cements</td>
</tr>
<tr>
<td>Acid, picric</td>
<td>pickling agents</td>
</tr>
<tr>
<td>Acid, sulfuric</td>
<td>etchants of alloys; copper plating solutions</td>
</tr>
<tr>
<td>Alcohol, isopropyl</td>
<td>solvents; wiping agents</td>
</tr>
<tr>
<td>Alcohol, methyl</td>
<td>denatured alcohol</td>
</tr>
<tr>
<td>Asbestos</td>
<td>soldering investments; crucible linings</td>
</tr>
<tr>
<td>Beryllium</td>
<td>base-metal alloys</td>
</tr>
<tr>
<td>Formaldehyde</td>
<td>sterilizing solutions</td>
</tr>
<tr>
<td>Iodine</td>
<td>iodophor disinfectants; antimicrobial hand cleaners</td>
</tr>
<tr>
<td>Lead/inorganic</td>
<td>lead compounds</td>
</tr>
<tr>
<td>impression materials (some polysulfides)</td>
<td></td>
</tr>
<tr>
<td>Liquid petroleum gas</td>
<td>burners</td>
</tr>
<tr>
<td>Mercury, inorganic</td>
<td>amalgam</td>
</tr>
<tr>
<td>Mercury, organic</td>
<td>topical antiseptics</td>
</tr>
<tr>
<td>Methyl acetate</td>
<td>solvents</td>
</tr>
<tr>
<td>Methyl methacrylate</td>
<td>denture base resins</td>
</tr>
<tr>
<td>Methylene chloride</td>
<td>solvents</td>
</tr>
<tr>
<td>Molybdenum</td>
<td>insoluble compounds; chromium-cobalt alloys; stainless steel alloys</td>
</tr>
<tr>
<td>Nickel</td>
<td>steel orthodontic appliances</td>
</tr>
<tr>
<td>Nitrous Oxide</td>
<td>nitrous oxide</td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Oil mist, mineral</td>
<td>handpiece lubricants</td>
</tr>
<tr>
<td>Petroleum distillates</td>
<td>solvents; waxes; jellies</td>
</tr>
<tr>
<td>Phenol</td>
<td>disinfectants</td>
</tr>
<tr>
<td>Phthalic anhydride</td>
<td>resins</td>
</tr>
<tr>
<td>Platinum soluble salts</td>
<td>impressions materials (additional silicones)</td>
</tr>
<tr>
<td>Platinum</td>
<td>casting alloys</td>
</tr>
<tr>
<td>Propane</td>
<td>burners</td>
</tr>
<tr>
<td>Rouge</td>
<td>polishing agents</td>
</tr>
<tr>
<td>Silica, amorphous</td>
<td>composite agents</td>
</tr>
<tr>
<td>Silica, crystalline (quartz)</td>
<td>composite resins; porcelain; investments</td>
</tr>
<tr>
<td>Silicon carbide</td>
<td>polishing disks; cutting wheels</td>
</tr>
<tr>
<td>Silver</td>
<td>amalgam; endodontic points; casting alloys; photographic solutions</td>
</tr>
<tr>
<td>Talc, non-asbestos form</td>
<td>gloves</td>
</tr>
<tr>
<td>Tantalum</td>
<td>nickel-chromium-cobalt alloys</td>
</tr>
<tr>
<td>Tin, inorganic compounds</td>
<td>amalgam; polishing pastes</td>
</tr>
<tr>
<td>Tin, organic compounds</td>
<td>impressions materials (condensation silicones)</td>
</tr>
<tr>
<td>Titanium dioxide</td>
<td>porcelain; impression materials</td>
</tr>
<tr>
<td>Toluene</td>
<td>solvents</td>
</tr>
<tr>
<td>Trichloroethane</td>
<td>solvents</td>
</tr>
<tr>
<td>Uranium</td>
<td>insoluble compounds</td>
</tr>
<tr>
<td>porcelain</td>
<td></td>
</tr>
<tr>
<td>Vinyl chloride</td>
<td>maxillofacial plastics; mouth guard trays</td>
</tr>
<tr>
<td>Xylene</td>
<td>solvents</td>
</tr>
<tr>
<td>Zirconium compounds</td>
<td>porcelain; polishing pastes</td>
</tr>
</tbody>
</table>

**Acid -etch materials** are solutions and gels used with the placement of composites, sealants, and orthodontic brackets. They usually contain phosphoric acid. Hazards with these materials include eye damage and acid burns with possible sloughing of tissue. Appropriate precautions include the following:
1. Handle acid soaked materials with forceps or gloves
2. Clean up spills with the spill cleanup kit.
3. Avoid skin or soft tissue contact.
4. Rinse with large amounts of running water in case of eye or skin contact.

**Asbestos** is used in lining materials for casting rings, crucibles, and some soldering investments. NOTE: The College should have asbestos free items. If you have a question concerning the possible presence of asbestos in any of the items you are currently using, please notify the Program Director. Asbestos hazards include respiratory diseases and mesothelioma of the lung. Safety precautions include wearing gloves, protective eyewear, and a NIOSH (National Institute for Occupational Safety and Health) approved mask when handling any asbestos-containing materials.

**Flammable gases** include nitrous oxide, oxygen, and liquefied petroleum gas. The chief hazard with these materials is fire. To maximize safety:

1. Test periodically for leaks.
2. Avoid contact between compressed oxygen gas and lubricants or grease.
3. Keep sparks or flames away from flammable gases.
4. Secure tanks of oxygen and nitrous oxide by chaining them to the wall or placing them in approved cylinder holders to prevent toppling.

**Flammable liquids** include such solvents as acetone and alcohol. As with flammable gases, the primary hazard is fire or explosion. To maximize safety:

1. Store in tightly covered containers.
2. Provide adequate ventilation.
3. Have fire extinguishers available at locations where these liquids are used.
4. Avoid sparks or flames in areas where flammable liquids are used.
5. Store any flammable liquid in excess of 10 gallons per location in a flame-proof cabinet.

**Beryllium** dust and fumes can arise from the melting, grinding, and milling of some base-metal alloys. Associated hazards include contact dermatitis, corneal burns, and inflammation and scarring or respiratory tissues. When handling alloys containing beryllium:

1. Use gloves, eyewear and mask during casting, polishing or grinding.
2. Provide adequate local exhaust ventilation in casting areas.
3. Use power suction methods rather than air hoses to remove dust from clothing and to clean machinery.
4. Dispose of wastes, storage materials, and/or contaminated clothing in sealed bags.

**Mercury** is extremely common in dentistry and is used most often in pre-measured amalgam capsules. It is also available in bulk form and found in scrap amalgam. Some associated hazards include nausea, loss of
appetite, diarrhea, fine tremors, depression, fatigue, increased irritability, headache, insomnia, allergic manifestations, contact dermatitis, pneumonitis, nephritis, dark pigmentation of the marginal gingiva, and loosening of teeth. When working with mercury:

1. Work in well-ventilated spaces and avoid direct skin contact. Beware that Mercury can become an aerosol and be inhaled easily. It can also be absorbed through the skin.

2. Store mercury in unbreakable, tightly sealed containers away from any source of heat.

3. Salvage amalgam scrap and store under water. Storage containers are available in the lab under third sink as you enter the lab. The NMSU hazardous waste pick-up team must dispose of waste. The storage area for this type of waste is in the darkroom in a specially marked area.

4. Clean up spilled mercury using appropriate procedures.

5. Place contaminated disposal materials in polyethylene bags (red bags used for biohazardous waste) and seal.

Nickel is found in some dental alloys, gold alloys, and solders; particles can be released during grinding of nickel-containing alloys. Hazards associated with this metal include allergic manifestations and irritation to the eyes and respiratory system. When working with alloys containing nickel, Wear protective eyewear and a mask during grinding procedures and use high-velocity evacuation systems.

Other metals are found in casting alloys (cobalt, chromium) and amalgam alloys (silver, tin, zinc, copper). Metal dust and fumes may irritate the eyes and respiratory system; contact dermatitis is another potential hazard. With any metal-containing alloys, always wear protective eyewear and a mask during grinding procedures.

Nitrous oxide is used in conscious sedation. Based on laboratory animal studies and several published reports of nitrous oxide abuse, high exposure may cause adverse effects, especially neuropathies and spontaneous abortions. When using nitrous oxide/oxygen for conscious sedation, use the minimal concentration necessary to achieve the desired level of sedation. Use a scavenging system and always maintain adequate ventilation. Periodically check nitrous oxide machines, lines, hoses and masks for leakage.

Organic chemicals include alcohols, ketones, esters, solvents, and monomers such as methylmethacrylate and dimethacrylate. The halogen-containing organic liquids used in dental offices primarily include chloroform, carbon tetrachloride, and some solvents and cleaners. Among the hazards associated with the use of these chemicals are fire, allergic manifestations, contact dermatitis, possible mutagenesis, irritation to mucous membranes, respiratory problems, nausea, liver and kidney damage, central nervous system depression, headache, drowsiness, and loss of consciousness. Use of organic chemicals requires the following precautions:

1. Avoid skin contact and excessive inhalation of vapors.
2. Work in well-ventilated areas.
3. Use forceps or gloves when handling contaminated gauze or brushes.
4. Keep containers tightly closed when not in use and store all containers on flat sturdy surfaces.
5. Clean the outside surfaces of containers after uses to prevent residual material from contacting the next user.
6. Use an appropriate solvent cleanup kit in case of spills.

Photographic chemicals are used in the developing and fixing of radiographic film. If used carelessly, they can cause contact dermatitis and irritation of the eyes, nose, throat, and respiratory system from vapors and fine particulates of chemicals. Proper manipulation of these chemicals includes the following:

1. Use protective eyewear; Wear heavy-duty rubber gloves to avoid skin contact. Wash off chemicals with large amounts of soap and water if contact occurs.

2. Minimize exposure to dry powder during the mixing of solutions.

3. Work in well-ventilated areas.

4. Clean up spilled chemicals immediately.

5. Regularly launder clothing that comes in contact with photographic solutions. These chemicals stain most fabrics.

6. Store photographic solutions and chemicals in tightly covered containers.

7. Save the lead backing on dental film for recycling.

**NOTE:** Dispose of all chemicals properly. Developer may be pored down the drain. However, the Fixer collects silver during film processing and must be disposed of by the DACC/NMSU Environmental Safety Department for proper disposal.

Pickling solutions are strongly acidic liquids used to remove contaminants from the surface of cases metals. They contain metal ions after use; the components may be volatile. If used carelessly, these solutions may cause burning and irritation of the skin and mucous membranes, damage to the eyes, and irritation to the respiratory system. When using pickling solutions:

1. Wear safety goggles for eye protection and use forceps to hold the object being pickled.

2. Avoid skin contact by Wearing heavy-duty rubber gloves.

3. Use in well-ventilated area to minimize the formation of airborne droplets. Store solutions in covered glass containers.

4. Avoid splattering; do not place hot objects into the solution.

5. Keep baking soda in the spill kit for acid spills. Spill kits are located in the clinic and lab.

Plaster and other gypsum products are very common dental materials used for study models, diagnostic casts, working models, etc. They contain such compounds as silica and calcium sulfate. Improper or careless handling can cause irritation and impairment of the respiratory system, silicosis, and irritation of the eyes. When handling these powders or trimming models, always wear protective eyewear and a mask, minimize the exposure to powder, and work in a well ventilated area.

Formaldehyde is found in Chemclave and Harvey sterilizing solutions, which are NOT in use in the DACC Dental Clinic. However they may be found in external clinical rotation sites. Formaldehyde is also found in some preservatives. It is a potential cancer hazard when levels exceed 0.5ppm (parts per million). Always wear rubber gloves, safety goggles or glasses, and a mask to avoid breathing vapors.
**Storage and Handling of Chemicals**

Chemicals should be stored in cool, dry areas at temperatures between 67 to 94 degrees F. unless the manufacture notes otherwise. There are two areas of concern when it comes to handling products. First, is identification and knowledge of the product. Second, is handling and mixing the product safely.

Always read the manufacturer or supplier’s directions and the SDS label before you use a product. Be alert to the possible hazards of the product. Make sure the proper information is on the label for products with hazardous chemicals. The SDS sheets will supply the information used on the label to determine what extent the student needs to protect herself/himself when working with a product that has a hazardous chemical in it. Protective clothing is necessary when the chemical can affect the skin, eyes and lungs. It is important to know the chemicals you are working with, for many chemicals can be harmful if not handled properly. Explosions, fire, and dangerous fumes are some of the typical reactions of improperly handled or mixed chemicals.

Always clean up spills immediately. Mix and use chemicals in well-ventilated areas. Storage of waste materials in another area may require special attention. Do not mix chemical wastes that may react. In order to limit the quantity of waste, obtain chemicals only in the quantities that are needed.

Make sure that the wastes you dispose of are done in a manner as not to poison the environment and possibly humans. Chemicals should never be poured down the sink.

By following the guidelines listed above, you will make the workplace safer for all students, staff and patients.

**Chemical First Aid**

**Read the Safety Data Sheet (SDS) for the chemical being handled.**

On the SDS form, information can be found about appropriate emergency and first aid procedures for the chemical listed.

This portion further explains the information found on the SDS form. Common first aid procedures will be described as well as a general guide to handling chemicals to avoid ingestion, inhalation, eye contact and contact with skin.

**Always notify an instructor immediately if first aid assistance is required.**

**Ingestion:**

Safety procedures:

- Swallowing chemicals can result in reactions that range from irritating the stomach to serious injury or death. The best way to prevent ingestion is by not using your mouth to start siphoning chemicals. Use an aspirating bulb or other device to siphon chemicals or liquids.

- Contaminated containers used to store food, or eating foods with contaminated hands, is another way to induce ingestion. Food or drink should not be consumed where chemicals are being stored. Do not store food and chemicals in the same refrigerator. Wash your hands before you eat.

- If mouth contact or swallowing of a chemical occurs, you must know what to do or not to do.

**First Aid for Ingestion:** The treatment objective in poisoning by mouth is to dilute or neutralize the poison as
quickly as possible. Induce vomiting except when a corrosive poison is swallowed or if the victim is unconscious or having convulsions. Maintain respiration, preserve vital functions and seek medical assistance without delay.

**What to Do When:**

1. You know the victim has **not** swallowed a strong acid, strong alkali, or petroleum product, but do not have the original container.
   a. Dilute the poison with water or milk.
   b. Induce vomiting **except** for those chemicals listed above.
   c. Get medical help immediately.

2. You do **not** know what poison the victim swallowed.
   a. Dilute with water or milk.
   b. Try to find what poison was taken and when.
   c. Get medical help immediately.

Remember: Do not induce vomiting, except if the label or first aid recommendations advise you to do so. Vomiting may cause more harm if the chemicals leave the digestive tract.

**Inhalation:**
Safety procedures:

* For fume poisoning from inhaled gases, remove victim to fresh air.
  
  ➢ Start artificial respiration if needed.
  
  ➢ Call for medical help. Toxic chemicals can enter the body through the lungs in the form of vapors, gases, dusts or even liquid. This can cause permanent injury to the lungs, nervous system, other body organs or even death. Know the chemicals you are handling. Do not smell chemicals that are not properly identified. The symptoms of severe poisoning may not be known for hours.

Handle chemicals in well-ventilated spaces or exhaust the fumes to remote areas. Use equipment to measure vapor and oxygen levels in closed spaces. Use breathing apparatuses when required. Be advised that the work area can contain vapor or dust levels too low to detect by smell. Effects of chemicals may be cumulative or not known for hours or years.

Maintain a clean work area. Wear approved respiratory protective equipment as advised. Do not smoke in areas where chemicals are handled.
Symptoms and First Aid for Inhalation: Irritation of the skin, eyes or respiratory system are symptoms of severe poisoning. Additional symptoms may include: difficulty in breathing, headache, nausea, sleepiness, or unconsciousness, poor coordination and staggering. If dizziness, sleepiness or nausea occurs, leave the contaminated area at once, get fresh air, and seek medical assistance.

Skin Contact:

- Avoid skin contact of chemicals by wearing protective clothing such as gloves, goggles, and laboratory aprons or other protective clothes. The skin can come in contact with chemicals from splashing, immersion or saturation of clothing. This contact can lead to dermatitis and chemical burns of the skin that include blistering and tissue death.
- Know the chemical you are working with. The protective clothing you may be using may not give adequate protection against the chemical due to the chemical breakdown of the material or permeation through it. When removing gloves that have come in contact with the chemical, wash the gloves before you remove them to prevent the chemical from being transferred onto the skin.
- Remove saturated clothing that contacts the skin.
- Using soap or detergent can be used to aid in the removal of some chemicals, but may not neutralize them. Know your first aid for the chemical you are working with.
- Do not use organic solvents in cleaning of any skin surfaces. These solvents may be absorbed through the skin or may increase the rate of absorption of other chemicals.

Symptoms and First Aid for Skin Contact: The symptoms associated with skin contact may include irritation, inflammation, blisters and tissue damage. Chemical burns may not be apparent immediately. If first aid information advises, or irritation or inflammation continues, seek medical attention. In case of contact with a chemical on the skin, flush the area with water for at least 15 minutes, unless the manufacturer advises otherwise.

Do not reuse contaminated clothing until they are properly decontaminated. Eye Contact:

Safety procedures:

- Wear proper eye protection when you are working with chemicals or when you are in an area where others are working with a chemical. Permanent injury or blindness can be caused by liquid, solid, or gaseous chemicals entering the eye.
- Do not touch your eyes with contaminated hands. Eye protection is necessary whenever particles or liquids may be thrown into the eye.
- The eye protection you use should include safety lenses that will not shatter.
- Contact lenses should not be worn in areas where chemicals, dusts, or particles can be thrown.
Gases can concentrate under the contact lens causing damage to the eye, or causing soft lenses to stick to the eye as the gases are absorbed. Small particles can get trapped under the lenses causing irritation and inflammation. Soft lenses can dry out in hot, low humidity environments. This can cause difficulty in removal in an emergency.

**Symptoms and First Aid for Eye Contact:** The symptoms of injury to the eye may include: painful burning sensation, watering of the eye, inflammation and sensitivity to light. Strong alkalis may not produce pain immediately. **A 30 second delay in treatment of eye contact with a chemical could mean the loss of one’s vision. Action must be in place immediately when an eye injury occurs.**

- Use a soft flow of water immediately when a chemical enters the eye.
- **Wash the eye for 15 minutes.**
- Hold the lid open and roll the eyeball around to wash the eye thoroughly.
- Seek medical attention immediately. Be familiar with the location and instructions for all the eye wash stations located in the clinic and laboratory. Eyewash stations are located in the dental laboratory and sterilization area.

**Safety Data Sheets (SDS)**

A safety data sheet (SDS) contains safety and technical information about a specific product. The SDS describes physical and chemical properties, physical and health hazards, routes of exposures, precautions for safe handling and use, emergency and first-aid procedures, and control measures.

Every hazardous chemical listed on the chemical **must** have an accompanying SDS. The collection of SDS forms are found in a notebook marked SDS in the sterilization area, the dental clinic and dark room.

Employees and/or students may check an SDS for safety information at any time. SDS’s will require some study to understand the information contained in them. Not all SDS’s look the same but they all must provide the same kind of information and in the same order. However, not all SDS’s contain the same detail of information; this varies depending on the degree to which the chemical is considered hazardous.

The SDS must be in English and must include at least the following:

**Section I Chemical Identity**

- The chemical and common name(s) must be provided for single chemical substances.
- An identity on the SDS must be cross-referenced to the identity found on the label.
- Recommended use
- Name, address, phone number of the SDS
- Preparer, distributor, or manufacturer and the date the SDS was prepared

**Section II Hazardous Ingredients**
• Hazard Classification of substance or mixture or a description of the identified hazard for physical or Health Hazards Not Otherwise Classified.

• Label elements:
  1. Symbol (image) or the name of the symbol (e.g., flame, skull crossbones)
  2. Signal word
  3. Hazard statement(s)
  4. Precautionary statement(s)
  5 Other hazards which do not result in classification.

Section III Composition/Information on ingredients

• When a hazardous product is a material or substance
  o 1. Chemical name
  o 2. Common name and synonyms
  o 3. Chemical Abstract Service (CAS) registry number and any unique identifiers
  o 4. Chemical name of impurities, stabilizing solvents and/or additives

• For each material or substance in a mixture that is classified in a health hazard class
  o 1. Chemical name
  o 2. Common name and synonyms
  o 3. CAS registry number and any unique identifiers
  o 4. Concentration

NOTE: Confidential business information rules can apply

SDS 16 points

Section IV First-aid measures by route of exposure:
  1. Inhalation
  2. Skin contact
  3. Eye contact
  4. Ingestion
  5. Most important symptoms and effects (acute or delayed)
6. Immediate medical attention and special treatment, if necessary

Section V Fire-fighting measures

1. Suitable extinguishing media
2. Unsuitable extinguishing media
3. Specific hazards arising from the hazardous product (e.g., hazardous combustion products)
5. Special protective equipment and precautions for fire-fighters.

Section VI Accidental release measures

1. Personal precautions, protective equipment and emergency procedures
2. Methods and materials for containment and cleaning up

Section VII Handling and storage

1. Precautions for safe handling
2. Conditions for safe storage (including incompatible materials)

Section VIII Exposure controls/ Personal protection

1. Control parameters, including occupational exposure guidelines or biological exposure limits and the source of those values.
2. Appropriate engineering controls
3. Individual protection measures (e.g. personal protective equipment)

Section IX Physical and chemical properties

1. Appropriate (physical state, color, etc.)
2. Odour
3. Odour threshold
4. pH
5. Melting point/Freezing point
6. Initial boiling point/boiling range
7. Flash point
8. Evaporation rate
9. Flammability (solid; gas)
10. Lower flammable/ explosive limit
11. Upper flammable/explosive limit
12. Vapour pressure
13. Vapour density
14. Relative density
15. Solubility
16. Partition coefficient-n-octanol/water
17. Auto-ignition temperature
18. Decomposition temperature
19. Viscosity

Section X Stability and reactivity

1. Reactivity
2. Chemical stability
3. Possibility of hazardous reactions
4. Conditions to avoid (e.g., static discharge, shock, or vibration)
5. Incompatible materials
6. Hazardous decomposition products

Section XI Toxicological information

Concise but complete description of the various toxic health effects and the data used to identify those effects, including:

1. Information on the likely routes of exposure (inhalation, ingestion, skin and eye contact)
2. Symptoms related to the physical, chemical and toxicological characteristics
3. Delayed and immediate effects, and chronic effects from short-term and long-term exposure.

Numerical measures of toxicity

Section XII

1. Ecotoxicity
2. Persistence and degradability
3. Bioaccumulative potential
4. Mobility in soil
5. Other adverse effects

**Section XIII Information on safe handling for disposal and methods of disposal, including any contaminated packaging**

**Section XIV Transport information**

1. UN number
2. UN proper shipping name
3. Transport hazard class (es)
4. Packing group
5. Environmental hazards
6. Transport in bulk, if applicable
7. Special precautions

**Section XV Safety, health and environmental regulations specific to the products. Section XVI Date of the latest revision of the SDS.**

**Labels**

As stated previously, every product used in patient treatment that is found to be hazardous must be labeled as such. The labels vary in size (2x2, 4x4, 1x1). The size of the label used depends upon the size of the product that requires labeling.

**Part A** on the 2x2 and 4x4 label is the identity of the chemical as it appears on the first line of the SDS sheet. Using the example, “Isopropanol” or “Isopropyl Alcohol” is written on this top line.

**Part B** The colored circles in correspond to the rating information found on the wall chart. The wall chart is the “key” that must be used to decipher the information on the labels. A wall chart is posted in the dental laboratory.

- Blue is for HEALTH
- red or hot pink is for FLAMMABILITY
- yellow is for REACTIVE
- the black circle or white space is for PERSONAL PROTECTION

The ratings for each category found under Sections IV, V, VI, and VIII of the SDS sheet are transferred to the appropriate colored circle. For example, the Fire and Explosive rating (Section IV)
of Isopropanol is “3” (serious degree of risk). Circle number 3 is entered in the red circle of the label (or pink square on the 1x1 label).

**Part C** of the 2x2 and 4x4 represents the Hazard Class rating found at the top of the SDS sheet. Isopropanol is “Flammable;” therefore the letter “E” is entered onto the label. Coding as Well as additional information for each classification can be found under the “Hazard Class Index” on the chart.

**Part D** of the 2x2 and 4x4 label includes the Routes of Entry, Target Organs, and other areas affected. This information can be found under Section VI of the SDS sheet. The 1x1 label will be found on small items located in the operatories.

The batch method of labeling is utilized. With this method, one label is attached to the drawer or shelf where the item is stored. It is important that students/employees be able to view the label for a particular product at any given time.

The National Fire Protection Association (NFPA) has developed a rating system for identifying the Health, Flammability, and Reactivity hazards of a chemical. The National Paint and Coating Association has also prepared a rating system similar to the NFPA rating.

The codes are described as follows:

<table>
<thead>
<tr>
<th>COMBUSTIBLE</th>
<th>REACTIVE</th>
<th>HEALTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>May not burn or have a flash point</td>
<td>0</td>
</tr>
<tr>
<td>1</td>
<td>Slightly combustible. Possible ignition if heated. Possible flash point at 200°F and beyond</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Moderately heated before ignition will occur; including flammable liquids, flash points between 100°F and 200°F</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Materials may ignite under most normal temperatures, including flammable liquids with flash points below 73°F</td>
<td>3</td>
</tr>
</tbody>
</table>
and boiling points at or above 100° F

| 4 | Very flammable gas or liquid. Flash points below 73° F and boiling points below 100° F |
| 4 | Materials are capable of detonation or explosion at normal room temperature and pressure. |
| 4 | Life threatening. Major or permanent damage can result from one or more exposures. |

**CONTAINER LABELING**

Under the Standard, all containers must be labeled with the identity of the contents and must show hazard warnings appropriate for employee protection. The hazard warning can be conveyed through words, pictures, numerals, or symbols that convey the hazards of the chemical(s) in the container. In most cases, the manufacturer, supplier, or distributor will already label the containers. Make sure that the labels are adequate - that they include a chemical name or trade name corresponding to an SDS on file, as well as appropriate hazard warnings. The manufacturer or importer is responsible for labeling products properly. If a product is not labeled when you use it or if you are transferring a product to another container, you must label it yourself.

Accepted guidelines for labeling containers are as follows:

- All chemicals must retain the labeling on the original containers.

- The designated coordinator will ensure that all hazardous chemicals in the clinic and laboratory are properly labeled and updated, as necessary. Labels should list at least the chemical identity, appropriate hazard warning, and the name and address of the manufacturer, importer or other responsible party. NOTE: Professional products regulated by the Food and Drug Administration (FDA) is exempt from the labeling requirement of the Standard.

- Although OSHA regulations state that a portable container into which hazardous chemicals are transferred from labeled containers and are for the intended use of the person who performs the transfer does not require labeling, it is the Program standard to label all containers for safety reasons.

*Listing and Labeling Hazardous Chemicals*

The workplace (or school) chemical list is an integral element of any hazard program. From the list, a work or school area can be quickly evaluated for its hazard potential, and an appropriate label assigned to the product.

A chemical list must be compiled and maintained for each hazardous material normally used (including the lab). The list must have the chemical name (as used on the Safety Data Sheets) and
container label, and the work area where the chemical is normally stored or used (lab, clinic, radiography or any combination of these). The date the chemical inventory was made is also vital.

The list is updated whenever a new chemical is introduced into the dental clinic. The list is easily available for employees and students. New students or employees will be made aware of the list before working in the clinic or laboratory area.

A hazardous chemical is defined as any chemical that is a physical hazard. This includes chemicals that are:

<table>
<thead>
<tr>
<th>Combustible liquids</th>
<th>Highly toxic</th>
</tr>
</thead>
<tbody>
<tr>
<td>compressed gas</td>
<td>carcinogen</td>
</tr>
<tr>
<td>explosive</td>
<td>reproductive toxin</td>
</tr>
<tr>
<td>flammable</td>
<td>irritant corrosive</td>
</tr>
<tr>
<td>organic peroxide</td>
<td>sensitizer</td>
</tr>
<tr>
<td>oxidizer</td>
<td>helatotoxin</td>
</tr>
<tr>
<td>pyrophoric</td>
<td>hephrotoxin</td>
</tr>
<tr>
<td>unstable (reactive)</td>
<td>neurotoxin</td>
</tr>
<tr>
<td>water reactive</td>
<td>agents that act on the hematopoietic system</td>
</tr>
<tr>
<td></td>
<td>agents that damage the lungs or mucous membranes.</td>
</tr>
</tbody>
</table>

Chemicals governed under the EPA (Environmental Protection Agency) and the FDA (Food and Drug Administration) will not be listed or labeled. The EPA controls such products as household cleaning agents and the FDA controls food, food additives, color additives, drugs and cosmetics.

The chemical list is kept in the sterilization area (on the shelf) near the sterilizers. This list is in notebook labeled “OSHA”. It is available for all students and employees to review.

DISPOSAL OF HAZARDOUS-BIOCHEMICAL WASTES
Infectious waste is waste that has the potential to transmit diseases. Infectious waste includes animal carcasses and waste, blood, bloodborne, pathogens, blood products, microbiological waste (i.e. cultures and vaccines), pathological waste (i.e. bodily organs, tissues and fluids removed in the course of surgery, biopsy or autopsy), sharps (i.e. needles and scalpels) and an assortment of other soiled medical paraphernalia (i.e. gowns, gloves, sheets, masks, gauze, bandages, tubes etc.) that are either reused or disposable.

A sound infectious waste management program should have as its primary objective the safe, efficient, and effective management of infectious waste from its point of generation to its ultimate disposal (preferably destruction by incineration). This is commonly called “cradle to the grave.”

Once the disposable infectious waste has been identified, it should be separated and safely placed in the proper container, such as:

1. Needles and sharps -- Do not recap used needles or remove used needle from syringes by hand. Do not bend, break or otherwise manipulate used needles or sharps by hand. Place used needles, scalpel blades and other sharp items in a puncture-resistant container (sharps container) and close to the point of origin (treatment area) as practical. All sharp containers should have properly labeled warnings.
1. Any other infectious wastes should be placed in a designated biohazard waste receptacle located at chairside or in the sterilization area. When the biohazard waste receptacle is full, it should be handled with all PPE and deposited in the large biohazard container located in the laundry room. There can be no “co-mingling” of municipal (regular) waste with biohazardous waste.

Spill Protocol

The main spill kit is located in the clinic above the teacher station on the shelf. While a secondary spill kit is located in room 80W in the cabinet over the computer.

Chemical Disinfectant Safety

Chemicals/disinfectants can be effective and safe tools when used properly. If misused, they can be harmful to humans, animals, and the environment. Safety and first aid begins with an understanding of some definitions.

Toxicity

Acute (short-term toxicity) is a measure of how poisonous a chemical is after a single exposure. A chemical with a high acute toxicity can be deadly if even a very small amount is absorbed. Chronic (long-term toxicity) is a measure of how poisonous a chemical is after small, repeated doses over a period of time.

Hazard

(risk) is the potential for exposure to a chemical or other hazardous material. Even slightly toxic materials can be very hazardous if the person using them is careless during use and allows themselves or others to come in contact with excessive amounts of the material. This can happen, for example, when a person uses a certain chemicals every day in his or her job and through familiarity becomes careless with its use and handling. The person is at a much greater risk or hazard than one who handles a very toxic chemical with the proper safety equipment and procedures.

Storage

Always store chemicals in their original containers with readable labels. A warning sign should be posted in the storage room or on the cabinet. Keep lids tightened when containers are not being used. Check containers periodically for corrosion, leaks, breaks, etc. so that faulty containers may be disposed of or replaced before they constitute a hazard. If a container is damaged, transfer its contents to a container that held exactly the same material or a properly labeled substitute. Never store chemicals near food or drugs, and never permit anyone to eat in a room where chemicals are stored.

Mixing

Before handling a chemical container, always put on gloves, and/or a mask and protective eyewear as required. Each time you use a chemical, read the directions for mixing before you open the container. When pouring out a chemical, keep the container and chemical below eye level to avoid a potential splash or spill on your glasses or face. Containers with chemicals in the form of powders should be opened with care to avoid inhaling the powder.

Recordkeeping/Documentation

Recordkeeping/documentation is an integral part of any hazard control program. It is not enough that procedures be followed but also that they be documented as being completed. Several aspects of the Hazard Control Program call for documentation.

Acknowledgment of Hazard training is documented by completion of a signature page that acknowledges an individual has had training on Hazard Communications and Control. Completed training forms are kept in the student’s employee’s permanent records, located in the Program Director’s office. Injuries/incidents must be
reported and an Incident/Exposure Report and an Accident Form completed. Forms are located in the emergency cart in the clinic.
Section 6. Health Information Privacy and Accountability Act (HIPAA)

Health Information Privacy

HIPAA

The DACC Dental Clinic will implement the following Health Information Privacy Rules as a matter of sound business practice. The rules protect the interests of patients, and fulfill legal obligations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

As a member of the workforce, a student in the program, or as a Business Associate, you are obligated to follow the Health Information Privacy rules. Failure to do so can result in disciplinary action and non-compliance of program protocols. Please refer to our section on Consequences for Non-Compliance of Standards of Conduct and if needed, refer to the Health Sciences Student Handbook for more information.

The follow pages address the basics of HIPAA and the Privacy Rules, and the expectation of their adherence in Clinic. They do not attempt to cover everything in the Privacy Rules. The Clinic Manual sometimes refers to forms that the Program uses to help implement the Privacy Rules.

Please note that while the Privacy Rules speak in terms of “individual” rights and actions, this Clinic Manual uses the more familiar word “patient” instead. “Patient” should be read broadly to include prospective patients, patients of record, former patients, their authorized representatives, and any other “individuals” contemplated in the Privacy Rules.

If you have questions or doubts about any use or disclosure of individually identifiable health information, or about other obligations under these Health Information Privacy Rules, or other federal or state laws, consult the Dental Hygiene Program.

The following twelve (12) procedures outline obligations to be taken to protect individually identifiable health information that is created, received, or maintained by healthcare providers.

1. General Rule: No Use or Disclosure

The Clinic must not use or disclose protected health information (PHI), except as these Privacy Rules permit or require.

2. Acknowledgement and Optional Consent

The Clinic will make a good faith effort to obtain a written acknowledgement of receipt of our Notice of Privacy Practices from a patient before the Program uses or discloses his or her protected health information (PHI) for treatment, to obtain payment for that treatment, or for healthcare operations (HCO).

The Clinic’s use or disclosure of PHI for payment activities and healthcare operations may be subject to the minimum necessary requirements.
3. Authorization

In some cases the Clinic must have proper, written Authorization from the patient (or the patient’s personal representative) before use or disclosure of a patient’s PHI for any purpose (except for HCO purposes) or as permitted or required without consent or authorization.

The Clinic will use the authorization form. The Program will always act in strict accordance with an authorization.

**Authorization Revocation** – A patient may revoke an authorization at any time by written notice. The Clinic will not rely on an authorization known to be revoked.

**Authorization from Another Provider** – The Clinic will use or disclose PHI as permitted by a valid authorization the clinic received from another healthcare provider.

The Clinic may rely on that covered entity to have requested only the minimum necessary protected PHI. Therefore, the Clinic will not make a “minimum necessary” determination, unless the clinic knows that the authorization is incomplete, contains false information, has been revoked, or has expired.

**Authorization Expiration** – The Clinic will not rely on an authorization the clinic knows has expired.

4. Oral Agreement

The Clinic will not use or disclose a patient’s PHI with the patient’s Oral Agreement or if the patient is unavailable. In order to release any type of medical/dental records, the clinic will require a written authorization form signed by the patient/guardian or legal representative.

5. Permitted Without Acknowledgement, Consent Authorization or Oral Agreement

The Clinic may not use or disclose a patient’s PHI in certain situations, without Authorization or Oral Agreement.

a) **Verification of Identity** – The Clinic will verify the identity of any patient, and the identity and authority of any patient’s personal representative, government or law enforcement official, or other person, unknown to the clinic, who requests PHI before it will disclose the PHI to that person.

The Clinic will obtain appropriate identification and, if the person is not the patient, evidence of authority. Examples of appropriate identification include photographic identification card, government identification card or badge, and appropriate document on government letterhead. The Clinic will document the incident and how it responded.

b) **Uses or Disclosures Permitted under this Section** – The situations in which the Clinic is permitted to use or disclose PHI in accordance with the procedures set out in this Section are listed below.
• The DACC Dental Clinic may disclose a patient’s PHI to that patient on request.

• The Clinic may disclose to a patient’s personal representative PHI relevant to the representative capacity. The Clinic will not disclose to a personal representative reasonably believed to be abusive to a patient, any PHI that may promote or further such abuse.

• The Clinic will not use or disclose a patient’s PHI for fundraising purposes without the patient’s authorization.

• The Clinic will not use or disclose PHI for marketing without a patient’s authorization unless the marketing is in the form of a promotional gift of nominal value that the clinic provides, or face-to-face communications between the patient and us.

• The Clinic may use or disclose PHI in the following types of situations, provided procedures specified in the Privacy Rules are followed:
  • As required by law with proper documentation
  • As requested by patients with proper documentation

6. Required Disclosures

The Clinic will disclose protected health information (PHI) to a patient (or to the patient’s personal representative) to the extent that the patient has a right of access to the PHI; and to the U.S. Department of Health and Human Services (HHS) on request for complaint investigation or compliance review.

The Clinic will use a disclosure log to document each disclosure the clinic makes to HHS.

7. Minimum Necessary - The Clinic will make reasonable efforts to disclose, or request of another covered entity, only the minimum necessary protected health information (PHI) to accomplish the intended purpose.

There is no minimum necessary requirement for disclosures to or requests by one another in the Clinic or by a healthcare provider for treatment; permitted or required disclosures to, or for disclosure requested and authorized by, a patient; disclosures to HHS for compliance reviews or complaint investigations; disclosures required by law; or uses or disclosures required for compliance with the HIPAA Administrative Simplification Rules.

a) Routine or Recurring Requests or Disclosures – The Clinic will follow the Privacy Rules, and limit routine or recurring requests for disclosures of PHI to the minimum reasonably necessary for the purpose.

b) Non-Routine or Non-Recurring Requests or Disclosures – No non-routine or non-recurring request for or disclosure of PHI will be made until it has been reviewed by the privacy officer on a patient-by-patient basis against clinic criteria to ensure that only the minimum necessary PHI for the purpose is requested or disclosed.

c) Other’s Requests – The Clinic will rely, if reasonable for the situation, on a request to disclose PHI being for the minimum necessary, if the requester is: (a) a covered entity; (b) a professional (including an attorney or accountant) who provides professional services, either as a member of the workforce or as a Business Associate, and who represents that the requested information is the minimum necessary; (c) a public official who represents that the information requested is the minimum necessary; or (d) a researcher presenting appropriate documentation or making appropriate representations that the research satisfies the applicable
requirements of the Privacy Rules.

d) **Entire Record** – The Clinic will not use, disclose, or request an entire record, except as permitted in these Privacy Rules, or standard protocols that the Clinic adopts reflecting situations when it is necessary.

e) **Minimum Necessary Workforce Use** – The Clinic will use only the minimum necessary PHI needed to perform our duties.

8. **Notice of Privacy Practices** -The Clinic will maintain a Notice of Privacy Practices as required by the Privacy Rules. See Eaglesoft letters for this notice.

a) **DACC Notice** – The Clinic will use and disclose PHI only in conformance with the contents of the Notice of Privacy Practices. The Clinic will promptly revise a Notice of Privacy Practices whenever there is a material change to uses or disclosures of PHI to legal duties, to the patients’ rights or to other privacy practices that render the statements in that Notice no longer accurate.

b) **Distribution of DACC Notice** – The Clinic will provide the Notice of Privacy Practices to any person who requests it, and to each patient. The Clinic will have the Notice of Privacy Practices available for patients to review and take with them if they choose to. The Clinic will also post the Notice of Privacy Practices in a clear and prominent location where it is reasonable to expect patients seeking services and will be able to read the Notice.

c) **Acknowledgement of Notice** – The Clinic will make a good faith effort to obtain from the patient a written Acknowledgement of receipt of the Notice of Privacy Practices.

The Clinic shall use, Acknowledgement of Receipt of Notice of Privacy Practices, to obtain the Acknowledgement. If the clinic cannot obtain written Acknowledgement from the patient, the clinic will use the form to document an attempt and the reason why the written Acknowledgement was not signed by the patient.

9. **Patients’ Rights** -The Clinic will honor the rights of patients regarding their PHI.

a) **Access** – With rare exceptions, the Clinic must permit patients to request access to the PHI the clinic or a Business Associate holds.

No PHI will be withheld from a patient seeking access unless the Clinic confirms that the information may be withheld according to the Privacy Rules. The Clinic may offer to provide a summary of the information in the chart. The patient must agree in advance to receive a summary and to any fee the Clinic will charge for providing the summary. The Clinic will contact Business Associates to retrieve any PHI they may have on the patient.

b) **Amendment** – Patients have the right to request to amend their PHI and other records for as long as the Clinic maintains them.

The Clinic may deny a request to amend PHI or records if: (a) the Clinic did not create the information (unless the patient provides us a reasonable basis to believe that the originator is not available to act on a request to amend); (b) the Clinic believes the information is accurate and complete; or (c) the Clinic does not have the information.

The DACC Dental Clinic will follow all procedures required by the Privacy Rules for denial or approval of amendment requests. The Clinic will not physically alter or delete existing notes in a patient’s chart. The Clinic will inform the patient when The Clinic agrees to make an amendment, and the Clinic will contact our Business
**Associates** to help assure that any PHI they have on the patient is appropriately amended. The Clinic will contact any individuals whom the patient requests the clinic alert for any amendment to the patient’s PHI. The Clinic will also contact any individuals or entities of which the Clinic are aware that there Clinic has sent erroneous or incomplete information and who may have acted on the erroneous or incomplete information to the detriment of the patient.

When the Clinic denies a request for an amendment, it will mark any future disclosures of the contested information in a way acknowledging the contest.

c) **Disclosure Accounting** – Patients have the right to an accounting of certain disclosures the Clinic made of their PHI within the 6 years prior to their request. Each disclosure the Clinic makes, that is not for treatment, payment or healthcare operations, must be documented showing the date of the disclosure, what was disclosed, the purpose of the disclosure, and the name and (if known) address of each person or entity to whom the disclosure was made. The **authorization** or other documentation must be included in the patient’s record. The Clinic use the patient’s chart to track each disclosure of PHI as needed to enable us to fulfill our obligation to account for these disclosures.

The Clinic is not required to account for disclosures it made: (a) before June 1, 2007; (b) to the patient (or the patient’s personal representative); (c) to or for notification of persons involved in a patient’s healthcare or payment for healthcare; (d) for treatment, payment, or healthcare operations; (e) for national security or intelligence purposes; (f) to correctional institutions or law enforcement officials regarding inmates; or (g) according to an Authorization signed by the patient or the patient’s representative; (h) incident to another permitted or required use disclosure.

The Clinic will temporarily suspend the accounting of any disclosure when requested to do so pursuant according to the Privacy Rules by health oversight agencies or law enforcement officials. The Clinic may charge for any accounting that is more frequent than every 12 months, provided the patient is informed of the fee before the accounting is provided. The Clinic will contact our **Business Associates** to assure the Clinic includes in the accounting any disclosures made by them for which the Clinic must account.

d) **Restriction on Use or Disclosure** – Patients have the right to request the Clinic restrict use or disclosure of their PHI, including for treatment, payment, or healthcare operations. The Clinic has no obligation to agree to the request, but if it does, the Clinic will comply with our agreement (except in an appropriate dental/medical emergency).

The DACC Clinic may terminate an agreement restricting use or disclosure of PHI by a written notice of termination to the patient. The Clinic will contact **Business Associates** whenever it agrees to such a restriction to inform the Business Associate of the restriction and its obligations to abide by the restriction. The Clinic will document in the patient’s chart any such agreed to restrictions.

e) **Alternative Communications** – Patients have the right to request us to use alternative means or alternative locations when communicating PHI to them. The Clinic will accommodate a patient’s request for such alternative communications if the request is reasonable and in writing.

The Clinic will inform the patient of our decision to accommodate or deny such a request. If it agrees to such a request, the Clinic will inform our **Business Associates** of the agreement and provide them with the information necessary to comply with the agreement.

f) **Applicability** – The Clinic will be aware of and respect these patients’ rights regarding their PHI, even
though in most situations patients are unlikely to exercise them.

10. Staff & Student Training and Management, Complaint Procedures, Data Safeguards, Administrative Practices

a) Staff & Student Training and Management Training*

All students and faculty are required to take the HIPAA training through trainingcentral.nmsu.edu The Clinic will complete the privacy training of the existing workforce annually and within three months of new employment.

The Clinic will also retrain each staff member whose functions are affected either by a material change in Health Privacy Rules or in the member’s job functions, within a reasonable time after the change.

*Discipline and Mitigation – Staff and students who violate Health Privacy Rules or other applicable federal or state privacy law will be subject to disciplinary action, possibly up to and including investigations for non-compliance with program’s protocols. Please refer to our section on Consequences for Non-Compliance of Standards of Conduct and if needed, refer to the Health Sciences Student Handbook for more information.

b) Complaints – The Program has implemented, as part of the Quality Assurance Plan, procedures for patients to complain about our compliance with the Health Privacy Rules. The Clinic will also implement procedures to investigate and resolve such complaints. The patient can use the Complaint form to document the complaint. Each complaint received must be referred to the Dental Hygiene Program Director immediately for investigation and resolution. The Clinic will not retaliate against any patient or workforce member who files a complaint in good faith.

c) Data Safeguards – The Clinic will update the Health Privacy Rules with additional data security procedures as needed to have reasonable and appropriate administrative, technical, and physical safeguards in place to ensure the integrity and confidentiality of PHI. The Clinic will take reasonable steps to limit incidental uses and disclosures of PHI made according to an otherwise permitted or required use or disclosure.

d) Documentation and Record Retention – The Clinic will maintain in written or electronic form all documentation required by the Privacy Rules according to NMSU record retention policy from the date of creation or when the document was last in effect, whichever is greater.

e) Updates to the Health Privacy Rules – Only the Program Director will make changes to the Clinic’s standards regarding the Health Privacy Rules.

11. State Law Compliance - The Clinic will comply with the privacy laws of each state that has jurisdiction over our practice, or its actions involving protected health information (PHI), that provide greater protections or rights to patients than the Privacy Rules.

A copy of the signature page that acknowledges an individual has received the training on HIPAA & confidentiality will be required. This must be signed and turned into the Clinical Coordinator or Program Director.

Confidentiality

All information in patients’ records is confidential. Patient information used in the context of a learning experience, case presentation, or research will be anonymous.

Patient information will not be released to any referring dentist, physician, or agency without the written
permission of the patient. Patients are asked to sign a Dental/Medical release form on Eaglesoft. Reviewing or helping a patient to fill out their medical history should be done in the student’s operatory. Conversations with the patient regarding their care should not occur outside the clinical teaching area. Noncompliance with patient confidentiality is a violation of HIPAA regulations, and could result in a lawsuit against the persons involved, as well as the Program. Patient records, including radiographs and/or personal information that can be linked to a patient’s name, must not be taken out of the clinical teaching area.
SECTION 7. CLINIC BUSINESS OPERATIONS

Clinic Business Office
The office is regarded as a professional business space where clinic administration is conducted. Students must respect the Business Operations Specialist’s need for quiet and focused attention to duties. Only students actively involved in clinical business should enter the office and then only as long as necessary to complete an activity.

The “Business Operation’s Specialist” referred to here and elsewhere in this document is a Records Specialist who oversees clinic business.

Patient Recruitment
It is the student’s responsibility to recruit patients throughout their time in the Program in order to meet all clinical requirements. (See Section 9: Clinic Procedures) **Those patients recruited directly by a student will be appointed with that student.** If the case is complex and the student has enough complex cases, the patient might be reappointed to another student who could benefit from the experience.

Eaglesoft Appointment Entries
To facilitate efficient and effective clinic activity, the following business office procedures will be implemented. Please be aware there may be more than one appointment book, a hard copy schedule for special clinics and one for regularly scheduled clinics.

The computer Eaglesoft system will be used to schedule regular appointments, establish the patient or a “patient of record,” record financial records, and more as faculty assigns. In hardcopy appointment book all entries must be made in pencil. All appointment entries must include:

1. Student’s full name
2. Operatory the student is assigned
3. Time required (Start and End time)
4. Procedure planned for the appointment
5. If the patient is a minor, include the guardian’s name
6. Indicate if the patient is new, cancelled or no show
As students make appointments for their own patients they must give the Business Operation’s Specialist the information, preferably 2 days in advance of the appointment. This is so it can be placed in the appointment book and the electronic chart made available before the time of the appointment.

As treatment is completed, the Eaglesoft system must be updated “Set Complete.”

Appointment Guidelines and Procedures
All patients must be informed of the following guidelines and procedures to help ensure that students’ clinical time is used efficiently and patient treatment can be rendered in a timely manner.

Common Codes for Appointments
Use the codes found on the fee sheet to identify the reason for scheduling of appointments. A full list of codes is available on the

Procedure for Screening Appointments
(Note: *We do not give out information on fee sheet or hand out fee sheets*)

The basic screening procedures include:

- Review of Patient Regeneration: Medical/Dental History including vital signs to determine need for referrals, premedication, radiographs etc.
- Extra/Intraoral Exam: findings are entered on the *Treatment Notes*
- Peridontal Screening (PSR) if pre-medication is not required
- Education on services provided in the clinic and appointment procedures
- General recommendations for basic oral hygiene
- Estimate of number and type of appointments expected to complete treatment
- Estimates of fees for potential treatment and procedures for payment at time of service

Both dentists and dental hygiene faculty can complete the screening process by confirming all assessment data and determining the level of student experience needed for the patient’s treatment (circles Junior or Senior on the form). Faculty will sign the *Medical History, Treatment Notes* and any necessary *Referrals*.

*Prescriptions* for radiographs must be signed by the attending dentist or be taken utilizing the dentist standing order. However, the hygiene faculty can recommend appropriate radiographs for purposes of initial treatment planning and discussion of fees at this appointment with a standing order for radiographs. All decisions regarding radiographs are to be based on the Guidelines for Prescribing Dental Radiographs and are dependent on the patient’s history and clinical condition.

The patient’s name is added to a list along with a notation of the periodontal status (classification). Rotators or students who “screen” patients must schedule an appointment for the screening patient prior to dismissing the patient. This will entail communication with the student who is next on the screening list, and knowledge of their availability in the schedule; therefore, students must keep their clinic schedule
updated in Eaglesoft.

Clinical faculty may need to assign screening patients to students based on the following criteria:

- Complexity of the case: more difficult cases will be assigned to senior students
- Specific types of cases may be assigned according to students’ needs for specific types of experience. This may supersede the sequence for assignment and is at the discretion of the clinical faculty who are tracking student requirements.
- If the patient cannot be seen in the DACC clinic, a referral should be made to the community. For example, Ben Archer, La Clinica, or given the names of several names of dentists or dental specialists can be given out.

Recare Patients

As students graduate, their patients are assigned to other students. Clients who are assigned to specific students must be contacted personally (by phone, postcard, or in person) by the student and scheduled for supportive therapy.

These patients are not to be “traded” to other students, without consulting the Clinic Coordinator; nor are they to be abandoned.

The chart should be reviewed before contacting the client. All contacts and attempts to contact patients must be documented on the patients chart. All students are expected to see their own patients through at least one recare cycle unless scheduling prohibits. In that case the student should discuss this with the instructor to see if the patient can be reassigned.

If “Maintenance (Recare) Patients” cannot be contacted, or fail to appear for two confirmed appointments, the student may request that a “referral to the community” be initiated.

Scheduling New Clients

Students must recruit and schedule clients with particular oral care needs in order to meet the clinical educational requirements of the curriculum.

First Client Contact

At first client contact, students should do the following:

- Determine whether the client qualifies for “limited care” appointments, such as one of the following: Radiographs, sealants, whitening, only. Follow the procedure outlined in the limited care section below.
- Discuss with all “full-care” clients, DACC clinic procedures and services performed, and re-care procedures including the following:
  - All services are provided by students under the supervision of licensed dental hygienists/dentists. DACC clinic is a teaching institution and should not be confused with regular private practice protocols.
  - All services are provided under “ideal conditions,” are very thorough, and reflect our philosophy of personalized, prevention-oriented care. Does this match their philosophy?
  - The patient’s oral health needs are well documented and are evaluated by faculty. If services are beyond the scope of treatment provided in the DACC clinic, clients will be referred to appropriate health-
care professionals.

♦ **The time required for care in the clinic is more than that customarily required in private offices,** but the reduction in fees helps offset time spent. Appointments can be several hours long and several are usually required. The number of appointments varies with the oral health condition of the client.

♦ **The services provided** (See the Fee Sheet or Treatment Plan for listing); Use language the patient can understand. Currently, preventive services are provided, including a comprehensive dental exam by a licensed dentist; this does not include fillings, crowns, root canals, or extractions.

♦ **Fees vary with the type of services provided.** Basic fees should be discussed and a request for payment at the first appointment should be made. Type of payment should be discussed and what types of documents are required when using check, credit card, or student account. “Is it going onto a student account or will the patient pay directly with cash, check, or credit card?”

❖ Determine what, if any, health alerts the client has that may require alterations in the first appointment (e.g., Heart or other conditions that require pre-medication, high blood pressure, etc.). Document all significant medical alerts in the Alert Box on the bottom of the first page of the HHX.

❖ Make arrangements to schedule the patient for a short screening appointment to deal with the issue if they are not prepared with their pre-medication, etc.

❖ Determine what preferences the patient has about scheduling specific days of the week and times of the day (e.g., can’t come any Monday, etc.). Schedule the client according to the procedures explained in the next section.

❖ Determine if the client can come on short notice. If so, place the client’s name and phone number on a “Personal Short Notice Call List”, after you have appointed them, if the appointment is several days/weeks away.

It is the student’s responsibility to inform the Business Operations Specialist of his/her schedule 24 hours in advance of the appointed clinic day to prevent double or conflicting appointments. If no patient is entered in the Eaglesoft schedule, the Business Operation’s Specialist may schedule a patient for the appointment time. The clinic appointment book will take precedence.

Students should reserve several appointments for a new client as soon as they are scheduled to help ensure that the client’s care will be completed in a reasonable time-frame. It is also important to develop a list of patients that can be called on “short notice” in case of a last minute change in the schedule.

**Treatment Sequencing and Limitations**
Because this is a teaching facility, and students are not in a position to provide all oral health care needed by all clients, clients are informed that multiple appointments may be necessary and that they will be referred to appropriate professionals to have their care completed if necessary.

**General Procedures for Scheduling an Appointment**
The student will post most appointment entries. Occasionally the Business Operations Specialist will post appointments as well. The following are general guidelines for scheduling.

Schedule an appointment time for the client on a day/time that will be convenient. Most new adult patients are scheduled for a three-hour block. Children are scheduled for one or one half-hour blocks depending on age. Unassigned patients will be scheduled for a screening appointment, unless the patient specifically requests a
student or has already been assigned to a student as a maintenance or returning client.

When scheduling an appointment, do the following:

1. Be sure the student is not assigned to a rotation!
2. Enter the client’s name, phone number, and the appointment code into the Eaglesoft appointment book in the operatory assigned to the student.
3. If the client is a child, enter the child’s name, age, and parent’s name and a phone number and appointment code. Mark through the entire timeframe the patient is expected to be present.
4. Give the patient a written appointment card with the information or repeat the information if you are appointing a patient on the phone.

Confirming Patient Appointments
It is advised to confirm a patient appointment at least the day before the scheduled time. Information to include:

► Your Name
► That you are a Doña Ana Community College Dental Hygiene Student
► Ask for Patient you are trying to contact/ Confirm you are speaking to the patient or guardian. (Do not leave appointment information with other people unless you have cleared this with the patient first)
► Date and Time of the Appointment
► Where the Appointment is Scheduled (on-campus or somewhere else?)
► What the patient is scheduled for- Screening appointment, Type of Treatment, etc.
► Expected length of appointment
► Reminder if patient requires pre-med.
► A phone number where you can be reached at the clinic. (Do not give out your personal phone number or address.)

Notify the Business Operation’s Specialist that there may be a possible call back. Enter all outgoing and incoming calls in the phone message log.

If at all possible, the student should try to speak directly to the patient, if an adult. Clearly state the day and time the patient is expected and if he/she seems hesitant, explain that a solid commitment is needed because students must have a patient during every clinical time in order to complete all educational goals.

Patients Sign In
Please be sure all patients sign-in at the Business office window when they arrive for each appointment. This record helps monitor different aspects of clinical business records, so is a very important part of appointment scheduling.
Scheduling Limited Care Clients
Limited care patients are those who receive only limited specialized dental hygiene services. This may include:

- Radiographs only
- Sealants only
- Tooth Whitening only
- Athletic Mouth Guards

“Limited care” patients may be scheduled with any student having an open appointment. However, an attempt should be made to schedule with students needing the specific educational experience.

Every “limited care” patient requires a chart with appropriate components. For example, it may not be necessary to include a plaque map but it is critical to include the Medical History and Treatment Notes. When a “limited-care” patient arrives:
- Have the client complete a DACC-DH Medical History form and sign the consent for treatment and HIPAA documents.
- Complete a fee sheet.
- Enter all appropriate documentation in Eaglesoft and secure patient signatures.

When treatment is complete, all patient records must be filled out and signed, with a completed Fee Sheet, signed by faculty.

Radiographs-Only
Clients may be referred by dentists from the community for radiographs or sealants or athletic mount-guard only. The client must present a current (within 1 month) written request for the services to be provided. When patients call to schedule this appointment, remind them to bring the written request.

- The client’s name, phone number, type of radiographs needed, and the name of referring dentist should be entered in the clinic appointment book.
- During Fall semester, radiology clients may be scheduled with Junior students, only after consulting with radiology instructors and the radiology appointment book.
- Remind patients that DACC keeps original copies of all radiographs. Remind students to use double pack films when a patient is coming for radiographs only, so an original set of films may be sent to the referring dentist if film radiographs are taken. There is no additional fee for duplicates on radiology class DHYG 118 patients.

Sealants –Only
Patients will be scheduled with any student who has a short appointment time available. It is advised that the clinician requests a student assistant for the procedure.
Tooth Whitening-Only
Patients must have a current prescription from their primary DDS/DMD (within last month), and have proof that they have had an exam and prophylaxis within the last 3 months. **Tooth Whitening patients will be scheduled with students who have met clinical requirements.** Two appointments are needed; one appointment to take impressions and one to deliver the tray. Each patient will receive tooth whitening products, storage/box (optional), product information and the models used to make the bleaching tray. Bleaching in our clinic is done on patients who are 18 and over. A younger patient may get bleaching upon bringing a prescription from his or her dentist.

Athletic Mouth Guard
Individuals requiring an athletic mouth guard must have a Medical History with Patient Registration and consent form signed by a legal guardian if under 18 years of age. In addition, a special Parental Release form is required. When the patient leaves, they will be given the appliance, information about the care of the appliance, storage box (if applicable), and the models the mouth-gaurd was made from.

Special Needs Patients
Preplanning for the case of patients with special needs is essential. Be sure to consult with the Clinical Coordinator and other faculty or health care providers prior to the appointment.

Fees
Patients served in the Dental Clinic are charged a nominal fee, which may be paid in cash, credit card, check, or by student account at the time of service. Any bounced checks will be charged an additional $20 dollar fee to the patient’s account. Although the nominal fees charged at DACC clinic may be a recruitment tool, the fee structure in and of itself should not be relied upon for obtaining patients. The dental treatment and services rendered in this clinic are of the highest quality. Meeting the client’s oral health care needs is a priority and students must promote the clinic with this in mind.

Students are expected to discuss basic fees when the client is appointed and request payment at the first appointment. Students are responsible for collecting all outstanding fees from their clients. **No academic credit will be awarded for work accomplished for client’s who have not paid in full.** No patient shall be dismissed without appropriate fees been collected. If a student is paying for the treatment performed, the student must pay fees as treatment is rendered.

Fee Sheet
**A Fee Sheet** is a dental bill that is used to keep track of services and fees charged. Every patient must have a Fee Sheet completed for each visit. If more than one clinician provides services for a patient, each clinician must complete a Fee Sheet for the procedures they complete. As the treatment plan is developed, the insurance code numbers and the procedures to be completed (i.e. DO150) must be circled on the fee sheet. As individual treatment items are completed they should be signed off on the Fee Sheet and the students Case Management form.

In addition, the section marked Adjustments must be checked off, when applicable. **Only the Program Director may determine which “Adjustments” can be made in clinic fees.**

The following will not be charged a fee for service once every 6 months. However, all services rendered must be circled and marked “No charge”. Products are not free.
Dental Hygiene Students
Dental Assisting Students
Dental Faculty and Staff

Occasionally, the Program Director may agree to reduce fees or eliminate fees for special community service projects and/or for special teaching cases. For example, if a patient is used for a Mock Board during senior clinic.

All other services radiographs, dental exam, and the other quadrants of scaling and root planning will be charged out.

In a case where a panoramic radiograph is needed in addition to an FMX, the fee for the Pano will need to be discussed with the patient. If the patient is unable to afford the radiograph, the radiograph should not be taken and it should be documented in the patient’s record (chart) that such radiograph was recommended (provide rationale for recommendation) but patient was unable to afford it. No radiographs will be waived or written off by any faculty member.

Patients up to age 21, are charged out D1120 Prophylaxis – child.

There is a fee for duplicating radiographs; however, the Program requires a one week notice from the patient. Blank Fee Sheets are kept in the lateral file in the locker/laundry room.

Fee sheets will be reconciled with chart entries on a daily basis to ensure that appropriate fees are being charged and collected and that fees charges correspond with treatment performed (See Section 9 Clinic Procedures).

DACC/NMSU Students
DACC/NMSU students will receive 50% off of the clinic’s regular fees after initial assessments have been completed and treatment has been approved by instructor or clinical coordinator. If additional radiographs are required by any faculty or dentist, the patient will be responsible for the additional fees. Make sure you notify the patient before taking any additional radiographs. This applies to ALL patients. DACC/NMSU students must present a current Banner ID, There are NO EXCEPTIONS to this rule. DACC/NMSU students must pay all clinic fees as services are rendered or pay in full at the beginning of treatment. Family members of student clinicians must pay as services are rendered or in full at the first appointment. The 50% discount does not apply to family members of faculty and students.

Private Dental Insurance
The Dental Clinic will provide all patients with an invoice (fee slip) that may be used to file an insurance claim for reimbursement of fees paid. The clinic does not file individual insurance claims at this time.

Medicaid – State of New Mexico
The Clinic does not currently accept patients on Medicaid- State of New Mexico unless they are able to pay clinic fees or are identified by the Program Director as free community service patients.

Fee Reconciliation
As part of the Student Chart Audit, the fee reconciliation analysis will be conducted and documented. The following is a list of categories data will be collected for.

- The value of services charged out but not paid for (This is when treatment was given and was charted in both the Treatment Notes as well as the Fee Sheet and the patient failed to pay for said treatment.
We classify this as “Bad Debt.”)

- The value of services written off using a "Patient Voucher"
- The value of services written off for students, faculty/ staff
- The value of services written off as a community service See Section 9 for more information

**Billing/Collection**

All monies taken in by the clinic must be recorded by the Business Operation’s Specialist in the Eaglesoft system. Cash payments are collected in a locked drawer. Receipts must be issued for all cash payments by Eaglesoft software. If necessary, written receipt can be obtained from a booklet, kept in the business office. DACC Dental Clinic does not routinely send patient statements or bill for services. Payment is expected at the time of service. Student paying by Student Account must have their Student Banner Id with them.

Payment by check needs a copy of the patient’s **Driver License** and **Date of Expiration**. Student makes copy of check. Payment by credit card required **Driver License** and **Date of Expiration**. Credit card must belong to the person paying for the fee.

Credit card payment requires a written receipt. To complete the transaction do the following and record on the bank sales slip.

- Write credit card number and expiration date.
- State amount of payment.
- Write the name on the credit card and Identify who the patient is.
- Enter “DACC Dental Clinic”
- Give patient receipt form and a copy of the signed bankcard sales slip.
- Record what type of credit card it is.
- Record initials of who is taking payment.

Clients who have not paid for services in full after 90 days will be sent to a collection agency. The student responsible for that patient will not receive a grade until the patient has paid for services rendered. It is the responsibility of the student to establish a clear understanding of DACC clinic payment procedures. Please remind patients, there is a return check fee of $20.00.

**End of Appointment**

At the end of each appointment the patient must be escorted to the reception area to pay fees and make appointments. Even if the patient is paid up and/or needs no further appointments they must leave the clinic through the reception area not out the back door of the clinic.

**Phones**

There are several phones for student use. One phone at the lab and one at the teaching station. Calls should be limited to clinic business only. To call out - dial 8 then the local phone number. For emergencies, call 911 from a landline to reach NMSU emergency services. If you use a cell phone it will contact off campus emergency service and it will take them longer to respond, since they are not familiar with the campus.
Student should use a clinic phone to schedule patient appointment and when returning calls to patient students should not give out personal phone number.

Students will learn to use all features of the clinic business office phone system (e.g., transferring calls, forward to message machine, etc.) when on Office Rotation. Until then, they may answer any ringing line by selecting the line with the blinking light and picking up the phone. The clinic teaching station phone number is 528-7078, the clinic office phone is 528-7071.

Answer phones in a professional, courteous manner. For example:

*Good morning, Doña Ana Community College Dental Clinic, student speaking. May I help you?*

Assist the caller if possible. If not, offer to have the call returned by someone who can. **DO NOT** give out personal information about students, staff, or faculty such as a home or work number, home or work addresses, the whereabouts of the individual (classroom, lab, etc.)

Phones should be disinfected daily by the student on Office Rotation

**Phone Messages**

When taking messages or making a call, obtain and write the following information on a duplicate phone log form, found in the clinic office, laboratory, and at the clinic teaching station.

- Caller’s name
- Phone number
- Who the message is for
- The message
- Date and time of call
- When the caller can be reached

Sign the message and deliver it to the appropriate person or place it in the individual’s mailbox. In case of emergency, hand-deliver the message to the individual. If that person is not readily available, give the message to the Clinic Coordinator or to the Business Operation’s Specialist to follow-up.

If the message is an appointment cancellation, try to notify the student clinician. If that student is not available, be sure the Business Operation’s Specialist is aware of the cancellation.

**Returning Phone Messages**

1. Please return any messages from patients needing an appointment or needing their radiographs mailed to their dentist.

2. Any other messages that you are unsure of, leave for the Business Operation’s Specialist, faculty or temporary front desk employee.

**Written Communications**

Written communications to students and faculty may be placed in the individual’s mailbox. Student boxes are located in a file cabinet in the locker room. Faculty boxes are in the clinic office behind the Business Operation’s Specialist desk.
Correspondence sent from the Department by students must first be reviewed by faculty.

Patient Record File System
Students who are on office assistant rotation are responsible for filing patient’s records. Patients who are currently being treated in the clinic are filed in eaglesoft. Disposition of old records will be handled according to NMSU record retention policies.

Supportive/ Maintenance Records
When active treatment is completed, the Recare interval is entered on the Case Management Form in Foliotek. This information is then entered into the students excel sheet patient list. Students are expected to schedule and complete at least one Recare appointment for their patient. After that the patients is assigned to another student.

Chart Audit Protocol
The chart audit process is conducted on a regular basis to ensure that the dental hygiene care at DACC is appropriate, comprehensive, and of the highest quality; the audits are part of the Program’s Quality Assurance Plan. See Section 9: Clinic Procedures for the complete protocol.

Students on Office Assistant rotation will assist in the chart audit process. If deficiencies are noted during a routine chart audit, the clinician will be asked to correct errors. That chart is then presented to faculty/clinic coordinator to be signed as complete and correct. The patient’s name and results of the chart audit are logged into an electronic file under the clinician’s name and kept in a cabinet or electronic folder. Faculty will periodically review this log.

Patient Satisfaction Survey
The Patient Satisfaction Survey is also linked to clinic quality assurance. Patients will complete this survey at the conclusion of their treatment. The program director keeps a file of these surveys for quality assurance. Trends or deficiencies are discussed with faculty, staff and students in order to make changes and improvements where necessary.

Reference Documents/Logs
A variety of references are available at the clinic’s teaching station, Foliotek, or in the console where the X-ray heads are located.

- Student Chart Audit log
- Physician’s Desk Reference and various textbooks
- Checkout log for reference material or text
- SDS Notebook
- Oral-Photo Log
- Equipment Maintenance Log and Manuals
- Emergency File (In the emergency cart)
- Equipment/Supply Sign Out log.
- Spanish Dictionary
- Clinic Reference notebook that contains a variety of references, instructional material, and articles that support this Manual (located in X-ray console)
Radiograph log (located in X-ray console)

In the business office, you will find the Patient Referral Log and Master Patient Assignment excel sheets.

Termination of Care / Inactive Status

A patient may have their dental hygiene care “terminated” for a variety of reason. For example:

- The patient is moving and cannot complete appointments and they have notified us.
- *The patient cancels confirmed appointments at the last minute on at least two occasions.
- *The patients does not show up for confirmed appointments on at least two occasions
- The patient cannot be contacted to schedule appointments after both a phone call and a written request to contact the Clinic have been made.
- The patient request (s)he be removed from active status such as when family of a graduating clinician asks to be put on inactive list
- *The patient is uncooperative during appointments or has harassed students/staff or faculty
- *Other reasons deemed appropriate by the Program Director/faculty of staff

These are categorized by Letter of Termination and No Letter of Termination Required (the * indicates the need for a letter of termination).

In these cases, the patient will be sent a letter explaining that their dental hygiene care is being terminated, the reason why and that the chart will be inactivated. The patient will be referred to the community for continuing care.

The Business Operations Specialist has templates for multiple types of patient dismissals. Once the correct template is chosen, and developed, it must be reviewed by faculty and / or the Business Operation’s Specialist. It will then be printed on letterhead, signed and mailed. A copy of the letter will be placed in the patient’s electronic chart. A chart entry must be made regarding termination and the record will be filed in the inactivated file.

Long-Term Storage
Chart audit is completed before files are prepared for long term storage. Charts are prepared for storage by:

- Ensuring there is a signed entry in the Treatment Note about the reason for inactivating the chart and a copy of the termination is present.
- Unmounting all radiographs and placing them into labeled coin envelopes, which are then stapled to the chart; mounts are to be reused.
- Filing charts in the inactive file.

Charts are maintained in a designated area until ready for disposition according to NMSU record retention policies.

Copy Machine
This copier is for clinic and department use only.
Clinic Computers
Three computers are located in the teaching station and are available for clinic business and faculty use only. Students may only access these computers to scan files into their patient’s records. For all other purposes, student may use the computers in their workstations. Patient intraoral photos are also logged in the Eaglesoft system. The computer is not for personal use.

Office/Assistant Duty
The Office Assistant Rotation has many components. This experience provides the student the opportunity to implement basic clinical management skills. **It is expected that the person on Office Duty arrive in clinic promptly at 8.00 am or 1:00 pm.**

The schedule for Office Assistant:

8:00-8:45 or 1:00-1:45 in the business office to prepare for and receive patients
8:45-11:15 or 1:45- 4:15 in clinic to assist with Eaglesoft entries, complete Student Chart audits, collect fee sheets of patient’s being dismissed at mid- clinic and returning paperwork to Business Office
11:15-12:00 or 4:15- 5:00 in Business Office to assist with fee collection, receipts, appointment scheduling, and closing up business office. Schedules may be altered to meet the needs of Business Office or faculty.

Checking-In Patients for Clinic Hour
1. Put a Sign In Sheet in the front window for patients to sign in.
2. Alert student of their patient’s arrival.
3. Be sure new patients have a Registration form to complete and the HIPAA form to read and signed.

Making Patient Charts
All patients are now entered into Eaglesoft. Charts will be made only when or if Eaglesoft is not working. The labels for patient charts are color coded, according to last name letters and the year in which patients started treatment in the clinic. The Business Operation’s Specialist will give students specific instructions about creating and labeling new charts.

Doña Ana Community College Clinic Property
A variety of patient education models, large dentition sets, toothbrushes, puppets and visual aids are available for student use. When taking any item off campus for health fairs or public presentations, please contact the Business Operations Specialist/Faculty for a Sign Out log to sign out equipment/ supplies appropriately.

Security Window
The clinic business office has a locking window that acts as a security closure. The window is to be opened in the morning and closed at the end of the clinic day or when the office is closed.

Duplicate Radiograph Release
If duplicate films are needed, the patient will be required to make arrangements to have them processed. When the films are picked up, have the patient sign the release of radiographs or release of dental/medical records found in eglesoft letters. We will not mail or e-mail any medical/dental records to any patient or dental/medical professional. We will provide duplicate records to patients who pick them up in person. We will also provide digital version of the records via encrypted files to the patient or patient legal guardian or legal representative who appears in person to pick them up.
Public Relations

❖ To provide accurate information to news media, it is essential that all inquiries from the media be directed through the College President’s office.

❖ Refer all requests for information from external sources to the College President.

❖ All employees and students not involved in the information chain are not to discuss the situation with anyone, except when authorized.

All correspondence, patient recruitment materials must be approved by the Program Director or his/her designee (Clinic Administration Assistant or DH Clinical Coordinator)

Student Access during Non-Clinic Hours

• During non-clinic hours, student may access the clinic to use the computer and work on their patient information or to grade radiographs.

• Students MUST not interrupt the operations of the clinical staff (business operations, maintenance, clinical supervisor, etc)

• If students need access to paper charts, a request to have those charts pulled and available should be made at least a day in advance by completing the chart request form located outside the clinical business office. No charts will be pulled or made available if this protocol is not followed.

• Students failing to adhere to these guidelines may receive professionalism point deductions as outlined in section 2 of the clinic manual.

• Students may not interrupt the clinical operations of other classes. Example: Junior students should not be on the clinical floor when seniors or dental assisting students are utilizing the clinic, unless otherwise specified by their clinical coordinator or the clinical coordinator on the clinical floor.
SECTION 8. CLINIC PROCEDURES
The Clinic Environment

DACC Clinic Goals
The goal of the clinical experience is to create a learning environment that will enable the student to integrate theoretical, clinical, and professional skills into comprehensive patient care. Clinical experiences will emphasize preventive oriented, client-centered, evidence-based, ethical dental hygiene service.

Opportunities to provide clinical care in a variety of settings will be scheduled and may include: DACC Dental clinic; Residential Care Facilities; Regional Public Health Facilities; Indian Health Service Clinics; and others as appropriate.

Interruptions must be minimized to facilitate learning. Individuals not associated directly with classroom or clinic/lab activities will **not** be allowed to remain in the area for any extended period of time.

**Students not directly involved in the scheduled clinical activity:**

- will be asked not to enter the clinic;
- may retrieve equipment or supplies from the clinical area during clinical activities only with permission from clinical faculty;
- who need to access charts or phone messages will check with the Business Operations Specialist, or the person on office duty, through the window in the reception area.

Only extremely important and emergency messages will be delivered to students and faculty working in the clinic.

Flowers and other gifts may be delivered and kept in the clinic as long as they do not compromise the well-being of patients or those working.

Students are not to study for other classes during clinic, nor spend more than 15 minutes recruiting patients or “catching-up on” clinic record keeping. **Any “cancellation time” or other “unassigned” clinical time must be used to maximize learning. If a student has no patient during a clinic session, the session will be counted as an absence. Students are expected to remain in clinic and maximize learning performing assigned clinical activities.** Students are expected to use their time creatively to enhance their professional education. All “alternate” learning experiences must be written up and reported at post team meeting. The Clinical Coordinator may assign students without a patient to one of the following example activities or any other clinical activity deemed appropriate:

- Assist other students with patient care
- Assist in sterilization duties
- Assist in office duties
- Complete chart audits
- Assist in other clinical duties as necessary

**Note:** Infants and children will not be allowed in the clinical area unless they are receiving dental hygiene
services. Parents should make child care arrangements accordingly.

**Mentor**
At the beginning of Fall Semester, senior students will be paired with junior students to act as mentors to help with questions about the Program and advice on other issues. Occasionally, roles will be reversed, depending on the circumstance. The major point of establishing this relationship early, is the expectation that it will continue throughout the year, and will generate a collegial working relationship that is beneficial to everyone.

**Dental Assisting Students in Clinic**
The Dental Hygiene and Dental Assisting Program share clinical, laboratory and classroom space. Occasionally, students from both Programs will share the clinic at the same time, each working on their own curricular activities.

At other times, Dental Assisting Students will be assigned to clinical rotations during Dental clinics and will assist hygiene students with patient care and clinical management activities such as sterilization, radiography etc. It is very important that students from both Programs adhere to all clinic standards and procedures, and maximize the opportunity for everyone to learn.

**Dental Hygiene Program: Dress Code**
Clothing worn to class, labs or out to community events must be conservative, fit well and not be revealing. Clothes should be appropriate to the occasion. Remember, you represent DACC and the Dental Hygiene Program at all times in public.

While at school, casual or casual business attire is required.

- No tattered jeans, short shorts or very short skirts.
- No bare mid-drifts or halter tops.
- No hoods or hats.
- Shoulders and upper chest should be covered- in other words- no deep cleavage showing and no underwear showing.
- If clothing is imprinted with a message, it must be appropriate for a health-care environment.

The clinical dress code is based on principles of infection control and safety and the effect appearance has on clients’ perception of an individual’s professionalism. The dress code was developed by dental hygiene students with input from faculty and is to be followed whenever one is working in a clinical environment or attending dental hygiene functions.

By adhering to the dress code the overall impression clients and guests to our program will have, is that we are clean, healthy, neat, organized, and personable. The following guidelines apply:

- Optimal personal and oral hygiene is essential.
- Hair is to be neat and well controlled. It should not fall into the field of operation nor interfere with student’s or faculty observer’s vision. Hair colors should fall within “normal” range. Head bands are
not allowed due to the propensity to attract aerosols and become contaminated

• Nails should be well manicured in a length that will not interfere with instrumentation, injure patients’ tissues, or penetrate gloves. Nail polish harbors bacteria and should not be worn. False nails are not allowed.

• Hands should be clean and free from scratches, nicks, or other open, abraded, or weeping lesions. If any of these conditions exist, clinicians will be required to avoid intra-oral procedures until the condition improves.

• No jewelry is allowed other than a plain wedding band, one stud earring per ear, no necklace or bracelets on the arm (with the exception of medical alert jewelry) or ankles are acceptable for clinic attire. Additional body jewelry that is worn for body piercing and that is visible on the body when dressed in clinic attire is not acceptable. Examples are nose jewelry, tongue jewelry, eyebrow and lip jewelry. Failure to comply with the dress code will result in non-compliance of the program’s protocol. Please refer to our section on Consequences for Non-Compliance of Standards of Conduct and if needed, refer to the Health Sciences Student Handbook for more information. Lab Coats/procedure gowns, selected for each class will be worn during all clinical activities, including rotation assignments, unless otherwise specified by the supervising faculty. A clean coat must be worn each clinic day. Faculty will wear similar coats. Students and faculty must wear clean, neat scrubs under clinic coats. Students are to wear the designated color for the particular day.

• Scrubs should fit well, loose enough to permit freedom of movement, not revealing. Students are expected to routinely launder scrubs and other attire worn in the clinical setting using color-safe bleach to help disinfect garments. Garments should be wrinkle free. Students are expected to keep extra, clean clinic scrubs, shoes, and other clinic attire in their lockers in case a change of clothing is needed. The DACC clinic attire will be scrubs, top and bottom of two designated colors. At the beginning of each semester, you will be given a list of what color is worn at each clinic day.

• Clinic lab coats will be laundered in the department and kept in the laundry room. Pockets must be checked carefully, removing pens, nametags, radiology badges, etc., prior to placing in the biohazard bag in the laundry basket. Follow posted instruction to process laundry. Note: The Department is not responsible for replacing damaged clothing. If you run your lab coat with a pen you will be required to replace it at your expense.

• Lab coats are available for use in the lab and will be laundered by the department.

• Nametags will be worn during all clinic and lab sessions. Tags should be surface disinfected at the end of the clinic day.

• Dosimetry (radiation) badges should be worn during every clinic session. A fetal monitor will also be worn by pregnant students and faculty.

• Shoes should be clean, comfortable, and quiet, have a closed toe and heel and fit snugly. Shoes should be made of material that is impervious to puncture. Soft cloth shoes are not appropriate. Clinic shoes should be reserved for use in clinic only. Professional clinic shoes or plain athletic shoes that coordinate with scrubs will be acceptable. Clinic shoes will be either plain white or black. It would be most beneficial for you to leave your clinic shoes in your locker so that you can change into them when you are in clinic. They must be clean and free of dirt for each clinic session.
• Socks or stockings must be worn, be neat and cover exposed legs/feet to help minimize the potential for splash or airborne infectious materials to compromise ones health. Colors or plain patterns that coordinate with the clinical attire are acceptable.

• Strong perfume, cologne, hairspray, aftershave, or hand lotion, which may trigger allergies, asthma, or be unpleasant to others in close proximity, are highly discouraged.

• Make-up, if worn, should be light and carefully applied. No false eyelashes or hairpieces.

• Dental personnel are expected to role models of health. If one does smoke it is imperative that the smell of smoke be removed from hands, face, hair, and clothing before entering the clinical area, classroom or dental office suites.

• No chewing gum while in a clinical setting or at an external rotation site. Gum is considered a food product.

• For certain rotations and some internship a different dress code may be specified.

• Tattoos and piercing jewelry must be concealed or removed.

Unit Assignments/Maintenance
Dental Units are assigned to students at the beginning of the semester. Students must remain in their units. A junior and senior student will share one unit.

Students are not to switch their assigned units without the direct consent of the Clinic Coordinator. Please refer to individual syllabi’s for specific regulations regarding switching Operatories.

Students assigned to a unit will be responsible for restocking supplies according to the labels on unit drawers and cabinets. It is very important to follow the established patterns so that every unit is identical. This facilitates efficient utilization of all units. Personal items such as toothbrush, comb, water bottles etc. are not to be kept in the unit. Students are responsible for cleaning and maintenance of the unit area and must arrange among themselves to share the work. Students who may be assigned to “Float” from unit to unit will also be responsible for the care and maintenance of the units they use.

DACC Clinic Philosophy
“*We believe in providing an environment committed to health with an emphasis on prevention that encourages each individual to set and achieve personal health goals. Comprehensive dental hygiene care, based on individual needs and desires will be provided to patients seeking services at Dona Ana Community College Dental Clinic.*”

Patients’ Rights
• The patient has the right to a considerate and respectful care.

• The patient has the right to and is encouraged to obtain from physicians and other direct caregivers relevant, current and understandable information concerning diagnosis, treatment and prognosis.

• The patient has the right to make decisions about the plan of care prior to and during treatment and to refuse a recommended treatment or plan of care to the extent permitted by law and the dental clinic standards and to be informed of the medical or dental consequences of this action.

• The patient has the right to every consideration of privacy.
• The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential by the dental clinic, except in cases as suspected abuse and public health hazards when reporting is permitted or required by law.

• The patient has the right to review the records pertaining to his/her dental care and to have the information explained or interpreted as necessary, except when restricted by law.

• The patient has the right to expect that, within its capacity and standards, the dental clinic will make reasonable responses to the request of a patient for appropriate and dentally indicated care and services.

• The patient has the right to ask and be informed of the existence of business relationships among the dental clinic, educational institution, other health care providers, or payers that may influence the patient’s treatment and care.

• The patient has the right to be informed of dental standards and practices that relate to patient care, treatment and responsibility.

• The patient is entitled to continuation and completion of treatment initiated at the DACC Dental Clinic.

• The patient has the right to comprehensive preventive dental care. Care that is determined, by the Program standards and by law, to be beyond the scope of the Dental Program, will be referred, through oral and written communication, to seek dental care from a qualified dental care provider.

• Above all, the patient has the right to confidentiality, truthfulness, respect of privacy, administration of competent care, protection from harm of person or property, right to information, full disclosure of risks and benefits of treatment, freedom of expression, freedom from coercion, and the right to respect for and protection of the patient.

• The patient will be asked to sign an Informed Consent form prior to treatment and this is provided for their protection.

Program Standards
The following pages identify basic Program standards and procedures that are to be implemented in the Dental Clinic. Changes and/or additions may be made by faculty after consultation with the Program Director, other faculty, staff, and students. Changes will be made in writing and dated and signed by the Program Director. These forms should be added to your clinic manual notebook.

Informed Consent
Prior to any assessment and therapeutic procedures the patient will be asked to sign forms giving implied consent. The Anticipated Treatment and Informed Consent form requires the patient’s signature to indicate they have given informed consent to specific dental hygiene treatment as discussed with the student and faculty. Not obtaining patient consent is grounds for unprofessional behavior report. Proceeding with treatment without obtaining informed consent is legally considered assault.

Patient Records
A patient file/record must be created for each person who receives dental hygiene treatment. Every patient file/record must, at a minimum, have a Patient Registration/Medical/Dental History form and a Treatment Note. This includes screening patients, and special clinics such as radiology, whitening, mouth-guard, kids clinics. Patients who do not follow through with comprehensive care will be known as “limited care” patients.
Records of patients who receive comprehensive care will be a combination of Eaglesoft computer records and paper copies, entered into the computer if necessary.

The patient’s file/record is the legal record of education, treatment and referral provided to the patient. **All services and information provided to the patient must be recorded.** In addition, the record may contain information pertinent to the effective delivery of services. All information needs to be recorded in a manner that will be easily understood by future clinicians, therefore, only DACC and professionally approved abbreviations will be accepted. All notes must be written in clear concise, objective terms. All notes must follow the determined templates in eaglesoft.

All radiographs, copies of prescriptions, referral slips and other related documents shall become part of the permanent file. Only duplicate radiographs may be released to the client. The originals must be kept with the chart. Release of radiographs or other client records must be properly documented.

**Comprehensive Patient Care Case Management**

The concept of comprehensive-patient-care case management forms the philosophical basis upon which patient care is provided in the DACC Dental clinic. Each patient’s general and oral health is thoroughly assessed. Only then, is a comprehensive treatment plan developed based on the individual needs and desires of the patient with the goal to eliminate disease and restore the oral cavity to health and function. The Dental Hygiene Care Plan DHCP template is located in eaglesoft template notes (initial note).

Students, working under the supervision of faculty, are responsible for completing the comprehensive treatment plan for each client assigned to them. The faculty is responsible for evaluating the development, implementation, and completion of the plan using the case management located in the student’s Foliotek record.

**Community Liaison and Referrals**

The DACC DH Program wishes to maintain a close working relationship with the local dental hygiene and dental community, other health care providers, public health, and other service agencies. As part of students’ professional development they are encouraged to interact with community dentists and other professionals in the referral process. This is intended to help develop an appreciation for various roles in community health-care systems. Therefore, all clients will be referred to community resources with appropriate written and verbal communication.

All clients seen in the Dental Hygiene Department will be referred to a general dentist of their choice for regular oral examinations, following the protocol outlined below, even if no significant findings are discovered during DACC dental and dental hygiene assessments. This is because DACC is not the primary provider of all dental services for patients seen in this clinic. The referral will be given during the original sequence of treatment and at each re-care visit if it has not been followed through.

Referrals to other health care professionals will be based on the assessment of the faculty overseeing patient care. These referrals will be tracked on the student’s Case Management form, as well as in the patient record. Referrals will be followed up by students and faculty during subsequent appointments as part of the quality assurance process.

The Dental/Medical Referral form and the Dental/Medical Release form are part of the eaglesoft electronic health record. Copies of these forms may be found in eaglesoft letters.

**Dental Referral Protocol**
1. **All** patients treated in the Dental clinic will receive a referral for follow-up dental care.

2. Patients with noted pathology will be referred for their specific dental needs.
   - Periodontal pathology requiring referral to a Periodontist
   - Dental caries
   - Periapical pathosis or teeth requiring endodontic treatment
   - Oral Surgery needs including extractions
   - Prosthodontic needs
   - Lesions evaluated as requiring biopsy
   - Orthodontics needs

3. Patients with noted pathology having significant morbidity and or mortality risk will be referred and require follow-up to help ensure that the patient is compliant with the referral.
   - Any faculty member may initiate a referral follow up. Once a referral follow up has been initiated by a faculty member, it shall not be overridden by another faculty member.
   - Referral follow ups are required for the following:
     - Pathology and lesions referred for biopsy
     - Pathology suspect of possible airway obstruction if not resolved (i.e. extremely mobile teeth which could be accidentally inhaled or ingested).
     - Dental infections with malaise, fever and/or lymphadenopathy.

4. When a referral follow up is required the following steps must be taken:
   - Faculty will document on the Case Management Form and patient electronic health record. Indicate the type of specialist the patient is referred to.
   - A referral form will be written up and given to the patient and a copy will be put in the patient chart/Eaglesoft.
   - The student must enter the patient’s name, patient’s contact information, and referral information, which requires a Dental Faculty signature and the date the referral was made.
Clinic Supervision
All clinics are supervised by licensed dental hygienists. Patients are examined by the attending dentist, prior to commencing dental hygiene treatment, to determine if an immediate medical or dental referral is necessary. If no attending dentist is available or if the patient has a dentist, the patient receives a referral to a community dentist or his/her dental home. The student/faculty ratio in the clinic is 6:1 in order to meet Accreditation Standards for Dental Hygiene Educational Programs. No patient may be seated in the clinic unless a faculty person is on duty.

Supervision & Signatures Required for Students to Proceed with Patient Care
Depending on the level of experience, students have and the requirements of faculty overseeing each of the clinics, students must adhere to the established protocol regarding supervision. For clinics in the early part of the Program, students need to have many steps of the patient care process evaluated by faculty and signed off before proceeding with other procedures. As students gain experience and develop clinical competency, fewer procedures will require signatures before proceeding with patient assessments and treatment. At all levels of experience, the student must have faculty sign off the medical history. It is expected that all students will carefully follow the supervision and signature protocols outlined each semester to ensure patient safety.

Sign-Up for Help
Students must sign up for assistance on clipboards that are located on the desk in the teaching station. Enter name, unit number, time of sign up and the procedure one needs help with. As faculty respond to requests they will initial and write the time of the check on the sign-up sheet.

Clinic Hours/ Student Schedules
It is important to remember that the Dental Hygiene program and the Dental Assisting program share the facilities. All students are expected to respect the class/lab and clinic schedules of both programs. This means no interruptions and maintaining a mutually respectful environment.

Clinic starts at 8:00 am and 1:00 pm (unless otherwise noted). Students should have their operatory set up and disinfected no later than 8:10 am. Patients are to be seated by 8:15 and 1:15.

Clinics operate until 12:00 pm or 5:00 pm (unless otherwise noted; however, patients are dismissed at 11:20 and 4:20 pm). Students should not be signing in for patient check after 11 am and 4 pm. In other words, 11 am and 4 pm is the time limit for students to sign up for faculty checks to ensure faculty can perform the last checks on a timely manner and students are able to dismiss their patients on time and write their notes and paperwork for faculty to check and sign no later than 11:45 am and 4:45 pm. Students might be deducted points on time management if these guidelines are not followed. It is the student’s responsibility to ensure that all paperwork gets proper signatures prior to unit cleanup. It is especially important to get the dentist’s signature and any part-time dental hygiene faculty signatures before they leave for the day.

At 15 minutes before the end of the clinic a post-clinic Team Meeting is conducted to share with everyone the learning that occurred during clinic.

Students on rotations may not be required to participate in pre/post-clinic Team Meetings if their work is not complete. The supervising clinical faculty will make that decision.

Every attempt is made to develop schedules as early as possible. However, in unforeseen circumstances schedules may not be available early and occasionally it is necessary to change schedules after they have been set and are in operation. Students are expected to be flexible and to accommodate the new schedules. The goal is to provide an exceptional educational experience and to take advantage of multiple opportunities for
learning.

Students may be required to participate in off-campus rotations or professional meetings that will enrich their education and help develop leadership, organizational and other professional skills. Each student will be expected to make their own arrangements for transportation, to arrive on time and stay until the end of the scheduled session.

Team Meetings
Team meetings are 15 minute time blocks designed to enhance efficiency and effectiveness of clinical learning. Students will engage in critical thinking and problem solving exercises and share their goals and accomplishments. All students and faculty assigned to a given clinic are expected to participate. The following are ideas for successful meetings. Not all of them will be implemented in a given meeting; rather meetings should meet the need of the group at any given time.

Pre-Clinical Team Meetings (Individual between faculty and assigned student)
- Students will have reviewed all scheduled patient’s charts prior to clinic and should be ready to summarize the patient’s condition, treatment plan and any needs for consultations, referrals or potential for emergency. A specific format “Patient Presentation Guide” will be used. (See Section 14 for the Patient Presentation Guide)

Post-Clinical Team Meeting
- Students should come to Post Team meetings with chart entries completed and signed off, and with all faculty signatures on evaluation forms.
- Students should share what they learned, not just what they did.
- Discuss problems encountered and how they were solved.
- Discuss what, if anything, might be done differently in future appointments.
- Celebrate successes!
- As a group, plan for additional assistance, tutoring or review.
- Add anything else appropriate for the team

Services Provided in the Dental Clinic:
The dental clinic provides primary preventive dental hygiene services.

Patient Recruitment
It is the student’s individual responsibility to schedule patients who meet the semester’s patient requirements, including AAP classification and Level of Difficulty, as stated in the syllabi. Students are expected to identify and schedule patients through their own recruitment efforts.

An ongoing maintenance schedule provides a source of continuing patients for student clinical activities, and these patients will be approved for continued care by the Clinic Coordinators.

All posters/advertisements used for the clinic and patient recruitment must be approved by full-time
Clinic Faculty and the Program Director prior to being published and distributed.

Patient / Clinician Assignments
In order to establish a fair system for assigning patients that will provide everyone with equal opportunities that are appropriate for the level of skill each student presents, the following protocol has been established and will be monitored by faculty. See Section 15: Clinic Business Operations for details of the process.

Excel List for Patient Assignment & Recare
To help ensure that all patients are adequately tracked, all students will be required to keep an Excel Spreadsheet of patients that they have seen, or that have been assigned to them. Clinical coordinators will provide information on whether or not the excel sheet is necessary.

Because the Provider History is generated from *Fee Sheets*, it is imperative that every patient have a *Fee Sheet* completed and submitted to the Business Operations Specialist -even if there was “no charge” for the procedure.

Appointment Book
Scheduling patients in the Eaglesoft system in advance is extremely important. This reduces confusion on clinic days, allows patient records to be pulled in advance, and ensures that the appointment is not filled by the Business Operations Specialist. If you need a number of clinical appointments open, the student must block his/her clinical calendar on Eaglesoft to prevent patients been scheduled for them by the business specialist.

Screening Patients
All adult “walk in” patients will be scheduled for a screening as necessary. In some instances and if students have time available, walking patient will be assigned to a particular students without a screening appointment. The purpose of the screening is to make preliminary determinations about the patient’s health status, and whether they will make a good teaching case.

Children do not have to be screened prior to being appointed. A student cannot schedule their personal patient as a screening patient.

The student completing the “screening” patients **must** schedule an appointment for the screening patient **prior** to dismissing the patient. This will entail communication with the student who is next on the screening list, and knowledge of their availability in the schedule; therefore, students must keep their clinic schedule updated in Eaglesoft.

See Section 10: Guidelines for Dental Hygiene Assessment and Diagnosis for details about the screening process. See also Section 15: Clinic Business Operations.

New Patient Routines
1. Patient checks in with receptionist and fills out *Patient Registration, consents, and HIPAA*.
2. Student is notified when patient is ready. Patient should be seated immediately.
3. Student escorts patient to his/her unit. (The unit must be fully set up by the start of clinic).
4. Student interviews patient, developing rapport and assisting patient in identifying health goals and goals for appointment. The student reviews and updates/enters the *Medical/Dental History,*
radiographic history, and release forms. Vital signs are taken and the patient’s ASA Classification is
determined. Education is provided as necessary.

5. Student signs up on “Help Request” form at teaching station. Instructor assigned to the student will
respond to the request and initial the “Help Request” list. If the assigned faculty is not available, ask
that faculty person if you can request help from another faculty person. If not, ask what you can
continue with, so you use time wisely. Be careful not to interrupt other faculty and students with
patients in a manner that would be disturbing. A calm, casual request when no one is talking is most
appropriate.

6. Instructor reviews and signs the Medical/Dental History and approves student’s decisions regarding
radiographs.

7. Student has patient perform a pre-procedural rinse before starting any examination procedures, then
performs extra-intraoral examinations, periodontal assessment, dental charting and exposes radiographs
(if appropriate). Student evaluates and documents quality of radiographs and determines need for
retakes (with guidance form the Dental Faculty). Dental deposits are classified and a treatment plan is
outlined. NO disclosing agents are applied until after faculty has evaluated the patient’s oral conditions.
**Student must get faculty signatures as they proceed with assessments according to requirements
for the level of the student’s experience.** More details are available in Section 14 Student Evaluation
and in course syllabi.

8. Faculty evaluates student’s assessments, radiographs, treatment plan and initials appropriate student
evaluation forms; also approves and supervises retakes. Prepare by:

- Placing mounted labeled radiographs on the view box or bringing radiographs up on Eaglesoft
- Verbally summarize what you want faculty to do
- Presenting clean instruments for faculty use.

9. Student presents Treatment Plan to patient, and obtains “informed consent” by having the patient sign
the Anticipated Treatment and Informed Consent form.

10. Student performs dental hygiene services as outlined in the treatment plan. **If multiple appointments
are necessary, all potential appointments are scheduled when the patient is at the first
appointment (if possible).** All appointment scheduling, patient education and general discussions are
completed in the operatory so when the patient is escorted to the reception area, the Clinic
Administrative Assistant can immediately work with the patient to collect fees, put scheduled
appointments in the book etc.

11. Before dismissing the patient from any appointment, faculty **must** “evaluate” the patient, post
treatment to walk-out on Eaglesoft, and release the patient.

12. The Fee Sheet should be filled out and signed off and dated by faculty for all treatment delivered for
that appointment and **be taken immediately** to the clinic business office for processing.

13. **Upon completion of each appointment, the student must escort the patient to the reception desk
with a completed fee sheet with all signatures and dates.** Fees should be collected as treatment is

14. When all treatment is complete, the patient is asked to complete a Patient Satisfaction Survey.
Reappointment Routines
1. Student updates Medical/Dental History and oral inspection.
2. Medical History update forms are checked and signed by the instructor and need for pre-medication or new vital signs are verified.
3. Student continues to follow sequence in the treatment plan.
4. Faculty evaluates the patient before dismissal. This may be a thorough clinical evaluation or it may be simply acknowledging to the patient and clinician that the patient is released to leave. **This decision will rest with the individual faculty supervising the patient’s care, not just any available faculty person.**

Children/Special Patients
1. The signed permission of the legal guardian is required in the Medical/Dental History and Treatment Plan/Consent for Treatment form prior to treating a patient under age 18 or any adult client who does not qualify to be their own legal guardian.
2. Appropriate guidelines for care of children and special clients must be implemented and may be modified after consultation with faculty.

Re-Evaluation/Re-Care/Maintenance Procedures
Once active dental hygiene therapy is complete, the patient will be placed on a re-care schedule at an appropriate time interval. See Section 12: Dental Hygiene Therapy for details of the appointment procedures.

Adjunctive Therapy
During treatment planning it may become evident that the patient requires adjunctive therapies to meet their needs/desires. The therapy may include athletic mouth guard, tooth whitening or other procedures. These procedures must be discussed with faculty. Students will only be allowed to provide these services if they have met all other clinical requirements.

Athletic Mouth Guards
Only athletic mouth guards may be fabricated for patients. Night guards for management of bruxing are not to be provided since they require continuous dental supervision.

Orthodontic Appliances
Patients wearing orthodontic s may be treated in the DACC Dental Clinic. However, unless arrangements are made for the Orthodontist in charge of the patient’s case wants to remove the appliances prior to the dental hygiene appointment and replace them following the appointment; the appliances will remain in place during dental hygiene treatment. **In no case will DACC students or faculty remove or replace orthodontic appliances.**

Tooth Whitening
Tooth whitening is an elective dental procedure that may be provided to patients of record in the DACC Dental clinic after completion of necessary periodontal therapy. See Section 12: Dental Hygiene Therapy for more information

**Only students who have met clinical requirements may provide tooth whitening services.**
A patient “not of record of DACC” may be referred by their DDS/DMD for the limited service of whitening. The patient must present a current prescription from their primary dentist recommending the procedure, and must show proof of having an exam and cleaning within the last 3 months.

Student Chart Audit
To assure the quality of patient care, charts are audited periodically by students. This helps to verify that all treatment was necessary, appropriate, and completed in a timely manner. Patient charts/records are analyzed for completeness and legibility of records including; signatures, fees, referral and consultation records, radiographs, chart entries, maintenance interval, etc.

Students will perform audits on completed patient charts from their class. If audits cannot be done on office/clinic rotation time, then they will need to be done on student’s own time. See Foliotek process for completing chart audits. This is located in Foliotek Resources.

NOTE: Patient charts are not to leave the clinic area. Audits need to be recorded on the Student Auditee’s and Student Auditor’s chart audit log by Faculty along with appropriate signatures.

The chart audit protocol is directly related to quality assurance standards mandated by ADA Accreditation and the standard of care for the profession.

Individual student’s chart audits will be randomly selected and evaluated by Clinical Coordinators to ensure that records are being kept properly. No credit will be given for patients completed unless all records are complete and accurate and the patient has paid all clinical fees.

The following guide explains DACC’s chart audit system.

CHART AUDIT

Senior Students

Each Senior Student is to have 9 of their completed patient charts audited by a fellow classmate during each of their senior semesters. The Student Auditor on rotation will audit 3 charts each clinic session as time permits, following the third week of each semester. Chart audits will be conducted during the first 3 weeks of each semester using 3 charts from the prior semester in order to keep an ongoing chart audit process.

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3 \text{ charts} \times 3 \text{ charts/session} \times 12 \text{ weeks/semester} = 108 \text{ charts/semester}
\]

\[
108 \text{ charts/semester} = 9 \text{ charts/session} \times 12 \text{ students} = 60\% \text{ of Senior Students}
\]

Charts will be assigned by faculty members to a student. The faculty member assigning the chart is also responsible for reviewing the chart as the student auditor completes the review. The student auditor uses a rubric
for the chart review process. The rubric used by the auditor is visible to the student auditee and the faculty member. The faculty member can add comments to the rubric and suggest edits. The student auditee will use a clean rubric to correct the chart and will submit to faculty for review and approval. This process is outlined in Foliotek Resources Chart Audit Instructions. Result from the chart audits are immediately available for review by the clinical coordinators and the Program Director. Corrective action is taken based on the outcome of the chart reviews. (if applicable)

**Junior Students**

Each Junior Student is to have 6 of their completed patient charts audited by a fellow classmate during their spring junior semester. The *Student Auditor* on rotation will audit 2 charts each clinic session as time permits, following the third week of each semester. 1 chart audit will be conducted during the first 3 weeks of the clinic one semester in order to maintain an ongoing process of chart review and quality assurance.

\[
\begin{align*}
2 \text{ charts} & \times 3 \text{ sessions} \times 12 \text{ weeks} = 72 \text{ charts} \\
\text{session} & \quad \text{week} & \quad \text{semester} & \quad \text{semester}
\end{align*}
\]

\[
\begin{align*}
72 \text{ charts} & = 6 \text{ charts} = 75\% \text{ of Junior Students charts} \\
12 \text{ students} & \quad \text{student}
\end{align*}
\]

Charts will be assigned by faculty members to a student. The faculty member assigning the chart is also responsible for reviewing the chart as the student auditor completes the review. The student auditor uses a rubric for the chart review process. The rubric used by the auditor is visible to the student auditee and the faculty member. The faculty member can add comments to the rubric and suggest edits. The student auditee will use a clean rubric to correct the chart and will submit to faculty for review and approval. This process is outlined in Foliotek Resources Chart Audit Instructions. Result from the chart audits are immediately available for review by the clinical coordinators and the Program Director. Corrective action is taken based on the outcome of the chart reviews. (if applicable)

**Faculty Review**

Clinic Coordinators will review the audit log at semesters end to ensure that Audits are conducted according to these guidelines.

**Termination of Care**

**Abandonment** is stopping the connection between the professional and the patient. The professional cannot refuse to treat a patient of record unless there is a reason to refer.

In cases where the relationship must be terminated, written notice of dismissal, including a statement of care remaining to be performed and suggestions for obtaining the care, must be mailed to the patient. All letters indicating termination of care must be reviewed by the Clinical Coordinator. See Section 15 Business Operations for more details.
Complaint Logs
If a patient wishes to file a formal complaint about the services received in the DACC Dental Clinic, a complaint form is available in the business office. The complaint will be filed with the Business Operations Specialist and brought to the attention of the Clinical Coordinator and the Program Director to be handled accordingly.

Quality Assurance
Students will have an opportunity to assist faculty in assessing the quality of the overall care provided to clients in the clinical setting. Skills learned in this process will be invaluable in future practice.

The Quality Assurance Plan for Patient Care (QA Plan) assesses the patient care component of the DACC DH curriculum, and is considered a part of the Curriculum Management Plan. This, along with other assessment measures, allows for the evaluation of the overall quality of the DACC Dental Hygiene Program.

The purpose of the plan is to help ensure that patient care is comprehensive, patient centered and will meet Accreditation Standard 6 especially as it relates to the ongoing review of patients and patient records to assess the appropriateness, necessity and quality of care provided; mechanisms to determine the cause of deficiencies in treatment and ways in which any deficiencies noted can be corrected.

DACC Patient Care Quality Assurance Plan
The DACC Formal System of Quality Assurance Plan includes eight (8) elements of assessment which are components of five (5) Quality Assurance Goals explained on the next few pages. This plan helps meet Accreditation Standards for the Dental Hygiene Program, and ensures standard, quality care for our patients.

GOAL 1 – Competencies and Standards of Care:
Ensure that all faculty and students recognize the “Competencies for Entry into the Profession of Dental Hygiene,” and will be able to implement the “Standards for Clinical Performance” to ensure appropriate application of the Dental Hygiene Process of Care. This process includes the following components: patient assessment, dental hygiene diagnosis, implementation of treatment plans (including appropriate adjunctive clinical services and education), evaluation procedures, and thorough, concise documentation throughout the process. All patient care will be provided in a safe working and learning environment.

Criteria and Procedures for Evaluations:
All students and faculty are required to read the Competencies for Entry in the Profession of Dental Hygiene” (see Section 2 of this Manual) and the “Standards for Clinical Performance” (see Section 14 of this Manual). Students will sign a document verifying that they understand the documents, and will abide by the standards and procedures while in the program.

Annually, all students and faculty will receive training in: risk management protocol, OSHA requirements, CPR/basic life support, radiation hygiene and safety, and maintenance and use of equipment. This training will be documented by the signature of all participants.

All standards will be reviewed periodically as part of clinical and theoretical course work for students, and as part of faculty in-service training.

Assignment of Duties:
Students will sign the verification documents and return them to the Program Director for filing in
student academic files during the first semester each year.

Faculty will sign verification documents and return them to the Program Director to be filed in administrative files in the first few weeks of the semester in which they teach in the program.

**Monitoring Schedule:** The Program Director will collect all necessary verification records for each semester.

**Record Keeping:** The Program Director will keep a log of the signed verification forms.

**Plan for Evaluation and Revision:** As the Clinic Manual is revised, the verification forms will be reviewed. If any revisions are needed they will be made at the time the Manual is revised. All data will be entered into accreditation tracking records

**In-service Training:** Students will receive information explaining the Competencies and Standards of Clinical Performance and other required training in the first semester of the first year of the Program. These will be reviewed as new skills are introduced throughout the curriculum.

Faculty will review the information in the first semester they teach during an in-service meeting or as a one-on-one discussion with full-time faculty and/or the Program Director. The information will be reviewed each semester and will be revised as needed.

**GOAL 2 – Maintenance of Competency:**
Develop and document ongoing maintenance of clinical competency for both students and faculty. **Criteria and Procedures for Evaluations:**

Through the use of a variety of assessment tools, faculty will determine a student’s competency to perform clinical procedures. Faculty signatures and dates of completion will be identified on all assessment forms.

Evaluations will occur during pre-clinic and all clinical session’s throughout the curriculum. Assessments will include direct observation using the following evaluation mechanisms: Clinical Skill Evaluations, Competency Examinations, Mini-mock boards, Mock Boards, Case Management forms, Daily s and other assessment tools as may be developed. Written assessments, such as examinations and case studies, will be used when appropriate.

Criteria/rubrics for evaluations are written for each type of assessment, and are contained on evaluation forms or in supporting documents in the Clinic Manual or course materials. Criteria relates to the Standards of Clinical Performance. Both students and faculty are expected to read and implement the criteria for evaluation.

The level of skill required for acceptable performance is elevated as students progress through the curriculum and is published in clinical course syllabi. For example, beginning students are expected to achieve 75% accuracy on evaluations while advanced students are expected to achieve 85% or higher.

Students who do not meet the expected level of clinical competency on a given Skill Evaluation will not be allowed to provide patient services relating to that skill until they have achieved competency. This may require special tutoring or other remediation activities, which will be implemented by full time clinical faculty or by special arrangement with adjunct clinical faculty.

Faculty is expected to maintain current licensure and meet legal requirements for continuing education. In addition, faculty is required to participate in clinical calibration exercises and other educational programs as
Assignment of Duties

Both students and faculty are required to review, and complete, the procedures developed for assessment of clinical skills. The schedule for completion dates are assigned by the Clinical Coordinators. A chart, “Clinical Skills Introduction,” is included in the Clinic Manual (See Section 14) and in clinical course syllabi to define specific schedules and evaluation criteria.

First and Second Year Clinical Coordinators are responsible for scheduling major evaluation activities such as Clinical Skill Assessments, Clinical Competency Exams and Mock Boards. Students and adjunct faculty are responsible for scheduling the ongoing assessments such as mini-mock boards, and the daily review of Case Management forms and Dailies.

Clinical Coordinators, with the assistance of adjunct faculty, are responsible for grading clinical competencies. Clinical Coordinators are responsible for scheduling any necessary remediation for skill development.

Monitoring Schedule: Clinical Skill Evaluations occur during the semester in which the skill was introduced, and continue until students demonstrate competency at the expected levels of achievement.

Competency Exams occur during the first year of the curriculum, and may be implemented during the second year for new skills, such as local anesthesia and nitrous oxide sedation.

Mini Mock Boards begin in the second semester of the curriculum and continue through-out the clinical curriculum.

Mock Boards occur during the Fall semester of the second year of the clinical curriculum.

Case Management and Daily analysis occur every clinical session from the first semester of the curriculum until graduation.

Faculty continuing education occurs throughout the year as in-service training planned by Clinical Coordinators, as courses the Program Director identifies as important, and as continuing education courses available in the community.

Record Keeping: Students are required to keep all completed clinical assessments tracked in Foliotek. Clinical Coordinators will review these records for completeness, and level of skill attainment, on a semester basis with the first review at mid-term and a final semester review prior to course grading. All data will be entered into accreditation tracking records.

Faculty records are reviewed annually by the Program Director to see that required continuing education is completed. A log of CPR Certification and other critical education is kept in faculty administrative records. All data will be entered into accreditation tracking records.

Plan for Evaluation and Revision: The development and maintenance of clinical skills is reviewed each semester by course faculty and suggestions for changes in assessment format and schedules may be made and implemented as needed. During the annual curriculum review, consideration is given to the effectiveness and efficiency of clinical skill assessment tools, and necessary curricular changes are implemented.

In-service Training: Students receive clinical education during theoretical and clinical courses each semester. Faculty receives in-service training each semester during faculty meetings, during continuing education
courses, and as one-on-one training by Clinical Coordinators and/or the Program Director.

**GOAL 3 – Observe and Audit Quality of Care:**
Assess patient care to determine the appropriateness, necessity, and quality of care provided by DACC Dental Hygiene students using a multi-faceted approach to determine the cause of treatment deficiencies. Assessments include patient review, outcome analysis, and corrective measures.

**Criteria and Procedures for Evaluations:**
Students will utilize the Dental Hygiene Process of Care ensuring that the *Standards of Clinical Performance* are met or exceeded. This includes comprehensive assessment procedures, dental hygiene diagnosis, treatment planning, implementation and completion of the treatment plan including re-evaluation procedures, necessary consultations, and referrals and scheduling recall appointments.

All patient chart forms will be appropriately filled out and signed by the patient, student and faculty as specified on the forms. Faculty will review all patient charts for completeness and accuracy. The appropriateness and necessity for care will be analyzed by review of the treatment plan, oral hygiene instruction, consultation forms, radiology prescriptions, and referrals. Faculty will consult with the student clinician and supervising dentist, if necessary, and make any needed additions or corrections to the plans. Treatment records will be completed in the recommended format as identified in the Clinic Manual.

Faculty will directly observe clinical care, and will evaluate student performance using *Case Management* forms, and other assessment forms such a *Clinical Skill Evaluation* forms and others as needed. Faculty will sign and date comments on the forms as treatment proceeds. Faculty will sign off completion of the patient’s treatment plan on the *Case Management* form, as well as in the patient records; only then will the student get credit toward fulfilling graduation requirements. *(All patient fees must be paid for the patient to count toward graduation requirements).*

Any deficiencies noted during patient treatment will be discussed with the student (and with the patient when appropriate), and will be corrected immediately by either the student (under close supervision) or by the attending faculty.

**Assignment of Duties:** Students will complete, and have all patient records signed off by Faculty during or immediately following each patient appointment.

Student will complete random *Chart Audits* on patients completed by peers. This will include a fee reconciliation procedure.

Faculty will review and sign off on all patient records and student academic records, including the *Case Management* form and *all Clinical Skill Evaluation forms*. They will supervise correction of any deficits in Student Chart audits, and sign off the corrections.

Clinical Coordinators will review students’ *Case Management* forms, and other completed assessments. The Clinic Coordinators will immediately enter progress in grade books, as well as on the student *First and Second Year Requirement* sheets. They will collect and review *Student Chart Audit* forms and sign off that correction have been made.

**Monitoring Schedule:** An evaluation of all patient care procedures will occur at the time of service. For Class III and IV patients, the results of treatment will be re-evaluated in four to six weeks following treatment. Patients will also be re-evaluated on appropriate recall intervals.
**Record Keeping:** After the academic assessment forms have been graded and entered in the grade book, students will file all forms into the *Graduation tracking in Foliotek*. The *Graduation tracking in Foliotek* will be reviewed by the Clinical Coordinators at mid-term and the end of the semesters throughout the two year curriculum. The *Graduation tracking in Foliotek* will be archived with accreditation tracking records upon graduate. All data will be entered into accreditation tracking records.

Completed clinical assessments, completed and in-progress patient, and special evaluation procedures are logged into the student’s First and Second *Year Requirement* sheets; this becomes part of the *Graduation tracking in Foliotek*.

Patient records will be kept for seven years by the Business Operations Specialist, and filed so that records of patients who have either elected to receive care outside the Program, or those who have received care for one recare cycle, will be accessible for referrals or other legal activities.

**Plan for Evaluation and Revision:** Clinical Coordinators and adjunct faculty will continuously review assessment procedures and forms, and revise as needed for implementation during the academic year. All revisions will be placed in updated versions of the Clinic Manual each summer during the annual curriculum retreat.

**In-service Training:** Students will be oriented to patient care procedures and clinical assessment mechanisms each semester by clinical faculty. Faculty will be oriented during scheduled meetings each semester and/or on a one by one basis.

**GOAL 4 – Assess Patient Satisfaction and Clinical Protocol:**
Assess: patient evaluations, implementation of recare, the status of referrals and patients’ satisfaction surveys, and the quality of patient care.

**Criteria and Procedures for Evaluations:**
Patient care will be evaluated by both students and faculty at the time of treatment, and at re-evaluation appointments and recare intervals using the same procedures and forms used during active treatment. A comparison of patient data, such as periodontal records, dental chartings, plaque scores, etc., will be made to help document progress toward health. Patient compliance on self-care regimen and their follow-up on all referrals will also be evaluated.

New comprehensive *Treatment Plans* will be developed and implemented for recare patients. These will be based on the analysis of current patient status. Both students and faculty are responsible for educating the patient about areas of improvement and/or neglect, and should encourage patient participation in solving any problems which remain.

With faculty assistance, students are required to identify appropriate intervals for re-evaluation and recare for each patient. These dates are documented on *Case Management* forms, as well as in the patient treatment records, and are entered on the Business Operations Specialist’s computer recare system.

Students are required to see recare patients for one (1) recare cycle. If the recare appointment cannot be scheduled before graduation, the patient may be assigned to another student. A recall list will be generated on the computer, and given to students to call and schedule appointments. The number of patients each student sees in each category (new or recall patients) will be tracked through analysis of *Case Management* forms and entries in *Student Requirement Sheets*.

When the treatment plan is completed, the student will request that the patient fill out a *Patient Satisfaction*
**Survey.**

**Assignment of Duties:** Students are responsible for documenting re-evaluation and recare dates at the end of active treatment, and for rescheduling recare appointments with their patients at appropriate intervals.

Faculty must sign off on the appropriateness of re-evaluation and recare intervals, and must sign off on new treatment plans.

The Business Operations Specialist will compile a computer list of recall patients for student use.

**Monitoring Schedule:** Patient re-evaluation and recare appointment dates will be monitored mid-term and at end of term when *Case Management* forms are evaluated.

Appropriateness of re-evaluation and recall treatment plans will be evaluated at these student conferences.

**Recall lists** will be developed each semester as students complete recare appointments, refer the patient to the community or to another students. This procedure must be entered on the student’s patient assignment Excel sheet. Patient scheduling will be monitored monthly by the Clinic Coordinator.

**Plan for Evaluation and Revision:** The process of re-evaluation and recall of patients will be analyzed twice a year (December and July) by Clinical Coordinators and the Business Operations Specialist to determine if changes need to be implemented.

**In-service Training:** Students and faculty will receive information about patient re-evaluation and recall systems in the Clinic Manual at the beginning of each academic year and it will be reviewed as needed.

**Goal 5 – Set Goals for Patient Care:**
Set personal goals for achieving comprehensive patient care of the highest quality, and evaluate progress toward those goals.

**Criteria and Procedures for Evaluations:**

Students will set goals for developing clinical skills, critical thinking and problem solving abilities for each clinical session. Self-assessment is critical to the development of professionals, so faculty must emphasize the importance of using the *s* and any other format available to document students’ development of this skill. See the Clinic Manual for ideas on how to stimulate self-assessment for professional development.

*Student Production Reports* will be generated. These computer lists (known as “Audit Trail”) will provide a comprehensive view of each student’s clinical activity for a given period of time. They will include a list of all clinical services performed by each student for each patient and the dollar production generated.

*Student Production Reports* lists will be analyzed to help determine the breadth of clinical experience students have gained, and the impact of student production on clinical income.

Student progress on clinical skill development, patient care services, goal setting, and the development of professional qualities will be reviewed in formal conferences between students and Clinical Coordinators. These discussions will be documented on the *Student Progress Report* forms, and will become part of the student’s academic record. Topics discussed, any recommendations for special skill development activities, and a date for follow-up on pertinent issues will be recorded.

Students will receive copies of these *Progress Reports*, and are required to follow through with recommendations for skill enhancement.

Skill enhancement and/or remediation will be planned by both the student and the Clinical Coordinator.
Implementation may be assigned to the student as self-study or will be assigned to appropriate faculty to carry out with the students. Activities may include: individual tutoring, assignment to special clinical situations, peer mentoring, or any other reasonable activity designed to help the student succeed.

**Assignment of Duties:**

The Business Operations Specialist will produce the *Student Production Reports* from *Eaglesoft Records* and provide them to Clinical Coordinators and the Program Director for analysis.

Clinical Coordinators will review all evaluations with students in individual conferences.

The Clinical Coordinators, Program Director and the Business Operations Specialist will review all student service production reports to determine if students are meeting expectations for the types of experiences and number of patients required to help develop competencies. The production reports will also be reviewed to determine if sufficient fees are being collected to support clinic activities.

**Record Keeping:**

Clinic Coordinators will maintain individual student academic records, to include with *Progress Reports*, and will keep course grade books.

The Business Operations Specialist will keep *Student Production Records* indefinitely for future planning.

**Plan for Evaluation and Revision:** Evaluation of student progress and clinical service production will be made each semester to help in planning for the next semester. Any revisions that are needed will be implemented immediately.

**In-service Training:** Students will receive information about goal setting, self-assessment, professional development and ethics in the Clinic Manual at the beginning of each academic year. This will be reviewed and emphasized during clinical theory courses.

Faculty will receive similar information in the Clinic Manual and at periodic in-service meetings.

This *Quality Assurance Plan* has been designed to assist students and faculty in analyzing the quality of patient care services provided by students of DACC Dental Hygiene Program. The Program standards and procedures described here are to be strictly adhered to, and are themselves to be reviewed and revised as needed to ensure the highest standards of patient care. Any suggestions about this plan may be directed to the Clinical Coordinators and the Program Director.
SECTION 9. INFECTION CONTROL

Introduction
The purpose of this section is to acquaint the student with the DACC and the Dental Hygiene Program infection control standards.

Upon completion of reading this section, documentation of training shall be filled out. This form serves as verification of training, and must be signed and dated upon completion; the completed form will be turned in to the Dental Hygiene Program Director, and kept in a permanent student/employee file.

Following the Blood-Borne Pathogen Exposure Control Plan in this Section, are detailed instructions that outline how students and faculty will implement the procedures.
(See Section 11: Radiography, for infection control procedures related to radiographic techniques and the darkroom.)

DACC Dental Hygiene Program Infectious Disease Standards:
The following outlines the standards that pertain to the prevention and management of infectious diseases including Human Immunodeficiency Virus (HIV) and Hepatitis B (HBV) in the DACC Dental Hygiene Program environment. DACC is committed to educational programs, and institutional policies, which will respond appropriately and effectively in regard to all communicable diseases.

Policies, standards, guidelines, and procedures shall take into account both public health interests and individual rights, and be guided by the recommendations and regulations of the Occupational Safety and Health Administration (OSHA), the Center for Disease Control (CDC), the National Institute for Occupational Safety and Health (NIOSH), the American Dental Association (ADA), state regulatory agencies, and current professional journals containing the latest research and recommendations.

Basic Infection Control Standards and Procedures
1. These standards apply equally to, and must be complied with, by all faculty, staff and students.

2. These standards will be reviewed annually by the Dental Hygiene Program Director to ensure its accordance with current medical information and regulation. Questions regarding any part of these standards may be directed to the Dental Hygiene Program Director.

3. The DACC Dental Hygiene Program is non-discriminatory with regards to treating patients with infectious diseases, as well as non-discriminatory in accepting students, faculty, and staff into the Dental Programs.

4. If infectious disease risk is present, a patient, student, faculty or staff member may be referred for further evaluation that may involve serologic testing. Because of the informed consent law, HIV testing is referred to appropriate test sites.

5. Patients with active infectious diseases will be assigned to the appropriate clinic based on the patient’s medical condition, the experience level of the student, and the need for or availability of licensed and/or certified dental professionals.
6. The major objectives of the Infection Control standards and procedures are to:
   
   (a) reduce the number of pathogens so that normal resistance can prevent infections
   
   (b) break the cycle of infection and eliminate cross-contamination,
   
   (c) treat every patient and instrument as infectious, and
   
   (d) protect all patients and other personnel from infection.

7. The material found here is in compliance and complimentary to the NMSU Employee Safety Handbook.

Following standards and guidelines will help define responsibilities for infection control:

**Non-Discrimination**

The DACC Dental Hygiene Program does not discriminate against students, faculty, staff or patients who have infectious diseases. At times, it may be necessary to refer an individual to health care providers with advanced skills which cannot be provided in this educational environment.

**Immunizations**

Before entering any health science program, students, faculty and staff must document immunization for certain communicable diseases including:

- **Diphtheria-Pertussis- Tetanus (DPT): One dose**
  
  within the last ten years

- **Hepatitis B:**
  
  A series of three vaccines at specific intervals and a confirmation of immunity through a titer test following immunization.

- **Measles, Mumps, Rubella:**
  
  Those born after January 1, 1957 must show acceptable evidence of vaccination of two doses since January 1, 1968 or a titer showing immunity.

- **Varicella (chickenpox):**
  
  Two doses of vaccine unless the first dose was received prior to age 13. As an alternative, provide verification of a history of chickenpox.

The need for immunization against the flu or other diseases should be discussed with a personal health care provider and be considered by each student independently.

Students refusing required immunization will need to appeal in writing to the Program Director.

The completed immunization record is part of the student’s permanent record, and is kept on file in the offices
of the Program Director. Students are responsible for paying for their own immunizations.

**Hepatitis B Vaccine**
All faculty and students who have been identified as having exposure to blood, or other potentially infectious materials, are encouraged to obtain the Hepatitis B vaccine, unless they have previously had the vaccine or wish to submit to antibody testing which shows them to have sufficient immunity. Students, faculty, and staff who do not wish to have the Hep. B vaccine may petition the Program Director, and will receive counseling about the importance of this health care measure. Individuals who decline the Hepatitis B vaccine will sign a waiver. Individuals who initially decline the vaccine, but who later wish to have it may then obtain the vaccine. **Students are required to pay for their own immunization.**

**Tuberculosis (TB) Test**
Each student will have a tuberculin skin test, or chest x-ray prior (depending on past exposure), prior to entering the program, and each calendar year. The TB test must be repeated following known exposure to tuberculosis. Physicians are required to report all positive or suspected cases of tuberculosis that come to their attention. If a diagnosis of active tuberculosis is made, the student must obtain clearance from their physician before he/she will be permitted to enter the Program or to continue in the Program until they are considered non-infectious.

**Physical Exam Requirements**
Dental Hygiene students are required to have a physical exam prior to entry in to the program to ensure that they are healthy enough to participate in both academic and clinical activities. Documentation of having completed the physical exam is all that is required. It does not have to include a diagnosis. This record will be kept in the student permanent academic record, and is due prior to the beginning of clinical training. The student will be requested to complete a comprehensive medical history that will become a part their clinical dental chart.

**Admission of Students with Blood borne Infectious Diseases (HIV/AIDS, HBV, HCV)**
The DACC Dental Hygiene Program shall not inquire about the blood borne infectious disease status (to include the HIV status) of any applicant for admission to the programs, nor deny admission to any infected applicant unless it has been concluded, based on sound medical and scientific evidence, that such status would prevent the applicant from completing essential program requirements.

Further, that no reasonable accommodation could be made that would enable the applicant to complete such requirements. Individuals who believe they may be at risk of infection with Human Immunodeficiency Virus (HIV/AIDS), Hepatitis B Virus (HBV), and Hepatitis C Virus (HCV) are encouraged to seek HIV testing and counseling before seeking admission to the program.

**Screening for HIV Infection**
The Program will not initiate mandatory HIV screening of students, faculty and staff unless justified by evidence of significant risk to patients.

The Program encourages enrolled students, faculty and staff who believe that they are at risk for HIV infection to seek testing and counseling. Information about the availability of confidential and anonymous testing and counseling is available upon request.

**Medical Care**
The Program does not pay for health care for students. Students are required to obtain adequate health insurance and needle stick coverage during their association with the Dental Hygiene Program, and to consult with personal health care providers for medical care and counseling.

**Management of Personnel with Blood-borne Infections**
The Program encourages students, faculty and staff infected with any blood-borne diseases such as HIV, HBV,
or HCV to discuss their situation with the Program Director or the Director of the DACC Personnel Department.

Modification of the clinical training or working conditions of infected students, faculty and staff shall be determined on a case-by-case basis. They should not be restricted from clinical participation as long as they are physically and mentally able to carry out their clinical responsibilities in a satisfactory manner, and do not pose a risk to the health or safety of themselves or others. The clinical activity, technical expertise of the infected person, risks posed by HIV-infection, and the transmissibility of other carried infections shall be taken into account.

The Program may legitimately monitor the clinical activities of students, faculty and staff that are believed to pose an unwarranted risk to patients. The Program will cooperate with the HIV-infected individual, his or her physician, or other medical experts as appropriate, identifying and implementing special precautions and program modifications to safeguard the personal health and safety of such persons. Infected individuals should not be restricted from regular classroom participation as long as they are physically and mentally able to participate fully with reasonable accommodation.

The Program adheres to the “Standard Precautions” for prevention of transmission of human immunodeficiency virus, Hepatitis B Virus, and other blood borne pathogens in health care settings established by the Centers for Disease Control and the OSHA Blood-borne Pathogens Standards. HIV-infected students, faculty and staff shall be provided counseling about access to expert medical care and prevention or further spread of infection.

Confidentiality
The Program recognizes the importance of protecting, to the greatest extent possible and within the bounds provided by law, the confidentiality and privacy of any individual with infectious diseases, such as the HIV infection. Accordingly, such information should be handled by campus personnel with the same degree of care and sensitivity that would be accorded to other types of highly confidential patient information.

Since the Program maintains a responsibility to protect its patients, faculty, staff, and students from harmful acts or conditions, there can be no guarantee of complete confidentiality when this runs counter to other legal and ethical responsibilities. Information concerning the health status of an infected individual should not be disclosed outside of the therapeutic relationship between the individual and those treating him or her unless:

1. The infected individual consents in writing to such disclosure.
2. Disclosure is necessary to initiate the annual review process of the Infection Control Standards.
3. Disclosure is necessary to implement a decision to monitor, modify, or restrict the individual’s clinical activities, and he or she declines or fails to respond within a reasonable period of time to a recommendation that the immediate supervisor (Director, Dean or designate, if a student) be notified; or
4. Disclosure is required to protect the public health or is otherwise required or permitted by principles of law and/or ethics.
The number of persons to be advised of the existence and, if necessary, the identity of an infected individual will be kept to an absolute minimum. Information will be shared only to the degree necessary to permit the Program to respond as delineated in the Infection Control Standards.

It is expected that all students, faculty and staff will be bound to the principle of strict confidentiality in all patient care and related health care activities.

Obligation to Report

A health care worker or student who is infected with HIV, HBV, HCV or another blood borne pathogen is encouraged to report his/her status to Program Director. A health care worker or student with HIV, HBV, or HCV is not required to inform patients.

Student, Faculty and Staff Interaction with Patients with HIV/AIDS or other Infectious Diseases

To become a part of the Dental Profession is a privilege offered to those who are prepared for a lifetime of service to the patient. Students, faculty and staff have a responsibility to provide care to all patients appointed, regardless of their diagnosis. Failure to accept this responsibility violates a basic tenet of the dental profession; to place the patient’s interests and the welfare first.

Individuals who feel that their activities within the Program pose a special risk to their health because of exposure to infectious diseases, including HIV-infected persons, working conditions presenting a risk of exposure to infectious organisms, or the presence of infectious diseases in the individual himself or herself, should seek the consultation with Dental Hygiene Program Director. The Program Director will confer with the Dean and/or other appropriate College personnel in order to try to advise and provide recommendations for resolving the risk.

Responsibilities to Patients with Infectious Diseases

To be in compliance with the principles and philosophies of these Program standards, all faculty, staff, and students must afford certain rights and opportunities to their patients.

1. You may not refuse to treat a patient whose condition is within your realm of competence solely because he/she is infected with an infectious disease including HIV or HBV. When caring for an infected patient, you should be guided by principles of care and management that would be applicable to all patients.

2. You must treat all infected patients with respect for their rights to privacy and confidentiality, and with support and understanding to them and their families.

3. Referral: If you cannot supply the services required by an infected individual, you must refer him or her to those persons or facilities which can provide the needed services.

4. Records: All information regarding infectious diseases, including HIV or HBV or TB, should be included in the patient’s dental record. All such entries regarding HIV infections or antibody test results should contain only that objective information relevant to the patient’s care and treatment. The patient’s dental record must be afforded strict confidentiality, and must not be disclosed to others except as required or permitted by law or as authorized in writing by the patient.

5. Patient Assignment: Patients with active infectious diseases will be assigned to the appropriate level
clinic based on the patient’s medical conditions, the experience level of the student, and the need for or availability of licensed/certified dental professionals.

Responsibilities of College Personnel with Infectious Diseases

Individuals who know or who have reason to believe that they are infected with HIV, HBV, TB or other serious infectious diseases have a legal and ethical obligation to conduct themselves responsibly for their own protection and for that of patients and other members of the College community. Such individuals must not engage in any activity that creates a material risk of transmission of infectious diseases to others.

Infected individuals whose employment and/or academic responsibilities do not require the performance of exposure-prone activities (i.e., those procedures that might put a patient at risk of transmission of HIV, HBV, or HCV):

1. Should not be required to advise the College of their HIV status;
2. Should not be required to seek guidance from the Program Director regarding the necessity or advisability of modifying their employment and/or academic activities;
3. Should not be restricted.

Education of Students, Faculty and Staff about Blood-borne Infectious Diseases

The Program adheres to the OSHA Blood borne Pathogens Standard Precautions for the prevention of transmission of HIV, HBV, HCV and other Blood borne Pathogens in Health Care Settings published by the Centers for Disease Control and Prevention. Students in the Program will be given an orientation on communicable diseases, standard precautions, and safety prior to pre-clinic. The student is further trained in pre-clinic about the various diseases and routes of transmission, particularly HIV, AIDS and HBV, as well as the prevention of exposure to infectious organisms in professional and personal situations. Yearly training sessions will be held for all staff, faculty, and students according to OSHA Standards. Workshops or continuing education will be required for the enhancement of standards, guidelines, and procedures concerning blood-borne infectious disease when new information is published, and as deemed necessary.

Standard Precautions

The Centers for Disease Control (CDC) defines Standard Precautions as: “A set of precautions designed to prevent transmission of HIV, Hepatitis B virus (HBV), other blood borne pathogens when providing first aid or health care. Under standard precautions, blood and certain body fluids of all patients are considered potentially infectious for HIV, HBV, and other blood borne pathogens.

Because students and others must know how to prevent the spread of infectious disease for their safety, and for the safety of others, it is the standard of the Program that reasonable/adequate precautionary measures be taken when treating all patients. These precautionary measures may include, but are not limited to, use of Personal Protective Equipment (PPE)

The circumstances involved in the treatment of a particular patient, and with strict adherence to OHSA Standards, will dictate when it is appropriate to modify PPE. Students assigned to affiliate on or off campus clinical sites must comply with the OSHA Standards of infection control, and of the standards set by the particular clinic or dental office to which they are assigned.
Infection Control Standards
The following requirements have been instituted by the DACC Dental Hygiene Program:

1. Receive appropriate immunizations, including the hepatitis B vaccine, or have a medically documented reason for noncompliance.

2. Obtain a thorough medical history from every patient being treated in the clinic.

3. Know the signs and symptoms of common and serious infectious diseases.

4. Postpone elective dental treatment during the acute stages of an infectious disease.

5. Utilize appropriate barrier protection (PPE), as well as barriers on equipment and work surfaces. Replace when visibly soiled, wet or torn. Place barrier covers for light handles, switches, air/water syringe handles, etc. whenever practical. These covers must be changed between patients. Use appropriate disinfection procedures for all dental and x-ray units.

6. Use disposable supplies whenever possible.

7. Wash hands when leaving the operatory and between patients. Use soap and water for initial scrub and hand sanitizers between patients, unless visibly soiled, and then wash hands again.

8. Monitor the conditions of the gloves carefully. When gloves are torn, cut, or punctured, remove them immediately and wash hands thoroughly and reglove with fresh gloves.

9. Do not break the aseptic chain after washing or gloving. Use cotton pliers to retrieve supplies from drawers, use plastic bags or over treatment gloves to write on charts or to retrieve large items from cupboards.


11. Consider sharp items as potentially infective and handle with extraordinary care to prevent unintentional injury. Discard disposable sharp items in puncture resistant containers. When sharp containers are ¾ full move them to appropriate biohazardous waste containers for pick up.

12. Perform all procedures carefully to minimize the formation of droplets, splatters, and aerosols wherever possible. Be cautious to avoid splatter when using air/water syringes, hand pieces, ultrasonic instruments, air-polishing devices (Prophy-Jet) etc. Use high evacuation whenever possible; wear full-face shields.

13. Drape, cover or disinfect dental and x-ray units before each patient.

14. Perform all water-line flushes and self-contained water system protocol as recommended by the manufacturer.

15. Remove thoroughly, all blood and saliva from impression materials and all lab materials. Rinse impressions under water to remove blood and saliva. Disinfect impressions with an appropriate disinfectant.

16. Handle all dental prosthesis as infectious. Clean and refresh dentures and partials according to infection control protocol.

17. Perform sterilization or disinfection on all surfaces, instruments and equipment.

18. Dispose of all contaminated waste into “biohazardous waste” receptacle.

19. Follow all work area restrictions.
20. Implement a routine housekeeping plan that provides for proper cleaning and disinfection of all floors, cabinetry, countertops etc. and the removal of all regular trash.

21. Dispose of all regulated, infectious waste following county, state, and federal regulations.

22. Follow all infection control protocol and guidelines as set forth through OSHA, the CDC, NIOSH, the ADA and the American Dental Educators Association (ADEA).

Blood-borne Pathogens Exposure Control Plan

In accordance with OSHA Blood-borne Pathogens standard, 29 CFR 1910.1030, the following exposure control plan has been developed for the DACC dental clinic; detailed OSHA standards are available on the OSHA website at www.osha.gov or by calling their toll-free number (800) 321-OSHA (6742). The clinic uses the service of Stericycle to help us meet, and maintain, OSHA requirements.

1. Exposure Determination

OSHA requires employers to perform an exposure determination concerning which students & employees may incur occupational exposure to blood or other potentially infectious materials. The exposure determination is made without regard to the use of personal protective equipment (i.e. employees are considered to be exposed even if they wear personal protective equipment.) This exposure determination is required to list all job classifications in which employees may be expected to incur such occupational exposure, regardless of frequency. OSHA categorizes exposure evaluation as it relates to specific job descriptions. The categories are as follows:

- Category 1: Tasks that involve exposure to blood, body fluids or tissues
- Category 2: Tasks that do not involve exposure during normal work routine but may perform unplanned Category 1 such as clean-up, instrument processing or helping with dental procedures
- Category 3: Tasks that involve no exposure to blood, body fluids or tissues.

In addition, OSHA requires a listing of job classifications in which some employees may have occupational exposure. Since not all employees in these categories would be expected to incur exposure to blood or other potentially infectious materials, tasks or procedures that would cause these employees to have occupational exposure are also required to be listed in order to clearly understand which employees in these categories are considered to have occupational exposure. The job classifications and associated tasks for these categories are as follows:

- Dental Programs faculty, clinical staff, students and maintenance staff are considered Category 1
- Administrative staff is considered Category 2.
- Student workers are considered Category 3.

Category 1 and 2 personnel are required to follow universal precautions, receive infection control training prior to assuming duties, and receive HBV vaccine. Individuals in both categories need to recognize when they may potentially be at risk for exposure to infectious diseases and know how to minimize those risks. Occupational duties which require the following tasks are considered Category 1 and involve some risk of exposure.
Examples of Category 1 tasks are:

- Assisting in or performing dental procedures
- Cleaning and/or sterilizing contaminated equipment
- Disinfecting impressions
- Handling potentially contaminated laundry
- Exposing and processing radiographs
- Emptying trash receptacles for disposal of contaminated materials
- Flushing water lines in the dental unit
- Scrubbing contaminated counter tops and other environmental surfaces
- Performing clinical or laboratory dental procedures
- Performing service, maintenance, or repair of potentially contaminated dental equipment

2. Implementation Schedule and Methodology

OSHA requires that this plan include a schedule and method of implementation for the various requirements of the standard. The following complies with this requirement.

Compliance Method

Standard precautions will be observed in the clinic in order to prevent contact with blood or other potentially infectious materials. All blood or other potentially infectious material will be considered infectious regardless of the perceived status of the source individual.

Engineering and work practice controls will be utilized to eliminate or minimize exposure to faculty, staff, and students in the dental clinic. Where occupational exposure remains after institution of these controls, personal protective equipment shall also be utilized. In the dental clinic, the following engineering controls will be utilized:

- All operatory work surfaces shall be disinfected after each patient.
- Barriers shall be used to isolate work surfaces that cannot be practically disinfected.
- Instruments shall be heat sterilized in an autoclave after each use.
- Single use items (e.g. needles, prophyl angles, mixing tips etc.) shall be properly disposed of after use.
- Lab equipment shall be disinfected after each use and laboratory pumice shall be mixed using disinfectant solution. All potentially infected items (including impressions) from the clinic shall be disinfected prior to transporting them to the lab.
- Used sharps shall be disposed of in the sharps containers.
- After removal of personal protective gloves, faculty, staff and students shall wash hands and any other
potentially contaminated skin area immediately or as soon as feasible with soap and water and/or alcohol based hand-rub.

- Protective equipment shall be worn during patient treatment, operatory disinfection and sterilization procedures. (Note: additional protective equipment necessary will be used when handling hazardous materials as outlined by the Hazardous Material Communications plan).

The above controls will be examined and maintained on a regular schedule as follows:

- Yearly staff training.

- Monthly review of various work practice controls.

**Implementing Infection Control by DACC Dental Program**

The following procedures outline methods to be used to ensure effective infection control in the Dental Clinic.

**Work Area Restrictions**

Absolutely no food or drinks in the clinic areas, including the lab. All procedures will be conducted in a manner which will minimize splashing, spraying, splattering, and generation of droplets of blood or other potentially infectious materials. Methods which will be employed at this facility to accomplish this goal are:

- Pre-procedural rinses
- Rubber dam for appropriate procedures
- High volume evacuation
- Careful operating technique

**Labels and Signs**

The Clinical Lab Manager will ensure that biohazard labels are affixed to containers of regulated waste, refrigerators and freezers containing blood or other potentially infectious material, and other containers used to store, transport or ship blood or other potentially infectious materials. The label shall include the universal biohazard symbol/Global Harmonization Symbol. Regulated waste red bags or containers must be labeled. Secondary containers must be labeled with the name of the product and the manufacturer.

**Specimens**

Biologic specimens are not kept at the DACC Dental Clinic. However, donated, extracted teeth, which have been sterilized, may be used for instructional purposes.

**House Keeping**

Facility cleaning and decontamination will be done according to the following schedule:

- Operatories are cleaned and decontaminated by hygiene students following each patient.
Laboratories are cleaned and disinfected at the end of each lab session by students and staff.

Janitorial staff will empty trash nightly and maintain the floors on a weekly basis.

All contaminated work surfaces equipment and small items such as safety glasses, pens, pencils, clip boards etc. and will be cleaned and decontaminated after completion of procedures and immediately or as soon as feasible after any spill of blood or other potentially infectious materials. At the end of the work day any surface that may have become contaminated since the last cleaning will be re-cleaned.

Decontamination will be accomplished utilizing an “approved” disinfectant. It is critical that it be used according to the manufacturer’s directions, ensuring that time of contact for killing TB organisms is used.

All disposable items will be placed in appropriate containers. All trash receptacles receiving potentially infectious material shall have plastic liners used.

**Broken Glass**

Any broken glassware which may be contaminated will not be picked up directly with the hands. The following procedures will be utilized

- Utilizing tools and materials in the spill kit located above the clinic computer, contaminated glass will be picked up and discarded in a puncture resistant container labeled as biohazard.

**Vacuum lines and saliva injectors**

Lines will be flushed with water at the end of the day and vacuum cleaning solution (Evac) will be applied as well. Traps will be replaced bi-weekly.

**Water bottles**

Bottles utilize Sterisil Straws for microorganism control. Water lines will be tested annually for microorganism counts.

**Contaminated equipment**

Equipment which has become contaminated with blood or other potentially infectious materials shall be examined prior to servicing or shipping and shall be decontaminated as necessary unless the decontamination of the equipment is not feasible.

**Trash-Regular VS Regulated/Biohazard**

There is a difference between “regular trash” that can safely be sent to the landfill and “regulated/biohazardous” that must be sent to licensed facilities for proper disposal. Regulated waste must always be disposed of in accordance with all appropriate local, state and federal regulations. Stericycle, a licensed commercial company, is contracted to remove and properly dispose of all biohazardous waste on a monthly basis.

Biohazardous (infectious) materials include: Absorbent materials (e.g. gauze sponges and cotton rolls) which are dripping with blood or have dried blood that might flake off. Extracted teeth and surgically removed soft tissue are also biohazardous.

Biohazard trash bins are under the counters in operatories and in the sterilization area. They will contain red, marked bags. Preferably all biohazardous material will be disposed of in the sterilization area unless the procedure underway in the operatory necessitates immediate disposal of the material.

**ONLY BIOHAZARDOUS material should be disposed of in these marked, red-bag lined containers!**
NO “regular trash” in these bags!
“Regular trash” is paper, contaminated gloves and masks, gauze (unless dripping with blood), cotton rolls, anything that is not a sharp or considered a biohazard. Regular trash receptacles are available near each sink, under counters in operatories and sterilization area etc.

Lead Foil
Lead foil, from dental x-ray film packets, is considered regulated biohazardous waste, and cannot be put into regular trash for disposal; nor is it put into the biohazard trash bags. It is collected in containers located in the dark room; the containers are picked up the NMSU Environmental Safety Office for proper disposal.

Film Processor Chemicals
Chemicals used to process radiographic films are considered biohazardous. Fixer must not to be flushed down the sink. It must be bottled and picked up by the NMSU hazardous waste service. The Developer is safe to pour down the sink.

Sharps
All sharp items must be handled with extreme care to avoid injury and potential infection with disease causing microorganisms. All injuries with sharps must be reported immediately to supervising faculty and the Dental Hygiene Program Director so that appropriate first aid and counseling can be provided and the incident properly documented.

Sharps Definition
Any contaminated product can be hazardous if sharp, including, but not limited to, the following:

- Needles and canulas
- Anesthetic cartridge
- Orthodontic wire
- Glass microbiology slide
- Broken glass
- Contaminated instruments

Guidelines for Sharps Containers
All sharps must be disposed of in proper containers and be disposed of with other regulated waste:

- Containers need to be a standard recognized Sharps container. They are red in color and may have a biohazardous symbol or other warning label on the container.
- Containers are located in each unit for easy access, in the sterilization area and the dental lab. They are bright red.
- Containers should be labeled, closable, puncture-resistant, and shatter-proof.
- Do not fill containers past 3/4 mark.
- Containers are picked up by Stericycle and disposed of according to state and federal law.
Needles
Contaminated needles will not be bent, sheared or purposely broken. For dentistry, OSHA allows the exception of recapping and removing contaminated needles. Recapping of needles shall be done by the one hand “SCOOP” technique, or by using commercial sheath holders (preferred) to recap needles. Removal of needles shall be done carefully with gloved hands. Needles should be capped while on the tray and disposed of as soon as feasible in an approved sharps container.

Procedures for Sharps Injury
Notify your instructor and/or clinical coordinator of the incident. Follow the recommended protocol.

Laundry Procedures
Laundry contaminated with blood or other potentially infectious materials will be cleaned at the DACC clinic. It must not be taken home where it could potentially infect family or friends. Laundry will be handled as little as possible. It will be placed in appropriately marked hamper lined with a red bag until it can be cleaned. All individuals who handle contaminated laundry will utilize personal protective equipment to prevent contact with blood or other potentially infectious material.
Laundry at this clinic will be cleaned using the washer and dryer in the laundry room following the written instructions that accompany the equipment. Students are responsible for completing the laundry. It is critical that individuals doing the laundry check for dosimetry badges, pens, pencils, lip balm and other items in pockets before putting lab coats in the washer. Each lab coat costs $50.00, so following instructions carefully is very important to help maintain the specialized fabric and its professional appearance.

Operator Preparation
Dress
See DACC Dental Hygiene Dress Code in Section 9 of this Manual pages 98-100.

Hand Care
Faculty, staff and students who incur blood or other potentially infectious materials exposure to their skin or mucous membranes shall wash or flush any exposed areas with water as soon as feasible following exposure.
Alcohol hand rub is available at each operatory, lab, sterilizing and laundry areas. It may be used between patients instead of a soap and water scrub unless the hands are visibly soiled.
Hand lotion may be applied to help maintain healthy skin, but it should not be scented nor contain products that will compromise the integrity of gloves.
Clinicians must maintain short fingernails with healthy cuticles. No polish or fake fingernails are allowed since they harbor bacteria. The Center for Disease Control (CDC) recommends that no rings be worn. However, small wedding rings that will not puncture gloves may be worn in the DACC clinic.

Follow these guidelines when washing hands prior to clinical or laboratory activities:

- Use anti-microbial soap to remove or destroy transient micro-organisms and reduce resident flora. After initial anti-microbial hand-washing an anti-microbial, alcohol-based hand rub may be used if the hands are not visibly soiled.
- Wash hands before and after treating each patient (i.e., before glove placement and after glove removal and after barehanded touching of inanimate objects likely to be contaminated by blood, saliva, or
respiratory secretions).

- Vigorously wash hands and wrists for 20 seconds (do not use brushes, as this can cause minute skin lesions) and clean under fingernails. Rinse thoroughly. Repeat. Final rinse should be in cool water to help close pores.
- Dry thoroughly with a paper towel using a patting motion.
- Throw paper towels into designated trash containers.
- Faculty or students who have exudative lesions or weeping dermatitis should not perform or assist in intraoral procedures or handle equipment used for patient care.

**Personal Protective Equipment (PPE)**

Personal protective equipment will be chosen based on the anticipated exposure to blood or other potentially infectious materials. The protective equipment will be considered appropriate only if it does not permit blood or other potentially infectious materials to pass through or reach the providers’ clothing, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time that the protective equipment will be used. Protective clothing will be required in the following manner:

- **Non-latex exam gloves** are to be worn for all patient treatment procedures. Exam gloves shall also be worn where it is reasonably anticipated that one will have hand contact with blood, other potentially infectious materials, non-intact skin, and/or mucous membranes. Disposable gloves are **NOT** to be washed or decontaminated for re-use and are to be replaced as soon as practical when they become torn, punctured or when sticky or covered in blood, saliva or debris that makes it difficult to control instruments.

- **Masks** should have a 95% filtration rate and be changed between each patient or when wet. (Do not wear mask on neck or top of head or dangling from an ear.) Mask is worn for all patient treatment procedures. Masks in combination with eye protection devices, such as goggles or glasses with solid side shields, or a chin length face shield are required to be worn whenever splashes, spray, splatter, or droplets of blood or other potentially infectious materials may be generated and eye, nose, or mouth contamination can reasonably be anticipated. Situations at this facility which would require such protection are as follows:
  - All patient treatment procedures
  - Lab procedures, such as grinding and polishing
  - During sterilizing procedures

- **N95 masks** are a class of disposable respirators that have been approved by the FDA and are suitable for use where fluid resistance is a priority. They have a minimum 95% efficiency rating against particulates which are 0.3 microns or larger and have met CDC guidelines for TB exposure. Training in the use of this mask will be given during the medical emergencies portion of the DH curriculum. The N95 masks will be stored in the clinic in the red crash cart.
► Long sleeved, high necked lab coat that covers the lap when seated must be worn for all patient treatment procedures and procedures that may involve potentially infective materials. All garments which are penetrated by blood or other potentially infectious liquid shall be removed immediately, or as soon as feasible.

► Protective eyewear is worn for all patient treatment procedures, sterilization procedures and all lab and darkroom procedures. The type of protective eye-ware may differ depending on the procedure being performed. For example, UV protective eye-ware is required when using a sealant light. Goggles may be needed when using air-powder polisher or working with darkroom chemicals. All patients are required to wear some form of protective eyewear during clinical procedures. Clinician eyewear and patient safety glasses should be cleaned with soap and water or disinfected with appropriate chemicals after every patient and or clinician use.

► Face shields are worn in situations where significant spatter is expected. It is still essential to wear a mask beneath the shield. Shields must either be discarded or properly sanitized using soap and water and a surface disinfectant that will not distress the finish on the mask.

► Utility gloves are worn when handling instruments during cleaning and sterilization procedures and when working with film processing chemicals. Utility gloves may be decontaminated for re-use provided that the integrity of the glove is not compromised. Utility gloves will be discarded if they are cracked, peeling, torn, punctured, or exhibits other signs of deterioration or when their ability to function as a barrier is compromised.

Loupes

Loupes are expensive optical magnification, which must be handled with care and kept clean between patient care. Read the instructions for the brand and style of loupes you have purchased.

Some loupes come with removable attachments which are used to manually adjust the position of the magnifiers. These may be autoclavable; if not they should be disinfected between patients.

Some loupes come with lens caps which protect the expensive optical from scratches. Use them routinely while working.

All personal protective equipment will be removed prior to leaving the work area. All personal protective equipment will be cleaned, disinfected, laundered, and/or disposed of at the clinic.

Pre-Procedural Rinse:

All patients must use a mouth rinse prior to dental treatment to decrease oral microbes, thus decreasing the bioburden in aerosols created during dental procedures. Water, commercial mouth rinses, or prescription antimicrobial rinses are all acceptable.

Patient Protection

- Safety glasses, or UV filtered glasses (to be worn for procedures that require light curing), need to be worn by all patients for all clinical procedures. Safety glasses need to cleaned and disinfected appropriately after each use.

- Patient Napkin – clinician must not place anything on the patient napkin. Disposable bib attachments
should be used whenever feasible. If a bib chain is used it must be autoclaved after each use. Never wipe instruments on the patient’s bib.

- Clinician must advise patient not to fully close lips around the saliva ejector, due to the vacuum it creates thus exposing patient to contaminated materials.

- Lip balm must NOT be petroleum based product because these break down latex and other types of glove materials.

**General Guidelines for Exposures to Communicable Diseases**

In the event that someone becomes exposed to a communicable disease, the following procedures are recommended:

1. Report the exposure to a clinical instructor and Clinical Lab Manager immediately
2. Follow the DACC exposure guidelines found in the exposure incident in the office of the Clinical Lab Manager.
4. Assess the clinical status of the source if possible.
5. Test the exposed individual as soon as possible after exposure (within 72 hours for blood borne pathogens) following CDC and OSHA guidelines.
6. Seek counseling and adhere to the recommendations for the prevention of transmission of infections or communicable diseases.
7. Maintain confidentiality of medical records and share information on a “needs to know” basis only.
8. Obtain confidential screening for various communicable diseases from a health care agency.
9. Students are responsible for medical fees.

**Post-Exposure to Blood-borne Pathogens: Evaluation & Follow-up**

When a faculty or student incurs an exposure incident, it should immediately be reported to the Clinical Lab Manage, the Clinical Coordinator, and the Dental Hygiene Program Director. All faculty and students who incur an exposure incident will be offered post-exposure evaluation and follow-up in accordance with the OSHA standard. Although students are not covered by health insurance through DACC, they are STRONGLY encouraged to receive a confidential medical evaluation and follow-up. This follow-up will include the following:

- Documentation of the route of exposure and the circumstances related to the incident.
- If possible, the identification of the source individual and, if possible, the status of the source individual. The blood of the source individual will be tested if consent is obtained for HIV/HBV infectivity.
- Results of testing of the source individual will be made available to the exposed individual with the exposed individual informed about the applicable laws and regulations concerning disclosure of the
identity and infectivity of the source individual.

- The exposed individual will be offered the option of having their blood collected for testing of their HIV/HBV serological status. The blood sample will be preserved for up to 90 days to allow the exposed individual to decide if the blood should be tested for HIV/HBV serological status. However, if the exposed individual decides prior to that time that testing will or will not be conducted, then the appropriate action can be taken and the blood sample discarded.

- The exposed individual will be offered post exposure prophylaxis in accordance with the current recommendations of the U.S. Public Health Service.

- The exposed individual will be given appropriate counseling concerning precautions to take during the period after the exposure incident. The exposed individual will also be given information on what potential illnesses to be alert for and to report any related experiences to appropriate personnel.

- All Exposures shall be logged in the Exposure Incident Log.

- A Postexposure Counseling Packet will be available by the coordinator or lab manager.

A written opinion shall be obtained from the health care professional who evaluates exposed individuals of this clinic. Written opinions will be obtained in the following instances:

- When a faculty, staff or student is sent to a health care professional following an exposure incident.

- When the faculty, staff or student is sent to obtain a Hepatitis B vaccine.

- Health care professionals shall be instructed to limit their opinions to:
  
  - Whether the Hepatitis B vaccine is indicated and if the student or employee has received the vaccine, or for evaluation following an incident.
  
  - That the individual has been informed of the results of the evaluation.
  
  - That the individual has been told about potentially infectious materials. The written opinion to the DACC Dental Program Director is NOT to reference any personal medical information.

Blood-borne Pathogen Training
Training for all faculty, support staff, and students will be conducted prior to initial assignment to tasks where occupational exposure may occur. Refresher training for all faculty, support staff, and students will occur annually.

**Students will not be permitted in clinic until this training has occurred and documented.** Training records shall be maintained according to NMSU Record Retention Policies.

Record Keeping
All records required by the OSHA standards will be maintained by the Program Director.

These records will be kept in a locked file cabinet in the Director’s office. Medical records shall be kept confidential, and not disclosed without written consent. Each faculty, staff, and student whose is at risk for exposure to blood or other potentially infectious materials will have a medical record which will include:

1. The name and Banner ID number of the student/employee
2. A copy of the student/employee’s HBV vaccination status, including the dates of vaccination and ability to receive vaccination.

3. A copy of all results of examination, medical testing, and follow-up procedures.

4. A copy of the information provided to the healthcare professional, including a description of the student/employee’s duties as they relate to the exposure incident, and documentation of the routes of exposure and circumstances of the exposure. This shall be in the form of an Incident Report.

5. A confidential copy of the healthcare professional opinion.

6. OSHA and Infection Control Compliance Records:
   a. All records concerning OSHA compliance must be kept.

7. All records monitoring biological indicators for autoclaves must be kept current.

Infection Control Products Used at DACC-DH Clinic:
A list of products that are used for surface disinfection and water line maintenance is available in the SDS book. It is important to read the product labels and Safety Data Sheets (SDS) for each item for full details.

Preparation of the Operatory
Before preparing your operatory, wash hands according to hand wash procedures outlined earlier in this section

Surface Disinfection
All surfaces must be “clean” before they can be disinfected. Use soapy water if visible debris is noted. DACC uses the “Clean-Spray-Wipe” concept for surface disinfection recommended by the CDC. Wear all PPE when disinfecting the operatory. Adhere to the following steps when disinfecting surfaces:

- Maxi-Spray Plus™ or Cavicide surface disinfectant will be used in the clinic, sterilization area and the darkroom. All containers must be properly labeled.
- Using a wet disinfectant wipe, vigorously scrub down all of the following surfaces, replacing the wipe when it gets dry or when it becomes visibly soiled.
  - countertops and equipment left on the counter
  - all cupboard door and drawer handle
  - dental chair
  - operator and assistant chairs, especially the adjustment handles
  - x-ray head and arm, control panel, exposure button
  - unit tray, hoses, air water syringe head, unit arm, chair control panel
  - assistants package with air/water syringe, saliva ejector, high speed vacuum, chair control panel, all
hoses and the support arm

♦ dental light fixture, controls, and support arm (NOT the light shield—this must be removed and cleaned with soapy water, rinsed and dried thoroughly. Disinfectant solutions etch the plastic.)

♦ clip board, pens and pencils, tooth model and patient mirror (polish the mirror after disinfection.) Re-wipe all areas to be touched during patient treatment and let air dry 10 minutes.

   Clean light cover with warm soapy water and dry thoroughly or use eye glass cleaner wipes. Wipe down the chair bases and rheostats.

❖ Replace water line disinfectant with filtered water from the reverse osmosis “RO” water tap (marked with green tape) in the sterilization areas. Run both air/water syringes until the lines are clear—about one full bottle of water. If the high speed handpiece is to be used run water through that line as well. Refill the bottle with “RO” water for patient care.

❖ Run water through sonic handpiece and ultrasonic lines for 1 minute to clear them.

❖ Insert disposable tips for air/water syringe and saliva ejector and if Cavitjet is to be used, insert a highspeed suction tip before placing the plastic barriers. HINT: check for leaks prior to wrapping.

❖ Saliva ejector/suction tips—run water through the hoses for one minute to lubricate the controls and lines before placing the disposable tip.

❖ Pick up any trash in your area.

❖ Check daily and clean as needed the spaces between the operatories.

❖ Use vacuum line cleaner weekly or as indicated by the Clinical Lab Manager

❖ Change unit filter/trap weekly or as indicated. Used filters/traps go in the biohazard waste located in the sterilization lab.

❖ Do not let liquid contact any electrical system.

Operatory Setup
Adhere to the following guidelines when setting up the operatory (it may be set up with clean non-gloved hands):

Obtain all disposable barriers for wrapping unit and equipment to be used during patient care.

♦ Chair covers

♦ place over dental chair. HINT: position so that there is sufficient room to adjust the headrest.

♦ cover x-ray tube-head if films are to be taken during the appointment.

♦ Sticky back plastic to cover

♦ the arms of the dental chair,

♦ chair control panels,
- handles of the operator and assistant stools,
- view-box controls,
- x-ray control panel,
- handle of patient mirror, top of clipboard,
- Any other surface that requires a barrier that cannot be protected with a plastic sleeve or consider using over gloves.

- Computer controls/Keyboard
  - Small plastic sleeves – a variety- to cover:
    - dental light switch and adjustment handles on both sides of the light,
    - saliva ejector head and hose,
    - air/water syringe head and hose (both syringes),
    - high speed suction head and hose,
    - pens and pencils.
    - computer mouse
      - Headrest cover on:
        - Cavijet unit to protect controls and handpiece rest.
        - foot control of the Cavijet when stored in drawer.
          - plastic tray on unit.
- Wrap other equipment needed for appointment, such as electric pulp tester, curing lights, intra-oral camera, with appropriate barriers.
- Place a plastic cup on the tray for disposables contaminated with blood or saliva. You may use the same cup used for the pre-procedural rinse. As an alternative, hang a paper bag on the tray or counter. If disposables are dripping with blood or saliva dispose of them in the red biohazard bag.
- Place a patient bib or tray cover on the counter near the operator’s position to hold items that will be needed during treatment, but which should not go on the instrument tray. This may include: disclosing solution, sealant materials, fluoride bottle and trays, floss, topical anesthetic, etc. Also place sterile cotton pliers on this cover to use to retrieve items from the drawer during treatment. For example, extra gauze, sealant brushes, etc.
- Pull up the radiographs on the computer.
- Pull up the Patient Chart on the computer, Case Management form will be on Foliotek, Fee Sheet on the counter, and any necessary Clinical Skill Evaluation indicated in the daily presentation for the instructors’, all prior to seating the patient.
- Place pens, pencils, hand mirror, extra gloves, masks, overgloves and special equipment on the counter prior to seating the patient.
**Instrument Tray**

When preparing instrument tray, do the following:

- Place plastic tray in a plastic barrier.
- Set up tray according to treatment plan. Do not open sterile instrument packages until patient is seated.
- Prepare tray immediately prior to seating patient. If a delay should occur, place a patient bib over tray to minimize airborne contamination.

**Cavitron Jet Combination:**

For Complete Operating Instructions of the Cavitron Jet & Dual Select System See Section 8

**Equipment & Supply Maintenance**

At the beginning of the day:

- Turn on unit and purge hand piece over a cup for 2 minutes.
- Place a sterilized insert into the handpiece handle. If the Dual Select Dispensing Unit is to be used with the Cavitron, fill the dispensing bottles with the appropriate solutions and set the controls for use.

**Between patients:**

- Remove the handpiece for sterilization and flush the handpiece line for 30 seconds with dionized water to clear the lines. If solutions such as chlorhexidine or iodine are allowed to remain in the lines it will crystallize and ruin the machine.
- Clean and disinfect all components of the machine and the storage drawer area. **At the end of the day:**

- Remove the handpiece for sterilization and flush the handpiece water line for one minute with dionized water from the Dual Select Dispensing Unit. Again, be sure that all solutions from the Dual Select unit have been thoroughly rinsed from all Cavitron Jet lines.
- Clean and disinfect the Cavitron Jet equipment as described for the beginning of the day.
- Turn off the machine, coil cords and place the foot control in a plastic bag and return all to the storage drawer.

**Air Powder Polisher**

See Sec. 8: Equipment & Supply for complete Air Polisher Information.

**Dual Select Dispensing System**

See Section 8 for details on maintenance of the Dual Select System.

At the Beginning of the Day:

- Flush each line (“A” & “B”) of the system with dionized water for one minute. The dionized water (or sterile water if preferred) bottle is placed first in A position. Close the dispenser’s shield and turn the
selector knob on the front of the machine to “A”. Activate the Cavitron handpiece so the water is flushed through the line. Repeat with the dionized water bottle in position “B”.

- Disinfect the outer surfaces of bottles and bottle cradle.
- Fill bottles with desired solutions. The following are the only medicaments that may be used in the Dual Select Dispensing System for use with the SPS Cavitron JET Combination System:
  - Chlorhexidine Gluconate 0.12%
  - Cetylpyridinium Chloride (Cepacol)
  - Essential Oils (Listerine)
  - Hydrogen Peroxide, 3% USP
  - Providone Iodine, 10% Solution
  - Saline Solution
  - Sanguinaria Extract (Viadent)
  - Sterile Water, (for irrigating and system maintenance purposes). Between Patients:
    - Remove the ultrasonic tip.
    - Follow the same instructions to purge the lines with sterile or dionized water for 30 seconds.
    - Disinfect the Dual Select Dispensing System cradle and bottles.
    - Refill bottles with desired solution. End of Day:
      - Remove the ultrasonic tip.
      - Follow the same instructions to purge the lines with sterile or dionized water for one minute.
      - Place an empty bottle in Position “A”, close the shield, set the selector to “A” and operate the ultrasonic handpiece for 30 seconds at maximum water flow to air purge the lines. Repeat at “B”. At the end of the cycle the lines should be relatively dry thus reducing the potential for bio-film development. No solutions should be left in bottles overnight.
      - Disinfect the Dual Select Dispensing System cradle and bottles. End of Week:
        - Flush and air purge the lines for “A” and “B” as described above for end of day.
        - Prepare a 1:10 sodium hypochlorite (NaOCl) solution (Bleach) by filling the disinfectant bottle with 5.25% sodium hypochlorite to the designated line on the disinfectant bottle. Fill the disinfectant bottle with sterile or dionized water. (The disinfectant bottle should only be used for disinfection purposes.)
        - Place the filled disinfectant bottle in position “A”, close the shield and set selector to “A”. Operate the ultrasonic scaler/Jet at maximum water flow for at least 30 seconds until the solution drains from the handpiece.
        - Repeat procedure for “B” running solution for 30 seconds.
Open the shield, remove the disinfectant bottle and leave the unit undisturbed for at least 10 minutes but no more than 30 minutes to allow the bleach solution to soak in the lines. (Place a sign on the machine to alert everyone that the unit is being disinfected with a strong disinfectant and should not be used.

- Fill a bottle with sterile or dionized water and flush both “A” and “B” as before for at least 3 minutes. It is critical that all disinfectant is removed from the lines and the ultrasonic handpiece. No residual odor should remain in the system.

- Air purge both “A” and “B” lines as described before.

Infection Control During Procedures

Once you’ve begun procedures, there are a number of guidelines to help you maintain a sterile and safe environment including:

**Procedure Selection**

Take a thorough medical history, have it evaluated and signed by an instructor before any procedures are started. This eliminates the need for gloves and mask during this procedure.

Have a well-thought-out treatment plan. This will enable operator to decrease contamination by preparing appropriate instruments and equipment before seating the patient.

**Maintaining an Aseptic Field**

The following guidelines will help you keep your operating environment aseptic:

- Have patient use a pre-procedural rinse. Non-alcohol mouth rinses are provided near all sinks.

- Use saliva ejector or high volume suction during all aerosol producing procedures.

- If you drop an instrument, leave it until clean up (you may want to push it with foot into a safe place out of harm’s way until it can be retrieved).

- If you drop a saliva ejector/hose, handpiece, or any other equipment that will be used again, call for assistance or pick up with paper towel, remove barrier wrap and discard, wipe with disinfectant, place on a clean paper towel, wipe and dry, cover with new barrier wrap, (replace prophy angle, saliva ejector, or any disposable item).

- Anytime you are away from your chair or patient, remove your gloves and wash your hands.

- Use over-gloves, Ziplock bags or sterile forceps to get supplies or to go into drawers. Set up tray with everything you need to cut down on unnecessary trips to get more supplies/instruments.

- Do not touch non-sterile objects while working on your patient; if you do, change your gloves and disinfect object.

- All patients need to wear protective eye covering and patient napkins during all intraoral procedures.

- Clip or tie hair back to avoid having it hanging down into the field of operation; hair will be contained prior to entering the clinic.

**Charting (Without an Assistant)**
Use Ziplock plastic bags as over gloves and a clear acetate sheet laid over the chart to eliminate chart contamination during charting procedures.

**Dismissing Your Patient**

When dismissing your patient, remove patient bib and place over instrument to try to reduce contamination to others as well as reducing “visual clutter”. Remove gloves and wash hands. Escort the patient to the reception desk for appointment, payment and dismissal.

**Patient must not be released out of the south door in clinic.**

**Cleanup of Instrument Tray & Operatory at End of Appointment**

1. Wear all proper PPE.
2. Turn the plastic bag that covered the patient chair inside out and loop one corner of it over the back of the patient chair. Place all disposables from the tray and counters, and procedural gloves and masks into this bag. Tie the bag shut before placing it in the Black trash bin under the counter.
3. Carefully wipe excess debris from instrument tips and handpiece with wet gauze. Arrange instruments in cassettes. Remove Cavijet tips and any other sterilizable items (such as XCP kits, etc.) and carry all to the sterilization area. Be sure the tray is placed on the “contaminated” side of the room.
4. Clean and wipe all contaminated surfaces as in operatory preparation. Check surrounding area, including the floor, for splatter and debris.
5. Run water down all suction hoses for one minute.
6. Refill water bottles if needed.
7. Complete all patient records and student evaluation records and remove from the operatory.
8. Set up the operatory for the next patient unless it is the last clinic session of the day.

**Instrument Preparation and Sterilization**

Wear PPE including a mask and utility gloves during all instrument preparation and sterilization procedures. Protective eyewear must be worn by anyone who is in or passing through the sterilization area. Only student on sterilization rotation is allowed to be in the area.

1. Cavitron tips are only wiped with water soaked gauze to remove external debris, dried and bagged for sterilization. Do not place in the ultrasonic bath.
2. Hand-pieces that must be lubricated are run through the Assistina automatic lubricator, wiped clean and bagged for sterilization.
3. All other contaminated instruments are run for 10 minutes through the ultrasonic cleaner which has been filled with water and enzyme tablets. All parts of the instrument and/or cassette must be fully submerged. After this debris removal procedure, instruments are rinsed with water and dried.
4. After ultrasonic cleaning, all cassettes must be opened and a sterilization monitoring strip is placed
inside each cassette. The cassette is closed, wrapped, and taped shut with a strip of autoclave tape. The package is labeled using a Sharpie with the clinician’s name.

5. For instruments that are to be bagged separately, the monitoring strip is built in, and labeled with the clinician’s name and cubby #.

6. Heat sterilizes all non-disposable instruments according to the autoclave manufacturer’s instructions. Be sure to load machines loosely. When the sterilization cycle is complete, remove the packages and place them on the “clean counter” to dry. Date stamp each package as it comes out of the sterilizer, using the color coded stamp for the machine used, before placing them into students’ or clinic drawers. (See Section 8: Equipment & Supply Maintenance for more detail on the operation of Sterilizers).

7. Biological testing will be completed weekly by the student on sterilization duty and monitored by the Clinical Lab Manager. The results will be logged in the Sterilization Log Book and signed/dated.

**Cleanup of Operatory at End of Clinic Day**

1. Complete clean up and disinfect the operatory.

2. Return patient chair to upright position and raise it to a “middle” level. Raise unit tray to a level high enough to let cords hang straight. **Place foot controls on the side of the base of the chair.** Align the unit arm and dental light with the patient chair and position light close to headrest.

3. Turn the unit off.

4. Turn the unit light off.

5. Place operator and assistant’s chair close to the back counter.

6. Remove all extra supplies from the counter and close all cupboards and drawers.

7. Turn off the x-ray machine and computer.

8. Turn off the Ultrasonic.

9. Return all extra supplies and equipment to proper storage areas. (Eg. Nitrous tanks, vitality testing equipment, etc.)

**Cleanup of Operatory at End of Clinic Week**

At end of last clinic session of the week, the following procedures need to be completed in addition to those above.

1. Prepare a liquid cleaning agent for the vacuum system and run the prescribed amount down each suction hose is each unit.

2. Place a clean filter/trap in the assistant’s branch of the dental unit.

3. Once a week, the student on Assisting Rotation will lubricate the sides in the saliva ejector and the high-speed suction hoses. In addition, he/she will replace the gauze in the filter of each unit in the small canister below the back of the instrument tray.
<table>
<thead>
<tr>
<th><strong>Clinic Tasks</strong></th>
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<tbody>
<tr>
<td><strong>DAILY</strong></td>
</tr>
<tr>
<td>Clean base of unit chair and all chairs with appropriate disinfectants.</td>
</tr>
<tr>
<td>Clean and disinfect plastic light shield, it may be removed for cleaning if necessary</td>
</tr>
<tr>
<td>Sanitize light arm and post</td>
</tr>
<tr>
<td>Disinfect top of cabinets and all door and drawer handles and interior of Cavitron storage shelf</td>
</tr>
<tr>
<td>Ensure all equipment and supplies are present and accounted for</td>
</tr>
<tr>
<td>Disinfect clipboard, pens/pencils, magnifying glass</td>
</tr>
<tr>
<td>Disinfect unit</td>
</tr>
<tr>
<td>Check floor for debris and clean if necessary</td>
</tr>
<tr>
<td>Clean top of control box on floor, make sure the cover is on securely</td>
</tr>
<tr>
<td>Sort trash according to bio-hazardous waste regulations.</td>
</tr>
<tr>
<td>Dust area behind Partitions that are between units</td>
</tr>
</tbody>
</table>

**Follow procedures for unit maintenance**
Eye-Wash Station
There are several emergency eye-wash stations in the dental facility (sterilization, darkroom, and laboratory). The eye-wash is used in cases where infectious materials or other damaging chemicals, such as acids, have been splashed into the eyes. The eyes must be flushed for fifteen minutes and followed up with medical care.

Sterilization Duty Responsibilities
All faculty, staff, and students must be cognizant of the lay out of the sterilization area. It is paramount that the “Clean” and “Dirty” sides of the area are adhered to, and that cross contamination is strictly avoided. Please inquire with the Clinic Lab Manager if there are any questions or concerns regarding use of the sterilization area.
Sterilization supplies are stored over and under the counters labeled with their contents. Sterile Clinic owned instruments are stored in labeled locked cupboards, drawers and in marked plastic bins.

Beginning of a Clinic Session
The student on sterilization duty must maintain infection control in the sterilization area including: counters, faucets, cupboards drawer handles, lid handles, sterilizer handles and doors, etc. See “Sterilization Rotation” Clinical Skill Evaluation found in the lateral file.
At the beginning of each clinic session, check the water level in all autoclaves and replenish with distilled water prior to turning on the power to warm up the machines. See Section 8 Equipment and Supply Maintenance and read machine instruction manuals located on a shelf on the north wall of the sterilization area.
If necessary, fill the counter-sunk ultrasonic cleaner with tap water and 5 enzyme tablets. Prepare the small counter ultrasonic for use; do not confuse the instrument ultrasonic with the small ultrasonic for appliance cleaning-they are clearly marked. See Section 8 Equipment and Supply Maintenance for more information. All sterilization supplies must be restocked as needed.

End of Each Clinic Session
The person on sterilization duty will prepare all contaminated instruments for sterilization and run all sterilizers if there is sufficient time to wait until the cycles are complete (about 15 minutes after the close of clinic.) If the cycle cannot be completed in that time DO NOT start the cycle. The only machine that can be left running overnight is the Lisa autoclave. It will turn itself off after two hours of inactivity.

- The sterilization area must be disinfected and all equipment and supplies must be put away.
- The ultrasonic cleaners must be drained and wiped with a surface disinfectant.
- All sterile instruments must be put away once they have cooled.
- All equipment including room lights must be turned off.

Biological Monitoring
Once per week all sterilizers will be tested using a spore ampules test and incubator manufactured by 3M
Health Care, and consists of a small steam incubator pre-set at 56 degrees Celsius. The spore used to evaluate steam sterilization is *Bacillus stearothermophilus*. The student on Sterilization Duty will run the tests (Confirm test) according to the manufacturer’s instructions and will record the results in the biological monitoring log, which is kept in the sterilization area. A load test indicator and a control indicator will be run for each evaluation.

If the load ampule tests positive (yellow), the procedure will be run again with a light load. All equipment run through the inadequate sterilizer since the last “Attest” will be rerun through another machine. This means checking all packages for date stamps that match the machine in question and the date in question and re-sterilizing all of the packages from that machine. If the sterilizer continues to test positive DO NOT USE it until the machine is checked out and STERILIZATION HAS BEEN DOCUMENTED.

**Radiography and Darkroom**
See Section 11: Radiology for details about infection control related to radiographic equipment and the Darkroom. The “Radiology Rotation” Clinical Skill Evaluation found in the lateral file.

**Dental Laboratory**

The dental lab must be meticulously maintained to enhance safety and ensure infection control. Lab benches and counters must be clear of clutter and be routinely cleaned with appropriate surface disinfectant. It is important that any wax, stone, or other dental materials be cleaned off of all surfaces prior to disinfections.

**Contaminated Lab Materials**

When performing laboratory procedures on contaminated material, protective cover-up, gloves, mask, and glasses should be worn. Use materials that are individually packaged or that may be sterilized.

**Steps for Impressions**

1. Use disposable or impression trays which can be sterilized
2. Mix impression material with disinfected bowl and spatula
3. After taking the impression, rinse it carefully in running water and saturate a paper towel with disinfectant, wrap the impression, seal it in a plastic bag and let it sit for at least 10 minutes
4. Rinse before pouring up Study Model
5. Handle the impressions with gloved hands only.

**Steps for Study Models**

1. Disinfect the laboratory area;
2. Mix stone/plaster in with disinfected bowl and spatula;
3. Pour model and allow setting up; placing models in a case pan with proper identification.
4. Trim model using a model trimmer connected to water. Label completed models.
5. Disinfect area when procedure is complete.

6. DO NOT LEAVE MODELS ON LAB COUNTER. They will be discarded!

**Extracted Teeth**

Extracted teeth may be used for laboratory and/or tooth identification activities. They must be properly collected and sterilized before use.

The CDC guidelines are as follows:

Prior to being used in an educational setting, teeth should be heat sterilized to allow for safe handling. Pantera and Shuster demonstrated elimination of microbial growth using an autoclave cycle for 40 minutes. Autoclaving teeth for preclinical laboratory exercises does not alter their physical properties sufficiently to compromise the learning experience. However, autoclave sterilization of extracted teeth does affect dentinal structure enough to compromise dental materials research.

The use of teeth that do not contain amalgam is preferred because they can be safely autoclaved. Extracted teeth containing amalgam restorations should not be heat sterilized because of the potential health hazard associated with possible mercury vaporization and exposure. If extracted teeth containing amalgam restorations are to be used, their immersion in 10% formalin solution for 2 weeks has been found to be an effective method of disinfecting both the internal and external structures of the teeth.
SECTION 10. GUIDELINES FOR DENTAL HYGIENE ASSESSMENT & DIAGNOSIS

Dental Hygiene Process of Care
The DACC Dental Hygiene Program utilizes a critical thinking model used by the dental hygiene profession to guide clinical decision making. This model is referred to as the dental hygiene process of care. The dental hygiene process of care provides a framework through which the individualized needs of the patient can be met. The process defines a method guiding the practitioner in making assessments, sound clinical decisions and judgments based on their identification of the causative or influencing factor of a condition that can be reduced, eliminated, or prevented by the dental hygienist.

The six components of the dental hygiene process of care are: Assessment, Diagnosis, Planning, Implementation, Evaluation and Documentation.

All of the patient assessments and patient electronic records is completed using Eaglesoft clinical software.

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

Once the information is gathered from the assessments, it will be collectively used to formulate the dental hygiene diagnosis and an individualized, comprehensive patient care plan for each DACC dental hygiene patient.

Medical/Dental History
Prior to any dental hygiene treatment, every patient will have a completed patient registration, medical/dental history, consent to treat, and patient bill of rights on file. All components of the form must be completed. DACC Dental Clinic does not discriminate against anyone who may have an infectious disease. However, professional judgment may require that patients with conditions beyond the scope of practice, or the ability of clinicians to treat satisfactorily, may be referred to other healthcare providers.

Criteria
The following criteria must be fulfilled in order to complete a patient’s medical/dental history:

- The patient will complete a medical/dental history, sign and date the form. The patient will be orally interviewed concerning the information recorded. All positive responses will be ‘checked’ and a comment written explaining the response will be provided in the ‘Comments’ section of the Health/Dental History.

- All findings that need follow-up or referral (e.g., hypertension, need for premedication, etc.) must be recorded, explained to the patient, and implemented by the student after consultation with clinical faculty.

- There may be certain medical conditions that will need medical clearance before assessments may
be started. Students and faculty will explain this to the patient and a medical clearance letter will be
given to the patient (the Medical Clearance letters are located in the lateral file). This must be
returned to the clinic before the patient’s next appointment. The results of the medical clearance will
determine if the patient can be seen for further treatment, as DACC is a teaching facility.
❖ The medical history is to be updated at each appointment. If the patient’s file was developed one year
prior to the current appointment, a new medical history form must be completed. This will establish a
current statement of “Informed Consent” and “Permission for Release of Information.”

Antibiotic Premedication Guidelines
Antibiotic premedication/prophylaxis recommendations exist for two groups of patients:

1. Those with heart conditions that may predispose them to **infective endocarditis**.

2. Those who have a **total joint replacement** and may be at risk for developing
hematogenous infections at the site of the prosthesis.

The DACC Dental Clinic follows guidelines from the American Heart Association Guidelines for
antibiotic premedication. When in doubt, contact the patient’s heart doctor or orthopedic surgeon.

Premedication Protocol

Prophylactic Regimens for Dental. Oral, Respiratory Tract, or Esophageal Procedures

<table>
<thead>
<tr>
<th>SITUATION</th>
<th>AGENT</th>
<th>REGIMEN—30-60 MIN</th>
<th>SINGLE DOSE BEFORE PROCEDURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard general prophylaxis</td>
<td>Amoxicillin</td>
<td>ADULT 2.0 g orally</td>
<td>CHILD 50 mg/kg orally</td>
</tr>
<tr>
<td>Unable to take oral medications</td>
<td>Ampicillin or</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cefazolin or ceftriaxone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergic to penicillins or ampicillin-oral</td>
<td>Cephalexin b</td>
<td>2.0 g orally</td>
<td>50 mg/kg orally</td>
</tr>
<tr>
<td></td>
<td>Or Clindamycin</td>
<td>600 mg orally</td>
<td>20 mg/kg orally</td>
</tr>
<tr>
<td></td>
<td>Or Azithromycin or</td>
<td>500 mg orally</td>
<td>15 mg/kg orally</td>
</tr>
<tr>
<td></td>
<td>Clarithromycin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergic to penicillins and unable to take oral</td>
<td>Cefazolin or ceftriaxone b</td>
<td>1.0 g IM or IV</td>
<td>50 mg/kg IM or IV</td>
</tr>
<tr>
<td>medications</td>
<td>Or Clindamycin</td>
<td>600 mg IM or IV</td>
<td>25 mg/kg IM or IV</td>
</tr>
</tbody>
</table>

IM =intramuscular; IV = intravenously
Total child dose never exceeds adult dose
Cephalosporins are not prescribed for individuals with immediate type hypersensitivity reactions (urticaria, angioedema, or anaphylaxis) to penicillins or ampicillin.

SOURCE: American Heart Association. Endocartisis Prophylaxis Information. Dallas, TX. American Heart Association
Antibiotic Prophylactic Regimens for Dental Procedures


Guidelines for Joint Replacement Premedication

The dental team must consult with the patient’s orthopedic surgeon regarding the need for premedication and the type of antibiotic recommended.

The following procedures and events do not require premedication:

- Routine anesthetic injections through non-infected tissue.
- Taking dental radiographs, placement of removable prosthodontic or orthodontic appliances.
- Adjustment of orthodontic appliances.
- Placement of orthodontic brackets (not bands).
- Shedding of primary teeth.
- Bleeding from trauma to the lips or oral mucosa.

Drug Sensitivities and Overdose
The medical/dental history will be carefully screened to identify potential sensitivities and allergies to drugs or other compounds used in the dental environment. For example, a latex allergy would preclude the use of latex gloves, iodine sensitivity would preclude use of the Iodophor disinfectant, and fluoride sensitivity may contraindicate fluoride therapy.

If a careful screening reveals no potential problems and a patient develops a problem anyway, it will be treated as an “emergency” and an instructor will be summoned immediately. If necessary, the Safety Data Sheet or other manufacturer’s information sheet should be consulted for directions on how to manage untoward reactions to chemicals and drugs.

Vital Signs
Determining and recording the five vital signs are standard assessments that will be taken on every patient at each appointment. Vital signs are used to determine a patient’s health status, need for referral, need for treatment modifications, as well as, used as a baseline for comparing future assessments. The five vital signs are:

1. body temperature
2. pulse
3. respiration
4. blood pressure
5. smoking status

Refer to the following charts for significant values for adult and child vital signs in a clinical dental hygiene setting.

<table>
<thead>
<tr>
<th>Adult Vital Signs</th>
<th>Significant Values in Dental and Dental Hygiene Appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body Temperature</td>
<td>Normal 37 ºC (98.6 ºF) Normal range 35.5 to 37.5 ºC, 96.0 to 99.5 ºF</td>
</tr>
<tr>
<td>Pulse Rate</td>
<td>Normal range 60 to 100 per minute</td>
</tr>
<tr>
<td>Respiration</td>
<td>Normal range 14 to 20 per minute</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Blood Pressure</th>
<th>Systolic mm Hg</th>
<th>Diastolic mm Hg</th>
<th>Follow-up Recommended DACC Protocol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypotension</td>
<td>&lt;90</td>
<td>&lt;60</td>
<td>Observe for possible light-headedness and syncope. If persistent, referral for evaluation indicated.</td>
</tr>
<tr>
<td>Normal</td>
<td>&lt;120</td>
<td>&lt;80</td>
<td>Proceed as planned; recheck at each appointment (for Clinic, vitals will be taken at each appt.)</td>
</tr>
<tr>
<td>Pre-Hypertension</td>
<td>120-139</td>
<td>(or) 80-89</td>
<td>Retake after five minutes; if still elevated, inform patient of prehypertension status; recommend physician consult and encourage lifestyle modifications; recheck at each appt.</td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage 1</td>
<td>140-159</td>
<td>(or) 90-99</td>
<td>Retake after five minutes; if still elevated inform patient of elevated BP; refer for physician consult; Employ stress reduction protocols; modify local anesthesia to 1:100,000 vasoconstrictor; retake each appointment.</td>
</tr>
<tr>
<td>Stage 2</td>
<td>&gt;160</td>
<td>(or) &gt;100</td>
<td>Retake after five minutes; if still elevated inform patient of elevated BP. Do not treat-refer for urgent physician assessment; delay dental treatment until hypertension is controlled</td>
</tr>
</tbody>
</table>

Please note that normal vital signs for children are currently based on height, size, age, and gender; the below are generalizations.
Child Vital Signs | Significant Values in Dental and Dental Hygiene Appointments
--- | ---
Temperature | 37.3º C (99.1º F) to 36.7º C (98.0º F) Decreases with age, same range as adult after age 12.
Pulse Rate | 130 bpm to 70 bpm, the pulse rate falls steadily during childhood, same range as adult after age 10.
Respiration | 30-18 per mm., the respiratory rate falls steadily during childhood, same range as adult after age 15.
Blood Pressure | Mean systolic 108-136 | Mean diastolic 70-84
Blood pressure rises from a low of 108/70 at age 3 to 136/84 between ages 16 to 18. After age 18 the adult ranges are appropriate.


**Temperature**
Temperature should be evaluated: for all new patients, at maintenance appointments, if an oral infection is present, prior to the administration of local anesthesia, and at any time the patient reports feeling ill Infrared forehead thermometers are used in the clinic. Students will be trained in their use in Pre-clinic. Temperature in excess of 101º F usually indicates an active disease process. If it appears that a dental infection is the cause, the clinical dentist will determine whether to prescribe antibiotics and/or antipyretics. If the temperature is elevated, dental treatment should be postponed because the patient’s ability to tolerate stress is significantly reduced. If the patient’s temperature is 104 º F or above, immediate medical referral is indicated.

**Pulse/Heart Rate**
The pulse, which is the count of heartbeats, is taken from the radial pulse on the thumb side of the wrist using the tips of the first three fingers. Once the radial pulse is felt, use light pressure and count for **1 full clock minute**. The rate is recorded as beats per minute and the regularity and quality of the pulse are recorded (e.g., regular, irregular; weak, thready or bounding, etc.).

A pulse **over 100** is considered abnormal for an adult.

Note: On patients experiencing medical emergencies, the carotid artery in the neck is palpated. Pulse and rhythm are monitored throughout an emergency.

**Respiration**
Respiration is one breath taken in and let out, and is recorded for **1 full clock minute (you will need a**
watch/clock with a seconds hand), while the patient is unaware of the process. The rate is recorded as the number of breaths per minute. The rate, rhythm, depth, and quality are noted. Abnormal characteristics such as shallowness or wheezing, for example, could be an indication of an underlying systemic condition or medical emergency.

In medical emergencies the respiration is monitored throughout the emergency.

**Blood Pressure**

The patient’s blood pressure will be taken at each appointment and recorded on the Health/Dental History.

*The patient should always be told what their blood pressure reading is so that they can keep track of differences themselves. Establishing a baseline reading for your patient in a non-stress producing environment produces a more accurate reading if you need to make a medical referral. Screening for blood pressure by the dental professional has proven to be extremely effective since many patients with hypertension may be unaware of their condition.*

**Techniques for Obtaining the Most Accurate Blood Pressure Readings**

*The National Heart, Lung, and Blood Institute suggests that before blood pressures is taken, the following conditions should occur at least 30 minutes prior to the measurement in order to provide the most accurate blood pressure reading: no smoking, no exercise, and no coffee or other caffeine.*

When recording blood pressure, the notation should include the arm used. The same arm should be used consistently for evaluating blood pressure. When multiple readings are taken, wait 5-10 minute or use the other arm. Otherwise an erroneously high reading is likely. If the reading is high, lay the patient back and retake again after five minutes. Record all readings and the time interval between the readings on the Medical History form.

If the patient presents with hypertension (note: this determination cannot be based solely on one reading), a medical referral will be made, copied into Smart Doc, and the original given to the patient. form The blood pressure readings taken in the clinic should be entered on the referral form and the physician should be asked to evaluate the patient for hypertension. In order for dental hygiene treatment to begin, the physician must provide medical clearance by completing the Medical Clearance form, and returning a copy to the dental clinic. This is of the upmost importance when hypertension is suspected and the administration of local anesthetics is treatment planned.

Typically, patients will not be treated in the DACC Clinic if their blood pressure is higher than 145/90. However, if the physician provides a release to treat, and the attending dentist is comfortable with the patient’s blood pressure, the planned treatment may be implemented. Also, it is appropriate to proceed with non-invasive procedures that do not stress the patient until the patient’s medical release can be obtained. If, however, the BP is 160/95, dental services will be terminated for the day, and the patient will be referred for further diagnostic care and will require a medical release.
Vital Signs Continued

**Height** is considered when evaluating a patient’s physical condition. It is not commonly documented in dental records unless it is well outside of normal range due to a medical, systemic, or genetic condition. Height as well as formation of the skeletal and muscular systems, and gait of the patient is noted while escorting the patient into the clinical environment. Observations made during this assessment should be followed up during the review of the Medical/Dental History and documented as needed.

**Weight** is documented on the Medical/Dental History so that it can be considered if a drug dosage needs to be determined. For example, use of local anesthetic or a prescription of antibiotics.

Signs of obesity should be documented since this “is the single most prevalent metabolic disorder in countries with an abundance of food”. Weight changes should be monitored. They may reflect an increase in adipose tissue or an accumulation in fluids which could signal problems with the cardiovascular, renal, hepatic or adrenal problems. Significant weight changes may also signal potential diabetes complications or wasting diseases such as HIV or cancer.

Weight changes should be discussed with the patient and documented in the patient chart. At press, the Program does not currently have a scale to assess the patient’s weight, however, the process of acquiring one is in motion. Until then, patients will be asked if they are aware of their current weight and this will be documented under vitals in the chart notes.


**Tobacco Use Status** will be recorded as “the fifth vital sign” on the Medical/Dental History at the initial appointment. On subsequent appointments the tobacco use status will be entered on the Medical Update in the SOAP note. If warranted, the student clinician will use the National Cancer Institutes “Four A’s: Ask, Advise, Assist, Arrange” model to guide the patient towards tobacco use cessation.

**Normal Laboratory Values**

The following lab values may be helpful in evaluating the patient’s medical status and/or a physicians’ evaluation following a request for medical release to provide dental hygiene treatment.

**Blood Clotting Readings: Normal, PT, INR, and PTT**

When we bleed, the body launches a series of complex steps that help the blood to clot. These steps are referred to as the coagulation cascade. The cascade has multiple coagulation factors and two main pathways (intrinsic and extrinsic). Through a sequence of steps, the body converts collagen, activated platelets, and tissue factor, respectively, into a fibrin clot to control and halt bleeding.

**Normal Clotting:** The normal time range for someone who is not taking a blood thinning medication or suffering from a blood clotting disorder is **11-13.5 seconds**.

**Prothrombin time (PT)** is a blood test that measures the time it takes for the liquid portion (plasma) of blood to clot. PT is valuable in screening for disordered coagulation in various acquired conditions such as vitamin K...
deficiency and liver disease, for example. It is also used to monitor patients on anticoagulant therapy.

Prothrombin time (PT) test results can be presented in two ways:

1. **Prothrombin time in seconds**:
   a. *Prothrombin time is usually measured in seconds — the time it takes for blood to clot. This way of determining prothrombin time creates results that will vary depending on the laboratory and the method used to test the blood, but a sample range is approximately 10 to 14 seconds.*
   
b. *A number higher than average means it takes blood longer than usual to clot. A lower number means blood clots more quickly than expected.*

2. **INR**:
   a. *For people taking the blood-thinning medication, such as warfarin (Coumadin), results are given as a number that represents a ratio called the international normalized ratio (INR).*
   
b. *The INR is a formula that adjusts for differences in the chemicals used in different laboratories so that test results can be comparable.*
   
c. *An INR range of 2.0 to 3.0 is generally effective for people taking warfarin who need full anticoagulation, but may need to be slightly higher in certain situations.*
   
d. *If the INR is higher than this range, that means the blood clots more slowly than desired.*
   
e. *A lower INR means the blood clots more quickly than desired.*
   
f. *The INR is used only for people on oral anticoagulant therapy. It's not useful in people whose PT is higher for other reasons.*
   
g. *A patient taking warfarin will have their INR measured regularly by their physician.*

**Partial thromboplastin time (PTT)** is a more specific test used in conjunction with the PT, and screens for specific coagulation factors at specific areas in the pathway/cascade.

All patients with known blood clotting disorders and those patients on anticoagulation therapy must provide the clinician with their most current values. These numbers will be documented on the patient’s Health/Dental history. A patient with an INR above 3.0 will be dismissed from treatment and a medical consultation will be necessary; treatment may resume once the patient’s INR is within normal range; a medical clearance must be provided.

Because it is difficult to manage a patient’s blood clotting time with medication, many physicians **do not** want patients to discontinue or decrease prescribed medication regimens prior to invasive dental procedures, unless it is essential for a positive outcome of the dental procedure.

Follow the physician’s recommendations.

**Blood Cell Counts**
**WBC** = White Blood Cell Count Normal value is:

3800 - 10,800 cells / µL

- Neutrophils: 1500 - 7800 cells / µL
- Lymphocytes: 850 – 4100 cells / µL

(Note: normal CD4/Helper T cell count ranges from 500–1,000 cells/mm³; important to know with patients living with HIV/AIDS)

- Monocytes: 200 – 1100 cells /µL
- Eosinophils: 50 - 550 cells / µL
- Basophils: 0-200 cells / µL
- Platelet count: 130 – 400 platelets /µL

**RBC** = Red Blood Cell Count

- Male: 4.4 – 5.8 X 10⁶ cells / µL
- Female: 3.9 – 5.2 X 10⁶ cells / µL

**Diabetic Patients**

**Individual Blood Glucose Test Values Related to Control of Diabetes**

<table>
<thead>
<tr>
<th>Level of Diabetic Control</th>
<th>FPG</th>
<th>PP</th>
<th>HbA1C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy, well controlled</td>
<td>&lt;126mg/dL</td>
<td>&lt;160mg/dL</td>
<td>&lt;6 %</td>
</tr>
<tr>
<td>Moderate control</td>
<td>&lt;160mg/dL</td>
<td>160-200 mg d/L</td>
<td>6%-7%</td>
</tr>
<tr>
<td>Uncontrolled</td>
<td>&gt;160mg/dL</td>
<td>&gt;200 dL</td>
<td>&gt;8%</td>
</tr>
</tbody>
</table>

FPG= fasting plasma glucose (at least 8 hours)

PP= postprandial (measurement after consuming a meal)

HbA1c= glycosated hemoglobin (measures amount of glucose irreversibly bound to hemoglobin); indicates glycemic control over a 2-3 month period)
Note: A normal fasting blood glucose target range for an individual without diabetes is **70-100 mg/dL**

In case of a suspected diabetic emergency, a glucose meter, test strips and lancets are located in the red crash cart. Students will be trained in the use of during in the ‘Dental Emergency’ course curriculum.

The most current A1c (w/in last 3 months) for ALL diabetic patients is required prior to beginning treatment, as well as the patients most current daily glucose reading. If the patient is unaware of either of these numbers, they will be asked to bring their own monitoring system and complete a test in clinic; if they do not have a monitoring system available, the test kit in the Red crash cart may be used by the patient; students are not permitted to test patients, as this is considered outside the scope of practice.

**Oxygen Saturation**

**Pulse oximetry**- a test used to measure the approximate blood oxygen level; uses a small device called a pulse oximeter— a small device that clips on to the finger (no needle required). Though the pulse oximeter actually measures the saturation of oxygen in the blood, the results are often used as an estimate of blood oxygen levels.

The pulse oximeter is located in the red crash cart. Student will be trained during their Dental Emergencies segment of the curriculum.

**Normal values** (at sea level):

- Oxygen saturation (SaO2) - 94 - 100%; Values under 90% are considered low, and referred to as **hypoxemia** (low blood oxygen)
- Partial pressure of oxygen (PaO2) - 75 - 100 mmHg
- Partial pressure of carbon dioxide (PaCO2) - 38 - 42 mmHg
- Arterial blood pH of 7.38 - 7.42
- Bicarbonate - (HCO3) - 22 - 28 mEq/L


**ASA Classification Guidelines**

Each patient’s overall health status will be classified according to the American Society of Anesthesiologists (ASA) Classification and the classification will be recorded on the patient’s Medical/Dental History.
Please note that there are multiple other considerations made by other health professional organizations; however, DACC will follow the guidelines provided in the Clinical Practice of the Dental Hygienist, Wilkins 12th Ed., which is below:

<table>
<thead>
<tr>
<th>ASA I</th>
<th>Without systemic disease; a normal, healthy patient with little or no dental anxiety</th>
<th>Able to walk 1 flight of stairs with no distress ADL/IADL level=0</th>
<th>No modifications necessary</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASA II</td>
<td>Mild systemic disease or extreme dental anxiety</td>
<td>Needs to stop after walking 1 flight of stairs because of distress Well-controlled chronic conditions Upper respiratory infections, Healthy pregnant woman, Allergies, Tobacco use ADL/IADL level=1,</td>
<td>Minimal risk; minor modifications to treatment and/or patient education may be necessary</td>
</tr>
<tr>
<td>ASA III</td>
<td>Systemic disease that limits activity but is not incapacitating</td>
<td>Needs to stop en route walking 1 flight of stairs Chronic cardiovascular conditions Controlled insulin-dependent diabetes Chronic pulmonary diseases, Elevated BP ADL/IADL level=2 or 3</td>
<td>Elective treatment is not contraindicated, but serious consideration of treatment and/or patient/caregiver education modifications may be necessary</td>
</tr>
<tr>
<td>ASA IV</td>
<td>Incapacitating disease that is a constant threat to life</td>
<td>Unable to walk up 1 flight of stairs Unstable cardiovascular conditions Extremely elevated BP Uncontrolled epilepsy Uncontrolled insulin-dependent diabetes</td>
<td>Conservative, noninvasive management of emergency dental conditions; more complex dental intervention may require hospitalization during treatment; caregiver training for daily oral care may be necessary</td>
</tr>
</tbody>
</table>
Medically Compromised Patients

Patients with medical complications require special treatment planning and care. To help identify these cases the Medical History must be carefully evaluated for any of the following conditions; the attending faculty will enter the condition on the Case Management; please note that it is ultimately the student responsibility to ensure that all patient data is correctly entered on the Case Management prior to requesting a submittal for grade; there are graduation requirements for treating medically compromised patients; please see Section 14 __

1. **Can** = Cancer  all types of cancer

2. **CV**= Cardiovascular Diseases and Related Conditions: Hypertension; infective endocarditis; ischemic heart disease; Cardiac arrhythmia; heart failure; stroke; angina; pace maker; Artificial valves; stints; congenital heart defects; Mitral valve prolapse

3.

4. **End/Met** = Endocrine /Metabolic Diseases: Diabetes mellitus, Adrenal insufficiency or hyperfunction Thyroid diseases, others

5. **GI** = Gastrointestinal Diseases and Related Conditions: Crohn’s disease; gall bladder; liver diseases, others

6. **Gen** = Genitourinary Diseases: Chronic renal failure & dialysis; Urinary tract infections/bladder problems; Sexually transmitted diseases; others

7. **Hem** = Hematologic/Blood Disorders: Disorders of red blood cells: (sickle cell anemia); Disorders of white blood cells: (leukemia; leukocytosis; leukopenia) Bleeding disorders: (hemophilia); Anticoagulant therapy: (aspirin therapy; Coumadin, etc.)

8. **Horm** = Hormonal Influences

Pregnancy; Pre pubertal Development; Puberty; Birth Control

9. **Imm** = Immune System Dysfunction: Allergies( latex allergy, etc.) , autoimmun disorders/conditions; AIDS/HIV infection and related conditions;

Organ and bone marrow transplantation

10. **MuS** = Musculoskeletal Diseases and Disorders

Rheumatoid and osteoarthritis; osteoporosis; prosthetic joints

11. **Neuro** = Neurological Disorders:

Epilepsy; Parkinson’s disease; Multiple Sclerosis; Muscular Dystrophy; Cerebral palsy; Lyme disease; Lou
Gehrig’s disease; other

12. **Resp** = Respiratory Conditions
   
   Asthma; chronic obstructive pulmonary disease (COPD) Chronic bronchitis; smoking/tobacco use; Tuberculosis

Sleep related breathing disorders; other conditions

**Patients with Special Needs**

To help identify these cases the Medical History must be carefully evaluated for any of the conditions listed below; the attending faculty will enter the condition on the Case Management; please note that it is ultimately the student responsibility to ensure that all patient data is correctly entered on the Case Management prior to requesting a submittal for grade; there are graduation requirements for treating special needs patients; please see Section 14.

**A-**

Soc = Complicating Social/Economic Issues including any of the following: Abuse and neglect; occupational stressors; financial distress, Cultural distress; language barrier; homeless

Ment = Intellectual Disabilities such as: Developmental delay; Downs Syndrome; acquired disabilities (trauma etc)

Oral = Oral conditions presenting special issues such as: Cleft palate; oral surgery; edentulous

Phys D= Physical Disabilities such as Loss of limbs; obesity; loss of motor control; trauma

Psych = Psychiatric/Behavioral Disorders, Depression; bipolar; panic attacks; emotional distress, Eating disorders

Sens D = Sensory Disabilities: loss of vision, hearing, taste, smell, etc.

Subs = Substance Related Disorders: alcoholism; recreational drug use

**Patient Responsibilities**

When filling out the Medical/Dental history, the patient has the following responsibilities:

- Completely fills out patient information;

- Reads clinic philosophy and patient Bill of Rights;

- Signs consent form and receipt of HIPAA privacy information;

- Accurately fills out dental and medical history;

- Signs & dates medical and dental histories for children under 18 years of age and for adults who are not their own legal guardians.

- When appropriate, updates histories signature for any new or corrected information;

- Answers any questions regarding the medical/dental history.
Student Responsibilities

When reviewing the Medical/Dental history, the student has the following responsibilities:

- Makes sure patient has filled out all necessary information;
- Interviews patient regarding medical/dental history;
- ‘Checks’ all boxes that have an affirmative response and comments on each finding in the Comments Section of the Health/Dental History
- Is aware, and becomes familiar with, all conditions that appear in the patient’s ‘Alert Box’
- Records vital signs, ASA Classification; and any medications
- Obtains any necessary Medical/Dental information from appropriate source (e.g., radiographs from previous dentist);
- Reviews medical history with an instructor prior to any Dental Hygiene Procedures;
- Obtains instructor’s signature.

On subsequent and recall appointments, the student must:

- Review medical history with patient; update any changes
- Take and record vitals
- Note any changes, and have patient sign Medical/Dental History.
- Have instructor review and sign.

Faculty Responsibilities

When reviewing Medical/Dental history, faculty has the following responsibilities:

- Reviews form, verifies alerts and treatment modification recommendations;
- Makes any comments necessary to patient and/or student regarding medical history; includes any significant findings in the ‘Faculty Note’.
- Helps student make any necessary corrections or additions
- Signs medical history
- Signs and dates student Case Management form and enters ‘Faculty Note’ in patient’s chart

No procedure shall be performed on anyone (student, Dental Hygiene Department personnel, or patient) until a Medical/Dental History form has been completed, reviewed, and signed by an instructor.

Extra-Oral/Intra-Oral Exams

Every new patient will have a complete extra-oral and intra-oral examination before any other assessment procedures such as radiographs, periodontal evaluation, dental charting etc. or any treatment is performed. The
student will verbalize all findings to clinical faculty as they examine the patient and all significant findings must be completely and accurately recorded.

At the beginning of each appointment in a continuing series of appointments, only a brief visual examination is required to determine if there are any changes in oral or head and neck structures. At each maintenance visit, another complete extra-oral/intra-oral examination will be performed.

Criteria for Documenting Extraoral/Intraoral Findings

Any non-normal findings should be photographed, and will be thoroughly documented, including: Anatomic location, Border, Color, change and configuration, diameter/dimension, Type, and duration. (See references located at the teaching station and the Clinic Reference Notebooks in the cupboard with the X-ray tube head for help in describing lesions)

The patient will be informed of any changes that occur in oral tissues. The description will be recorded and dated on the Intra-oral/Extra-oral exam record. The lesion will be observed during the course of clinic treatment and changes recorded. Any lesion that does not resolve within two weeks will be referred for immediate examination. Lesions that appear to be long standing will be referred for examination. The clinic has several types of equipment to help evaluate the health of soft tissue and these will be demonstrated by faculty as needed. It is important to note, that the Program will refer all cases requiring biopsy or other in-depth evaluation rather than managing that within the clinic.

Student Responsibilities

When filling out the Extra-oral and Intra-oral forms, the student has the following responsibilities:

- Records succinctly, all findings from extra-oral and intra-oral exam.
- Uses professional description of all findings;
- Notes dental pathology in comment section, including tooth number and condition;
- Follow-up evaluations of lesions must be recorded
- Records any pertinent findings on treatment plan
- Discusses necessity for re-evaluation or referral with faculty; enters information into the ‘Referral Log’ (kept in the Business Office) including all necessary information. (Please note: all entries into the referral log will be followed up during Office Rotation and all conversations with other health care providers or with the patient will be entered into the patient’s chart.)

Faculty and Dentist Responsibilities:

When reviewing and filling out the extra-oral, intra-oral, and dental charting, the dental hygiene faculty have the following responsibilities:

- Reviews intra-/extra-oral exam and makes any necessary comments;
- Helps students make any necessary corrections or additions;
Helps students relate to dental hygiene treatment plan
H. Determines need for re-evaluation or referral.
H. Signs and dates student Case Management form and enters ‘Faculty Note’ in patient’s chart

When reviewing and filling out the extraoral and intraoral forms, the dentist has the following responsibilities:

- Reviews x-rays (including need for retakes), dental charting and exam, confirms student periodontal diagnosis and makes any other necessary diagnostic evaluations;
- Signs Case Management in sections covered with the student (usually
- Makes any necessary referrals and signs referral form.
- Discusses dental treatment plan in relation to dental hygiene treatment plan;

Radiographs

Radiographs are exposed for diagnostic purposes only, and must be prescribed by a dentist on staff or on standing order. If the patient does not have current radiographs, a complete radiographic series is required prior to commencing dental hygiene treatment. **Dental hygiene treatment will not be provided if the patient does not have current, or a copy of current, radiographs** Radiographic technique must be evaluated at the time radiographs are taken. Films that need to be re-taken will be marked on the Radiographic Evaluation Form; **faculty will supervise the retakes.** Completed Radiographic Evaluation Forms must be **turned in within one week after radiographs were taken in order to receive credit.** (See Section 11 Radiography for more details.)

Dental Exam

All new patients will have complete assessments (including a full set of radiographs) a comprehensive dental examination (if a dentist is available) and will receive a referral for general care. The clinical dentist will evaluate the radiographs and the dental charting, confirm the patient’s condition, and make any special referrals if necessary. If a dentist is not present to make special referrals, including to an: orthodontist, pedodontist, periodontist, or oral surgeon, then the patient will receive a referral from the clinic for general; the only exception is if the patient requires a referral to a medical physician. Every patient seen in the DACC Dental Clinic will receive a “Dental

The Dental Referral is in “Letters’ in Eaglesoft; the form must be completed and signed by the student and any faculty who helped supervise the patient care. A copy of the completed referral form must be given to the patient as soon as all diagnostic data is collected, evaluated and a complete diagnosis is made.

Criteria for Dental Chart

The criteria used to fill out the dental chart include: existing conditions (both clinically evident and radiographic findings), occlusion, oral habits, and causative/contributing factors. The following is a list of the criteria:

- Charting of existing conditions (caries, restorations, missing and mal-positioned teeth, open contacts, impacted or partially erupted teeth, dental anomalies, etc.)
- Classification of occlusion;
- Assessment of functional occlusion;
Presence and condition of appliance, such as partials, dentures, orthodontic appliances;
Presence of factors or habits which may contribute to oral health problems, such as mouth breathing, deviant swallowing, etc.; and
Presence of dental deposits.
Have a faculty member or the Dentist evaluate and approve teeth for sealants.

Always use radiographic evaluation to confirm client’s condition when indicated.

**Student Responsibilities**
When filling out dental chart form, the student has the following responsibilities:

- Records all key findings; from both clinical observation and radiographs
- Explains the clinical and radiographic findings in terms to which the patient can relate;
- Encourages patient to develop goals and ways to evaluate success; and
- Records any pertinent findings on the treatment plan.

**Dentist Responsibilities:**
When reviewing dental exam form, the dentist has the following responsibilities:

- Prescribes radiographs and evaluates for any necessary retakes;
- Reviews dental exam form after completion by the student;
- Confirms radiographic findings noted on the dental chart;
- Helps student make any necessary corrections or additions;
- Helps student relate the dental exam to dental hygiene treatment plan.

- Signs Case Management under the ‘Dental Exam’ section and any other section covered with the student
- Signs referrals, enters, signs and dates ‘Dentist’s Notes’ in the patient’s chart.

**Periodontal Assessment**

A classification of both gingival and periodontal conditions and associated risk factors will be made using a gingival description assessment and a periodontal examination. Together with radiographic findings and other clinical data, these assessments will lead to development of the Dental Hygiene Diagnosis.

Every patient with permanent dentition will have a complete periodontal evaluation of all adult dentition in order to determine the AAP Classification. The following will be charted: probe depths (probe), position of free gingival margin in relation to the cemento-enamel junction(GM-CEJ)
loss of attachment (LOA), mucogingival junction line (if there is a defect or involvement), bleeding, suppurration, furcations, mobility and fremitis.

**For a child, all fully erupted permanent teeth** will be evaluated. Primary teeth should be spot probed on young patients who might be at risk for periodontitis due to family history or to other clinical signs.

Faculty will check all probe readings, on the initial charting. They will evaluate all furcations, check for mobility and recession, and verify the student’s classification of the severity of disease and the gingival description. On re-care patients, the faculty will randomly check probe readings but will check all probe readings that were originally charted as over 5mm or over, and areas that seem inconsistent with clinical health.

All patients who have received scaling in the presence of inflammation (D4346), limited SRP (D4342) or full quadrant SRP (4341) **must have a reevaluation**; this is considered standard care. The reevaluation is generally 2 weeks after completion of treatment for D4346 and 4-6 weeks for D4341 and D4342; no sooner than one month for SRP. All assessments are redone and compared to baseline. Patient education is reiterated and all changes are noted in the patient chart; a recare interval is established at this time.

**American Academy of Periodontology (AAP) Classification (type of disease)**

1. **Extent** (How much of the periodontum is effected)
   - Localized - ≤30% of all sites involved
   - Generalized - ≥ 30% of all sites involved

   **Note:** A patient may have both localized and generalized conditions as long as the severity of the localized condition exceeds that of the generalized condition.

   **Example:** A patient with 1-2 mm LOA on all teeth with 5mm LOA on the mesials of the mandibular first molars would have; Generalized slight periodontitis with localized severe periodontitis on the mesials of #19 and #30.

2. **Severity** (As determined by evaluating loss of periodontal attachment)
   (LOA = Loss of Attachment. It is also called CAL=Clinical Attachment Loss)

   - Normal/Healthy – (Class 0)
     - No LOA, no pockets > 3mm, no Bleeding on Probing (BOP)
     - No radiographic change in bone
   - Gingivitis – (Class I)
     - No LOA, no pockets > 3mm
     - Inflammation of the gingiva evidenced by change in color, contour and consistency with possible Bleeding on Probing (BOP).
     - No radiographic evidence of bone loss
   - Slight Periodontitis – (Class II)
     - LOA 1-2mm, no mobility, no furcation involvement
     - Radiographic evidence of mild changes in crestal lamina dura may be present but are not definitive signs of periodontitis.
     - Bone loss < 20% is usually classified as mild
   - Moderate Periodontitis – (Class III)
     - LOA 3-4mm
     - Possible pathologic tooth mobility
Furcations may be evident
Radiographic evidence of 20 – 50 % bone loss

Severe (Advanced) Periodontitis – (Class IV)
- LOA ≥5mm
- Pathologic tooth mobility
- Class II or III furcations
- Radiographic evidence of >50% bone loss

Refractory – (class V)
- Are patients that continue to demonstrate loss of attachment after appropriate periodontal therapy and compliance with self-care routines. The refractory disease may be at single or multiple sites

Once the severity of the disease is determined, many factors must be evaluated to classify the type of periodontal disease present.

- **Gingival diseases**
  - Gingival diseases associated with dental plaque only
  - Gingival diseases modified by systemic factors associated with the endocrine system (puberty, pregnancy, menstrual cycle, diabetes mellitus)
  - Gingival diseases modified by medications
  - Gingival diseases modified by malnutrition
  - Non-plaque induced gingival diseases (bacterial, viral, fungal infections; genetic origin; mucocutaneous disorders; allergic reactions; traumatic lesions)

- **Chronic periodontitis**

- **Aggressive periodontitis**

- **Periodontitis as a manifestation of systemic diseases**
  - Associated with hematological disorders
  - Associated with genetic disorders
  - Not otherwise specified (NOS)

- **Necrotizing periodontal diseases**
  - Necrotizing ulcerative gingivitis = NUG
  - Necrotizing ulcerative periodontitis = NUP

- **Abscess of the periodontium**
  - Gingival abscess
  - Periodontal abscess
  - Pericoronal abscess
- Periodontitis associated with endodontic lesions
- Developmental or acquired deformities and conditions
  - Tooth related issues, tooth anatomy, dental restorations, endodontic lesions, mucogingival deformities, occlusal trauma, etc.

**Loss of Attachment (LOA)**

Probing depth alone does not indicate the amount of periodontal destruction. If only probe depths are considered, attachment loss would be underestimated if recession is present. And, it would be overestimated if gingival enlargement is present. True attachment loss must be measured from the CEJ, not just from the gingival margin. **Note:** the normal/healthy position of the FGM is 1-3mm coronal to the CEJ. **One must try to detect the CEJ with the tip of the probe. If it is detected, loss of attachment has occurred.** (The position of the Free Gingival Margin (FGM) must be determined clinically and cannot simply be assumed to be a value between 1-3mm.)

Attachment loss occurs when the junctional epithelium (JE) migrates apically from the cemento-enamel junction (CEJ) as a result of connective tissue and bone destruction. Loss of attachment (LOA) is the distance between the CEJ and the base of the pocket or sulcus. LOA is the clinical measurement of the amount of periodontal destruction. LOA is also known as clinical/calculated attachment loss (CAL). LOA is determined either by direct measurement from the CEJ to the base of the pocket/sulcus (OR) by subtracting the distance from the CEJ to the free gingival margin (FGM) from the probing depth when the CEJ is covered by gingiva.

**Periodontal Charting and Loss of Attachment:**

A free gingival margin apical to the CEJ (recession) is recorded as a **positive** number. A free gingival margin coronal to (either normal-slightly above the CEJ or a pseudopocket-inflammed/overgrowth of tissue) the CEJ is recorded as a **negative** number. A free gingival margin at the CEJ is recorded as a **0**, which is still considered loss, as the FGM should be slightly above the CEJ by 1-3 mm depending on location- direct or interproximal.

Basically, there are four scenarios; the FGM is below the CEJ, the FGM is at a normal level above the CEJ, the FGM is excessively above the CEJ, or the FGM is at the CEJ; see examples below:

**Ex: 1**) Probe Depth = Probe Reading = 3 2 3

FGM apical to CEJ (recession) =

FGM = 2 1 2

Loss of Attachment = LOA = 5 3 5

**Ex: 2**) Probe Depth = Probe Reading = 3 2 3

FGM Coronal to the CEJ = FGM = 2 2 2

Loss of Attachment = LOA = 1 0 1
Ex: 3) Probe Depth = Probe Reading = 5 2 3
FGM at the CEJ = FGM = 0 0 0
Loss of Attachment = LOA = 5 2 3

Ex: 4) Probe Depth = Probe Reading = 3 2 3
CEJ at probe depth = FGM = 3 2 3
Loss of Attachment = LOA = 0 0 0

Mucogingival Involvement (amount of attached gingiva)
A pocket that extends to (mucogingival defect) or beyond (mucogingival involvement) the MGJ and into the alveolar mucosa.

To measure for involvement:
1. Measure the total attached gingiva by laying probe over the surface of the gingiva (no pressure) and measuring from the FGM to the MGJ = width of attached gingiva
2. Take the probe measurement
3. Subtract probing depth from the total attachment to get the amount of remaining attached gingiva. If the result is 0mm this is called a defect, if the number is negative, there is no remaining attached and this is an involvement.

The AAP considers 1mm of attached gingiva adequate.
There is a tool located in the periodontal probing section of Eaglesoft that will help students assess the above.

Furcations
There is an area in the periodontal probing section of Eaglesoft where furcations will be documented. The box to click is called ‘FG’ for furcation grade; the following definitions, along with the use of the Naber’s probe, will aid the student in determining and documenting furcation involvement:

I – pocket formation into the fluting of the furca, with interradicular bone intact. No gross or radiographic evidence of bone loss.

II – interradicular bone is destroyed on one or more aspects of the furcation. However a portion of alveolar bone and periodontal ligament remains intact.

III – interradicular bone has been destroyed so that a probe can be passed through from one surface to the other.

IV – This is a class III furcation with no gingival tissue covering the furcation. It is charted using the same symbol but with a notation, it is Class IV.
Mobility
Evaluate and classify using the following criteria,

Class I- first distinguishable sign of tooth movement in the faciolingual direction; tooth can be moved less than 1mm in the buccolingual or mesiodistal direction.

Class II- movement of the crown in a faciolingual direction up to 1mm; tooth can be moved 1mm or more in a buccolingual or mesiodistal direction; there is no mobility in the occlusoapical direction (vertical mobility)

Class III- movement of the crown in a faciolingual direction > 1mm and/or depressible in a vertical direction; tooth can be moved 1mm or more in a buccolingual or mesiodistal direction and occlusoapical (vertical mobility) is present

There is an area in the periodontal probing section of Eaglesoft where mobility will be documented.

Fremitis
Fremitis is the palpable movement or vibratory pattern that occurs when there is excess contact made between the maxillary and mandibular teeth. Because fremitus depends on tooth contact, determination is made only on the maxillary teeth. Any vibration felt upon assessment will be brought to the attention of the dentist on staff, and will be noted in the patient's chart.

Gingival Description
The gingival description summarizes the inflammatory state of the gingiva. The tissue must be described in sufficient depth to provide a thorough verbal picture of its condition. The description should be written using professional, descriptive terminology. It must be distinctive enough that one could track changes over time.

The Gingival Description should include the following characteristics:
A description of the extent of the condition as generalized or localized;

- A description of the severity of inflammation, if present, as mild, moderate, or severe;
- Identification of changes in tissue color (magenta colored erythema, cyanotic etc.);
- Identification of involved anatomical regions, i.e., papillary, marginal, or attached gingiva
- Description of changes in contour (recession, clefting, rolled margins, etc.);
- Description of changes in tissue consistency (moderate edema, fibrotic, hyperplastic, etc.)
- Description of changes in tissue texture (stippled, shiny, etc.);
- Identification of duration of condition as acute or chronic;

- Bleeding on Probing (BOP): Slight, Moderate, or Heavy Suppuration (identify area- e.g. Facial # 30 Plaque and Calculus Deposits (Light, Moderate, Heavy)

Students must document the gingival description using the proper sequence and correct criteria. Follow the established sequence of characteristics to make notes easy to read.
**Example of Description:**
“Generalized, acute, moderate, plaque induced, gingivitis characterized by bright red, shiny, erythematous margins, moderately edematous gingival margins with bulbous, blunted papilla and moderate BOP in 25 areas. Localized, severe gingivitis around tooth # 19 characterized by cyanotic papilla easily detached from tooth structure.”

**Hard Deposit Classification System**
Use the following information to help classify dental deposits:

**Light:** Light calculus and/or stain, limited to the cervical third of the lingual surfaces of mandibular anteriors and facial surfaces of maxillary posteriors OR the presence of light subgingival calculus in granular, nodule or spicule form.

**Moderate:** Presence of moderate generalized supragingival calculus OR presence of moderate subgingival calculus appearing as narrow bands or proximal ledges on most teeth.

**Heavy:** Presence of heavy generalized supragingival calculus OR presence of generalized heavy or tenacious subgingival bands or ledges of calculus.

Note: Hard Deposit Classification will also be used when determining “Degree of Difficulty,” which is part of the patient requirements for graduation. See section 14-Student Evaluations.

**Periodontal Descriptions**
Periodontal description summarizes the injury to the attachment apparatus and the subsequent clinical/calculated attachment loss LOA. It includes a listing of facts that characterize the periodontal condition.

**Periodontal Diagnosis should include the following characteristics:**

- Describe the Generalized (generalized or localized) condition and its Severity (mild, moderate, severe) and by Class I, II, III, IV.

- Identify the AAP Type of periodontal disease suspected (chronic, aggressive, necrotizing, etc)

- **Characterized by:** (List significant findings)
  - Radiographic findings of attachment loss
  - Horizontal bone loss, vertical defects, furcations, etc.
  - Clinical Findings of attachment loss LOA, mobility, furcations, purulent exudate, etc

- Describe the Localized condition and its Severity: (mild, moderate, severe or by Class I, II, III,
IV) Note: Localized findings must always be more severe than the general finding.

**Examples of Contributing Etiology:**

- Hormonal factors
- Nutrition
- Occlusion
- Overhangs and poor restorations
- Medications
- Immuno status
- Malpositioned teeth
- Poor Oral Hygiene

**Example of Description of Periodontal Diagnosis:**

"Generalized, severe, chronic periodontitis characterized by radiographic evidence of horizontal bone loss with recession and probing depths resulting in LOA of 5-6 mm. Localized severe periodontal disease on tooth #19 characterized by 8mm buccal attachment loss, class III furcation involvement and class 1+ mobility. Exudate is evident around #19.

**Active and Maintenance Cases**

Gingiva can be healthy or inflamed, perhaps even bleeding. Likewise, periodontal disease can be in an active stage of destruction, where the patient is continuing to lose attachment, or it can be in a quiescent stage, where tissues are healthy and no destruction is occurring. (Especially true after dental hygiene treatment is completed).

At DACC, we want to determine if a patient’s condition is active or is maintaining health. Therefore, after diagnosing the periodontal condition we will classify the condition as Active or Maintenance. This helps determine whether further treatment or education is needed. Clinical signs to help determine Active status include:

- Presence of bleeding or suppuration
- Visual signs of inflammation
- Continuing loss of attachment over time
- Addition of new symptoms, such as mobility, fremitis

**Student Responsibilities**

When determining a patient’s periodontal status, *the student has the following responsibilities:*

- Ensure that charting entries are accurate if someone is charting for the clinician, Charts six areas of probing depth and free gingival margin for each tooth;
- Furcation involvement;
Mobility; Fremitus
Mucogingival junction documented
Bleeding or suppuration
Description of plaque & calculus
Gingival description; using the format described in this section.
Periodontal Diagnosis with AAP Classifications and full description of the condition including determination of Active or Maintenance status.
Discusses findings with patient and relates to other findings;
Records Periodontal Diagnosis in the patients treatment notes under….

Faculty Responsibilities
When reviewing Periodontal Assessment form, the faculty has the following responsibilities:

- Reviews Periodontal chart;
- Helps student make any necessary corrections or additions;
- Helps student relate findings to the Treatment Plan;
- Provides referral for periodontally involved patients;
- Signs and dates student Case Management Form. and enters ‘Faculty Note” in patient’s chart.

Caries Risk Assessment (CAMBRA)
With the use of the Caries Risk Assessment form (See Foliotek form) the student clinician can assist a patient in identifying risk factors for decay. Using the patient’s age and modifiers given on the assessment form the clinician can rank the risk and give preventative treatment options and home care education to decrease the risk of caries.

Plaque Index and Calculus Indices
A plaque and calculus index will be charted to help determine the gingival surfaces with hard and soft deposits that might be influencing gingival inflammation and periodontal destruction.

The plaque index will be completed after the Gingival Description has been checked off by faculty, because the disclosing solution used to identify plaque will distort the color of the tissue.

After applying disclosing agent the student will chart plaque on the Plaque Index and compute the % of plaque as follows:

**Step 1:** Number of teeth present x 4 = Total Possible Surfaces (this index does not consider occlusal surfaces)

**Step 2:** Number of surfaces with plaque/Total Possible Surfaces = % Plaque present.

**Step 3:** Record % plaque under Ging: in the Treatment Notes.
The calculus score will be computed the same way, however students will use the following symbols to distinguish light, moderate and heavy pieces: | Light; ○ moderate; ● . This data will then be entered into the patient notes, as well as scanned into Smartdoc.

**Dental Hygiene Diagnosis**

The *dental hygiene diagnosis* identifies the health behaviors of individuals, as well as the actual or potential oral health problems that dental hygienists are educated and licensed to treat. The diagnosis provides the basis on which the dental hygiene care plan is designed, implemented, and evaluated. For the preparation of the dental hygiene diagnosis, the data from the assessment phase are critically analyzed and interpreted.” (E.M. Wilkins, 2010, *Clinical Practice of the Dental Hygienist, 10th Ed. 2010, Lippencott, Williams, and Wilkins p.7.*)

**Treatment Plans**

Each patient’s general and oral health is thoroughly assessed. Only then is a comprehensive dental hygiene care plan developed. The plan is based on the patient’s needs and desires, with the goal to eliminate disease and restore the oral cavity to health and function.

The Dental Hygiene Care Plan includes:

- A sequential outline of all educational, preventive, therapeutic and maintenance needs of the patient identified in the diagnostic work-up. This includes essential services and procedures to be carried out by the hygienist, dentist and patient.
- Referrals for dental hygiene services needed by the patient, but which are beyond the student’s level of skill must be included.
- A referral to the patient’s dentist or appropriate dental care agency for an examination and other necessary dental care.
- Referrals to other health care professionals as appropriate.

Students, working under the supervision of faculty, are responsible for developing a comprehensive dental hygiene care plan. Faculty are responsible for reviewing the care plan with the student, and ultimately evaluating the development, implementation and completion of the plan. Both student and faculty must sign the initial plan. After the plan is approved by faculty, it may be presented to the patient for signature; this is called the “Informed Consent Agreement”.

**Development of the Treatment Plan**

**Goals for the Plan:**

- Eliminate and control etiologic and predisposing disease factors;
- Eliminate the signs and symptoms of disease;
- Restore to normal function;
- Maintain health and prevent the recurrence of disease.
Design Logic

- Systematically review all patient assessments (e.g., Medical/Dental History, Radiographs, etc.);
- Identify each significant finding as a problem or a goal;
- Identify the etiology/cause of each problem or unmet goal
- Identify risks that the problem or not meeting the goal, presents to the patient
- Identify a proper course of action for each problem or goal;
- Prioritize each procedure;
- List a specific sequence for care assigned to deal with each problem or goal; this is to be sequenced in Eaglesoft which will identify the service to be provided at each appointment.
- Estimate fees and time for each procedure.

Criteria for Treatment Plan

Treatment planning is dynamic, and should be reviewed and updated at regular intervals.

Each of the following components on the plan must be completed and explained to the patient/guardian in terms they can understand:

1. Dental Hygiene Diagnosis (Explain the nature of the patient's condition)
2. Education Topics (include all pertinent topic areas and decide how best to present them to the patient/guardian)
3. Oral Hygiene Aids (suggested items/instructions & demonstrations for patient use)
4. Dental Hygiene Care Plan (therapy to be provided and how)
5. Potential Benefits Associated the Treatment (prognosis for improved oral, general health, and impact on social/economic issues)
6. Potential Risks Associated with Treatment (tailor discussion to concerns of patient while providing key information about possible problems that may arise)
7. Treatment Alternatives (alternate methods that will still accomplish goals)
8. Expected Outcomes Associated with NO Treatment (the patient can always refuse treatment and that choice must be well documented)
9. Expected Number of Visits
10. Estimated Cost of Treatment
11. Patient Signature on the Informed Consent Agreement
12. Student Signature on the Informed Consent Agreement
13. Instructor Signature on the Informed Consent Agreement
Treatment Plan Presentation & Patient Consent

Although the Patient Registration/Medical Dental History form includes an area for “Consent,” this is considered to be limited to the collection of assessment data such as radiographs, dental exam, periodontal exam etc. and basic patient education (called Implied Consent).

Once a dental hygiene diagnosis is established, a treatment plan must be developed and the patient must consent to it before treatment is started. When a treatment plan is initially developed, it is the student’s responsibility to present the plan to a faculty member before presenting it to the patient. Then the patient/guardian must have an opportunity to respond to the plan, ask questions and discuss concerns before giving consent and signing the Informed Consent Agreement.

Mutual understanding and co-operation should be established to:

- Define roles, responsibilities and limitations of clinician and patient;
- Decrease patient fears/concerns;
- Build trust;
- Establish a helping relationship that maximizes positive outcomes and enhances the probability of success.

Additional procedures or new elements in the treatment plan that were not discussed in the original case presentation of the treatment plan must be discussed and be consented to by the patient before being accomplished. This includes lengthened time frames for care, postponement of care and referral for care. A new Informed Consent Agreement containing additional services and/or referrals must be developed and re-signed by all parties.

Use a team approach to maximize the patient’s oral health and enhance interpersonal interactions. Reach agreement between the patient, dental hygienist, dentist and other interested parties before initiating patient treatment.

Student Responsibilities

When filling out the Dental Hygiene CarePlan, the student has the following responsibilities:

- While doing assessment, records key findings on assessment notes. For each finding, gives a treatment goal or modality to help patient reach health;
- Determines the sequence for treatment on the treatment plan worksheet;
- Estimates time and fees;
- Signs and obtains instructor signature when plan is developed;
- Presents case to the client or guardian, and secures the client or guardian’s signature after thorough discussion and necessary modifications;
Faculty Responsibilities

When reviewing the Dental Hygiene Care Plan, the faculty has the following responsibilities:

- Reviews Dental Hygiene Care Plan prior to student beginning treatment;
- Helps student make any necessary corrections or additions;
- Signs Care Plan/Informed Consent Agreement when initial plan is written up;
- Aids in Case Presentation if necessary and during CSE;
- Signs and dates student Case Management form and enters ‘Faculty Notes” in patients chart.

Treatment Notes

Students must document all phases of patient treatment in the Treatment Note section of the patient chart. All information needs to be recorded in a manner that will be easily understood by future clinicians, therefore, only DACC and professionally approved abbreviations will be accepted. All treatment notes will be entered using Eagle soft templates. Eaglesoft templates are arranged in specific order. Your clinical coordinator will provide specific instructions for accessing and entering notes. Below are some common abbreviations and explanation of the topics.

1. Vitals: Include Patients bloodpressure, pulse, respiration, temperature, tobacco status, and weight
2. Chief complaint-patient’s primary concern; reason patient is seeking care; example- “My teeth look brown, and I think I need a cleaning.”
3. Health History - Medical/Dental History Reviewed: Write No Significant Findings (NSF), no change, or basic information about the significant findings such as hypertension, diabetes, allergy to latex, etc., very complex medical conditions multiple meds may refer reader to respective assessment sheet
   - Review Patient Registration Information and Treatment Consent Form and the HIPAA Form for patient signatures and date.
   - Review and investigate each item on the Medical-Dental History at the beginning of each appointment. Identify the patient’s chief complaint and other important information. Document pertinent information in a concise, scientific and legible manner.
   - Use reference books to gather information on unfamiliar health conditions. Recognize conditions that require medical consultation prior to treatment, and obtain the appropriate written clearance.
   - Obtain and record measurements for blood pressure, pulse, respiration, temperature, weight and current tobacco use status for each patient on the initial and subsequent visit. Treatment will not be delivered for any patient with blood pressure over 160/95.
- Identify possible medical emergencies identified in the health history, and be prepared to manage the emergency should it occur.

- Complete medical alert label and place on top sheet of current medical history when significant findings are identified.

- For each recare patient or for a reappoint patient record an update on the *Medical History Update* form, noting significant findings or changes, place your initials and date above the entry, and obtain the patient’s signature on the form with date.

- Document the review of the history in the *Treatment Notes* in a concise and professional manner. Include any adaptations, significant findings, or instructions that relate to the health history.

- Present a verbal summary of the patient’s health status and/or case history to the instructor in a clear concise summation. Suggest appropriate interpretation and handling of the case for approval by the instructor.

- Obtain faculty approval and initials on the *Medical History or the Medical History Update* and the *Case Management* form prior to proceeding.

4. **ASA:** document the patient’s current overall health status using the American Society of Anesthesiologists guidelines (see this ASA Guidelines in this section)

5. **Dental history-** Patients last appointment, frequency of appointments, past experiences, amount of restorative work, current values regarding oral health, etc.

- **Medications:** Use reference books to investigate medications. For each medication reported, include the generic and brand name of the drug, the classification, indication, action and any considerations in dental treatment.

6. **Radiograph/Photo History:** When and where were the last RG taken; type of series; any issues e.g. tori, gag reflex
   - Rational for exposing; note radiographs that patient has had in the past.
   - Note all types of films taken (e.g. Full Mouth Radiographic Series with Four Vertical Bite-Wings, or Panoramic Survey and 2 Horizontal Bite-Wings, etc.)
   - Note patients experience/tolerance of RG.

7. **Tempromandibular joint-** any abnormalities, crepitus, pain, excursion, deviation, popping etc.

8. **EO:** External oral exam
   - Extra-oral: No significant findings (NSF), or location, color, shape, consistency, size, texture, duration/history

9. **IO:** Internal oral exam
   - Intra-oral: No significant findings or No significant findings (NSF), or location, color, shape, consistency, size, texture, duration/history
10. Occlusion (Angle’s Classification); note the right and left; overbite, overjet, crossbite, openbite, midline shifts, rotations, attrition etc.

11. Gingival Description
   - Use the criteria: color, contour, consistency, texture, BOP (light, moderate, heavy), suppuration, and amount of plaque and/or calculus (light, moderate, severe); for both mx. and md. arches; For reevaluations note changes i.e., improved color, no bleeding, reduced pockets etc.

12.

13. Per: Association of American Periodontal Classification and rationale including findings from PPD, GM-CEJ, any mobility or fremitus.
   - Extent-generalized/localized, severity- slight, moderate, severe, AAP
   - Classification- I, II, III, IV characterized by: LOA, RG findings of bone loss (horizontal /vertical), furcation, mobility, fremitus
   - extent and severity of any of the above criteria.

14. Dental Hygiene Diagnosis
   - Utilizing all collected data from performing the assessments, identify health behaviors and actual or potential health care problems that a RDH are educated and licensed to treat.
   - Must be written as a dental hygiene diagnostic statement, example: bleeding on probing as related to no flossing by patient report….halitosis as related to biofilm accumulation on tongue etc.
   - Specify causative/contributing factors

15. Prognosis
   - Forecast the probable course and termination of disease and response to treatment
   - Good, Fair, Guarded, Poor, Hopeless. This could describe localized or generalized conditions of periodontium, as well as individual teeth.

16. Care Plan
   - Design/developed based on the individual patient’s needs
   - List all anticipated treatment/interventions, planned adjunctive services, approximate length and number of appointments, approximate cost, recare or maintenance intervals, and cover PARQ; see below for procedure:
     - P – The Procedure or treatment to be undertaken.
     - A – The Alternative procedures or methods of treatment that is realistically viable. This includes no treatment at all.
     - R – The material Risks and possible complications.
     - Q - After giving this explanation, the student will ask the patient if they have any Questions or desire a more detailed explanation.
17. **Patient education:**
   - Oral Hygiene Instruction- Write the verbal or written instruction given, aids & toothbrushes, recommendations, need for referrals and all information provided.
   - Additional patient education- Nutritional counseling, tobacco cessation, etc.

18. **Appointment Sequence:** List of services to be provided in order of priority

19. **Referrals:** Type of referral given and explanation of why referral was made; all referrals will be created in ‘Letters’ in Eaglesoft and a copy will be given to the patient.

20. **Treatment Rendered**
   - List all services rendered:
     - Child Prophy with fluoride – (give details of fluoride application)
     - Adult Prophy or Adult Scale and Polish – For healthy or Cl I gingivitis
     - Full Mouth Debridement – Used when accurate probing and assessments cannot be performed due to heavy calculus or severe/acute infection.
     - Periodontal Scale and Polish [add Root Plane if that was part of the procedure- For Active Perio patients Class II, III or IV or those with localized periodontal pockets. State what type of treatment was performed: ultrasonic, hand scaled, area(s) treated, polish used,
     - Other treatment such as fluoride application, sealants, etc. Include description of the procedure, e.g. “Fours minute, 2.5 mg, tray application with mint, neutral sodium fluoride”. Or occlusal sealants on Tooth # 3,14,19,30 using [brand]. Indicate if there were any complications with any procedure.
     - **Local Anesthesia and Nitrous Oxide Sedation**- Place a pre-typed, white sticker on the Treatment Note page and fill in the blanks.
     - **Periodontal Maintenance**- Describe specific therapy provided for patients who have been treated for periodontitis.

21. Next visit/Recare Appointment be specific. Example SRP LR using LA; review patient use of Reach Flosser; Stress importance of 3MRC.

**Student Responsibilities**

When filling out the Treatment Notes, **the student has the following responsibilities:**

- Reviews previous treatment records to assure thoroughness and completeness of treatment.
- Records date and use accepted abbreviations (see list) and professional language;
Signs at the end of the entry signifying that no more treatment was completed on the date. Signs, using first initial, full last name, and SDH for Student Dental Hygienist.

Records treatment intending to be rendered at the next visit or special concerns (e.g., remove residual calculus, etc.).

If further notes are needed after signatures have been made and dated, simply write “Addendum,” include the note and resign and date.

Records appropriate maintenance interval.

All phone conversations with patients, no shows or cancellations must be dated and recorded in the patient’s treatment notes.

**Faculty Responsibilities**

When filling out the Treatment Record, the faculty has the following responsibilities:

- Thoroughly reads treatment notes before signing. Signs with first initial, full last name and credentials. (Treatment notes should be signed by the faculty who has had direct contact with the patient or student. For legal reasons, records must be signed the day treatment is completed or treatment is considered incomplete);

- Helps student make any necessary corrections to records.

- All treatment notes are on Eaglesoft. The clinical coordinator will provide more details and instructions on proper method of entering and signing notes.

**Adjunctive Diagnostic Procedures**

Occasionally special procedures for assessments may be required. Several of those are described below.

**Photographs**

Two types of cameras are available in the clinic to take photos of a patient’s conditions.

One is a digital extra-oral Canon camera and there are two (2) types of intra-oral cameras/wands. Photos are used to document interesting oral pathology / trauma etc. so that it can be monitored for changes over time. A series of photos, as described in course materials, is required for documentation projects related to dental hygiene treatment of interesting/challenging cases.

Get the patient’s permission to photograph. The medical history consent form includes a permission statement, but the patient may have forgotten he/she gave permission. It is wise to explain the purpose of the photographs and have the patient sign the Treatment Notes that describe the photos and their purpose.

The site photographed, type and number of projections taken should be noted in the Treatment Notes. For example: “anterior teeth facial aspect, anterior lingual, right occlusion, etc”. Include the type of camera used (digital extra/oral or digital intra/oral). A note about what the photo demonstrates should be included. (e.g. “Lesion on left lateral posterior border of the tongue” OR “Case Documentation Project”)

The best photos may be printed on medical quality imaging paper. The paper is quite expensive, so only the very best photos will be printed. All photos that are blurry, not centered or do not depict the appropriate area should be deleted.

Assembling a series of photos using the camera and the computer system may take at least 30 minutes of clinic time. Assemble all armamentarium and use an assistant. Initially, there may be some trial and error.

All photographs become part of the patient’s permanent record. Photographs may be used for educational purposes; however, the patient’s identity must remain confidential.

Students are responsible for preparing the mirrors and retractors for sterilization and ensuring that the camera is turned off before placing the camera back on the charger or the intra-oral/ camera-computer attachment in locked storage cart.

**Study Models**

Study models are used to document existing conditions, enhance patient education, as an adjunct to the case presentation, and are an aid to developing the dental and dental hygiene treatment plan. All case study models will be kept as teaching aids.

Criteria for acceptable Study Models include:

- Includes all oral anatomy extending into the facial vestibule to include, labial frena on both arches
- Mandibular model extends into the floor of the mouth to include the entire alveolar ridge.
- Models extend posteriorly, to include maxillary and mandibular retromolar pads,
- Maxillary model includes the hard and soft palate,
- Models are poured to exclude air holes and voids, are trimmed to present a professional look and can be articulated with a bite registration.

All Case Documentation models will be labeled with the clinician name, patient name and date and stored in the glass cupboards in the classroom. If models are made for bleaching trays or mouth guards, the models will be given to the patient when the appliance is delivered to the patient or be discarded.

**Vitality Tests**

When indicated, vitality tests will be performed to determine the status of the dental pulp. A Parknell Gentle-Pulse vitality pulp tester, percussion, and/or application of ice may be used to help determine pulp vitality. Faculty will supervise this procedure. The dentist will help interpret the findings and a referral must be made when the vitality of a tooth is questionable. Findings and the referral will be recorded in the patients chart. The following guidelines must be followed for completing a vitality test

**Indications of Questionable Pulp Status**

- Pain that is spontaneous or has thermal response with long duration;
- Discoloration of tooth crown;
Tooth fracture (crown or root);
- Large carious lesion or large restoration;
- Fistula with opening into the oral cavity over the apical region of the tooth;
- Radiographic evidence of apical radiolucency with widened PDL or condensing osteitis at apex.

Contraindications for Electric Pulp Test

10. Cardiac pace maker or other electronic life support mechanism;
11. Epilepsy, Central Nervous System Disorders;
12. Deciduous teeth.

Precautions for Electric Pulp Test

13. Avoid gingiva or other soft tissue;

Specialized Equipment

It may be necessary to use specialized equipment/procedures to help assess patient’s oral conditions. The Program has purchased new diagnostic assessment equipment; as with all dental equipment, the intraoral camera is expensive, and special training will be provided prior to use. As of publishing the equipment is new and more information will be provided as it becomes available.

Screening Patients & Procedures

Board or Mock Board patients are screened before making formal appointments. All other patients will be scheduled as needed to fulfill clinical requirements and clinical scheduling needs.

Patients who call for an appointment will be scheduled with the next available student. It is recommended that students block their schedule when they are aware that they DO NOT have an opening. Patients who are scheduled by the front office will take precedent when the student fails to block their schedule.

Patients who ‘walk in’ for an appointment will be seen by a student who may have had a cancellation; once assessments have determined the AAP and Degree of Difficulty of the patient, the patient may be ‘passed’ to a fellow student depending on graduation requirement needs.

If patients assessed in Pre-Clinic or Clinic I are deemed above the skill level of the class, they may be referred to the Senior class.
SECTION 11. RADIOGRAPHY

Radiographs
All patients treated in the DACC Clinic must have a current series of dental radiographs for diagnostic purposes. Radiographs must be available prior to commencing treatment. If the patient has films available in a community dental office, the students should instruct the patient to bring those radiographs or a copy of those to the DACC Clinic. If a patient is not able to secure a current series of dental radiographs a new set will be taken prior to commencing treatment.

If films are requested to be taken at DACC, by a community dentist, a copy of the prescription must be attached to the chart. This prescription would be uploaded or scanned into the patients Smart Doc in EagleSoft. Consent for Radiographs form is available for use in securing a community dentist’s permission for radiographs. This Consent form along with other Radiography related forms are located in EagleSoft in the Smart Doc under Letters. However, a signed letter or note on a prescription pad with the dentist’s signature is adequate.

Protocol for Radiographs and Exams

Radiographs

The following are acceptable radiographic combinations in our clinic.

PANO and 2/4BWS
- Long standing recall patients who have an FMX with no Perio and no high caries risk.
- Age 7 -Primary teeth, permanent teeth eruption, supernumerary, CM, other anomalies.
- Age 12- Canine alignment, permanent teeth at appropriate age, initial wisdom teeth formation
- Age 17-21-Wisdom teeth and idea of areas that need to be addressed, development
- Edentulous and partially edentulous patients

If taken as a combo the same day, the same fee applies to the combo regardless of the number of bitewings taken with the combo not to exceed 4 BWs.

If taken separately (during different appointments) the fees will apply as individual sets.

Full series of radiographs (not necessarily an FMX)
- Everyone that comes in as a new patient over the age of 18. These can include an FMX or Pano and BWS, and any additional individual radiographs needed to perform a comprehensive evaluation on the day the radiographs are exposed.

FMX
- 14 Periapicals and 4 BWs
- Any required retakes not to exceed 5.

Bitewings
- Once a year on anyone who has a history of of Pano and FMS
- Everyone who has history of decay
Occlusal
- Children 6 and under

Any additional radiographs not part of the full mouth series for comprehensive dental evaluation taken in a day other than the day of the comprehensive examination will be at the cost of the patient. If a Pano is requested in addition to a full mouth series (FMX), both the Pano and the FMX will be at patient’s expense.

Patient Refusal of Radiographs
If radiographs are deemed necessary for proper treatment of the patient and the patient refuses them, the patient will be referred to the community for treatment. The referral and the reason for it must be thoroughly documented in Student Treatment Notes under Treatment Rendered Today and Clinical Assessments (Initial) notes under Referrals in the patient’s chart.

Survey Selection
Radiographs are exposed for diagnostic purposes only. Determine your recommendation for radiographs based on the patients need, then consult with faculty to determine which films will be retaken. All radiographic surveys must be approved by clinical faculty and the patient before they are exposed. The frequency of exposing radiographs on patients depends on the individual’s need. Such factors as date and type of last radiographs, caries rate, periodontal disease, and patient compliance are considered. Typical radiographic series at DACC include:

- Full Mouth Series (FMX/FMS) for adults, 18 films total with 4 horizontal bitewings, or 4 vertical bitewings for those patients with active Class III-IV periodontal disease.
- Panograph with 4 Bitewings for 7-18 year olds
- 2 bitewings with 2 occlusal films for children 6 and under.

Retakes
When exposing radiographs, students must have their instructor assess ALL radiographs for retakes. If a retake is recommended, the instructor must indicate the number of retakes and initial the Radiograph Evaluation Form located in Foliotek. Students should not proceed to retake any radiograph without faculty approval or direct faculty supervision.

Selecting Radiographic Method (3 options)
DACC has the capability to produce intraoral dental radiographs using:

1. Traditional analog system with traditional film.
2. Intraoral phosphorus plates (PSP) to make digital images which can be entered into the patient’s computerized chart as digital images.
3. Digital system using intraoral sensor to enter images immediately into the patient’s Eaglesoft chart

Panoramic radiographs can be taken using either traditional analog system or PSP.

Many factors must be considered to determine which system is the best option for the patient. These will be discussed in detail in Radiology class.
Intraoral Film/Receptor Type

Digital sensors or PSP’s will be our primary film/receptor used in order to minimize exposure to patients and stay abreast with current trends. If analog film must be used, the fastest film available (F speed) will be used to help minimize exposure to patients. Double pack film will be used for intraoral films when it is expected that films will be sent out to a community dental provider within a short time frame.

DACC Intraoral Film Critique Guidelines

Intraoral radiographs taken using the paralleling technique are preferred. When anatomical conditions warrant, the Bisecting angle technique may be used.

Radiographs must be of good contrast and density and show undistorted image of all teeth and surrounding tissue. On any given radiograph series, each root apex and interproximal space should appear once, preferably twice with clarity, accuracy and without overlapping.

1. For periapicals, each apex and 2 mm of bone surrounding the apex should be visible. In addition, 2 mm of bone posterior to the area of interest in the radiograph should be clearly visible. This rule holds even if the area is edentulous or partially edentulous.
2. The margin between the crowns of teeth and the edge of the film should be even and 2-3 mm wide.
3. Films should not be foreshortened or elongated due to improper vertical angulation.
4. Films should not show superimposition of specified contact due to improper horizontal angulation.
5. Films should demonstrate reasonable density when viewed with conventional viewing devices (not too light or too dark).
6. Films should not be cone cut due to improper centering of x-ray beam.
7. Films should not demonstrate distortion or visible effects from bending, placing the film backward in the mouth, double exposure, movement, or processing errors.

1. Analog films should be labially mounted (raised dot) in proper sequence. The embossed dot on analog film or the ‘a’ locator on PSP’s should be on the incisal or occlusal surface of each PA film. For bitewings, the dot should be on the inferior edge.
2. All radiographic surveys must be labeled with the following:
   - Patient’s name,
   - Date of exposure,
   - Name of person who exposed the films.
3. When analog films are placed in a coin envelope, the same identifying information must be written on the envelope. Analog duplicates and digital image copies will include the same information. In addition, analog duplicates must be labeled with “R” to indicate the patient’s right side on the film.

<table>
<thead>
<tr>
<th>Film Coverage</th>
<th>Central Ray = open contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anterior Bitewing</td>
<td>Distal 1/2 of canines visible. All crowns of max. &amp; mand. premolars visible including interproximal alveolar crests. Contacts between canine and max 1&lt;sup&gt;st&lt;/sup&gt; &amp; 2&lt;sup&gt;nd&lt;/sup&gt; premolar open. Occlusal plane parallel to edge of film</td>
</tr>
<tr>
<td>Posterior Bitewing</td>
<td>Maxillary 1st and 2nd molar centered, D of 2&lt;sup&gt;nd&lt;/sup&gt; premolars. Contact between max 1&lt;sup&gt;st&lt;/sup&gt; &amp; 2&lt;sup&gt;nd&lt;/sup&gt; molar open. All crowns of max. &amp; mand. molars visible including inter-proximal alveolar crests. Occlusal plane parallel to edge of film.</td>
</tr>
<tr>
<td>Maxillary Central</td>
<td>Central incisors centered on film. Contact between centrals open. Incisal edges visible, 2 mm bone superior to apices.</td>
</tr>
<tr>
<td>Maxillary-Lateral/Canine</td>
<td>Canine/lateral centered on film. Incisal edges visible, 2 mm superior to apices. Canine M contact open. Lateral Distal contact open. *overlap may occur on distal of canine</td>
</tr>
<tr>
<td>Maxillary Premolars</td>
<td>Distal 1/2 of canine visible, 1&lt;sup&gt;st&lt;/sup&gt; &amp; 2&lt;sup&gt;nd&lt;/sup&gt; premolars and 1&lt;sup&gt;st&lt;/sup&gt; molar if possible. Open Contacts on premolars. Occlusal edges visible, 2 mm bone superior to apices.</td>
</tr>
<tr>
<td>Maxillary Molar</td>
<td>D of 2nd premolar, all of 1st &amp; 2nd Molar (3rd if possible). 2mm bone distal to 3rd molar region or take supplementary film. All contacts open. 2 mm superior to apices. Occlusal edges visible</td>
</tr>
<tr>
<td>----------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Mandibular Central</td>
<td>Central incisors centered on film. Open contact between centrals. 2mm bone inferior to apices visible.</td>
</tr>
<tr>
<td>Incisal edges visible.</td>
<td></td>
</tr>
<tr>
<td>Mandibular Canines</td>
<td>Canine centered on film, 2mm bone inferior to apices, Incisal edges visible, M contact open. *overlap may occur on distal of canine</td>
</tr>
<tr>
<td>Mandibular Premolar</td>
<td>Distal 1/2 of canine visible. All contacts open. Occlusal edges visible. 2 mm bone inferior to apices</td>
</tr>
<tr>
<td>Mandibular Molar</td>
<td>Distal of 2nd premolar. All of 1st &amp; 2nd molars (3rd if possible) All contacts open. 2mm bone distal to 3rd molar region or take supplementary film. Occlusal edges visible. 2mm bone inferior to apices</td>
</tr>
<tr>
<td>FMX</td>
<td>All contacts open at least once in series, All apices visible at least once in series, All edentulous area visible, 2mm surrounding each tooth area at least once, All incisal /occlusal edges visible</td>
</tr>
</tbody>
</table>

**Exposure Settings**

Exposure settings can vary depending on patients and the machines (x-ray units) in the clinic. Therefore to ensure correct density for individual patients, a film (maxillary anterior PA) should be taken at the normal setting, processed and evaluated to determine if the clinician needs to alter each setting before exposing the rest of the series of films.

The radiology equipment contains pre-set exposure values; these values are listed on a laminated chart inside the tube head cabinet and on the pano machine itself. The need to adjust the pre-set values is considered a variance.

If a variance in technique (i.e. increase in MA’s or kVp’s, using an adult setting for a child or vice versa) is required, the New Mexico Environmental Department requires that the variance and the reason for the variance is logged. The log is kept in the cupboard with the X-ray tube head.
After exposing films requiring a variance, students must enter the:

- Date
- Student initials
- Number and types of radiographs taken
- Reason for the variance
- What the variance was
- No patient information is to be included in this variance log.

**Exposure Records**

The type of radiographic survey taken, the number of films in the survey, and the type of film along with any variances in settings is recorded in the patient’s record under *Radiograph/Photo History* in the *Clinical Assessments (Initial)* note and in the *Student Treatment Notes* under *Treatment Rendered Today*.. This includes the number of retakes. Example: Digital sensor - 18 image FMX with 2 retakes and no variances in exposure, or Analog film – 4 film HBWX with no retakes and no variances in exposure. When determining the survey selection and retakes, this record should be evaluated to help ensure minimal radiation exposure in a short time frame and is based on the “Guidelines for Prescribing Dental Radiographs”.

**Diagnosis of Films & Referrals**

All films must be evaluated, first by students then by faculty for both technical quality and for radiographic evidence of pathology. Radiographs will be evaluated utilizing the *Radiographic Evaluation Forms (REF’s)* located in Foliotek. Digital films may be enhanced for optimal diagnosis, but changes must not be saved. Saving enhancements is considered altering an original legal document. Analog films should be evaluated on a lighted view box for optimal diagnosis. Magnifying glasses are available to enhance viewing.

All radiographs must also be interpreted by a dentist for diagnosis. Prior to interpretation by the dentist the student will do their own interpretation and enter their radiographic interpretation findings on the patients *Dental Chart* under *Conditions*. If a dentist in not available on the date of exposure to confirm the radiographic interpretation findings they will be reviewed by the students attending faculty.

If a dentist is present on the date of exposure they will also interpret the radiographs and they will confirm the students’ findings in the patients *Dental Chart* and make any necessary changes. They will also document the interpretation in the patient’s chart with the *Dentist SOAP Note*. The student will document the dentist’s findings under *DDX* in the *Clinical Assessment (Initial)* note and under *Treatment Rendered Today* in the *Student Treatment Note*. All confirmed findings will be presented and discussed with the patient.

If a dentist is not present on the date of exposure the radiographs will be entered into a ‘To be Evaluated’ Log, located in the shelves at the teaching station in the clinic, to be evaluated as soon as a dentist is available. Once the dentist interprets the radiographs the dentist will confirm the students charting in the patients *Dental Chart* and make any necessary changes. They will document the interpretation in the patient’s chart with the *Dentist*
SOAP Note and sign the ‘to be evaluated’ log stating the radiographs have been interpreted.

All patients will receive a referral for general dental care and a copy/duplicate of their radiographs. The general dental care referral will have two sections; one for clinical findings, and one for radiographic findings.

If a dentist is present the referral will include both clinical finding and radiographic finding that have been confirmed by the dentist and the referral will be signed by the student and the dentist.

If a dentist is not present the referral will only include clinical findings and the referral will be signed by the student and the attending faculty.

All digital radiographs will be copied to a disk or flash drive and all analog radiographs will be duplicated and accompany the general dental referral. The original radiographs must be evaluated for their technical quality before copies/duplicates are made. Copies/duplicates must be evaluated before any films are released to ensure that they are of the highest quality possible. Both the originals and copies/duplicates are must be properly labeled. The Dental Clinic requires one week for copying/duplicating radiographs. All duplicates/copies must be picked up by the patient. Radiographs will not be mailed or emailed out of the clinic. All patients will sign a release form prior to making the duplicate or copy. When the referral and a copy of the radiographs are given to the patient, a note must be made in the patients chart.

If the radiographs are analog, the original set of radiographs must be kept at DACC and the duplicate sent with the patient.

Other appropriate follow-up such as, additional films of various kinds, film duplication, etc., will be instituted with faculty input.

Evaluation of Radiographs

Use the appropriate forms for evaluating radiographs. (See Foliotek)

1. Intra-oral Radiographic Evaluation Form (REF): For periapicals, bite-wings, and occlusal films
2. Panoramic Radiographic Evaluation Form (REF): For panoramic films

The day the radiographs are exposed the technique needs to be evaluated and reviewed by faculty for “retakes”. These are entered on the REF and students have one (1) week to complete the REF and submit it to their attending faculty for review in order to receive credit for the films.

First year students will use the REF’s for both radiology lab and for all patient surveys taken during clinics.

Second year students who have passed their competencies in radiographic technique and interpretation will have the Case Management form signed by faculty during clinics and only those radiographic requirements needed to meet graduation requirements will be graded using the REF.

If faculty determines that a senior student is having either technical or interpretation problems, they may elect to
require the student to continue to complete REF’s until competency is established or re-established.

**Supervision of Radiography**
No student will expose radiographs until he/she has passed a written exam on radiation safety and protection. Distribution of analog film will ONLY be made by requesting them from the Clinical Lab Manager; this includes all film required for retakes.

The first several series on humans must be directly supervised by a faculty member until the student can demonstrate competency on the technique, using the REF’s technique section for three patients in a row.

**Retakes**

**All retakes will be supervised directly by faculty.**

Films are retaken only when they are un-diagnostic and when the area of interest cannot be visualized in another film in the series. The absolute number of retakes allowed is:

- FMX = five (5). Three or fewer are recommended
- Bitewings= two (2)
- Panograph = one (1)

Retakes and the rational for the retake will be entered, the day of exposure, by the faculty and tracked on the REF in Foliotex.

**Radiographs as Part of the Chart**

All radiographs become part of the client’s permanent record. Digital films are located in the patient’s chart in EagleSoft. Analog radiographs will be stored in an accordion file under the student’s name. This accordion file will be stored in the file cabinets in the business office.

Duplicate films will be labeled as such and they will also be stored in the accordion file under the student’s name until the patient picks them up.

**Dosimetry Badges**
All students and faculty in the clinic area must wear a radiation monitoring badge. Results of the exposure rates will be reviewed by the Program Director and filed by the Clinical Lab Manager. If exposure is out of the norm, the clinician will be contacted immediately to review the exposure in detail and rectify the issues. If necessary, further referrals will be made to ensure the health and safety of the clinician.

**Pregnant Students/Providers**
Pregnant clinicians will also wear a fetal monitoring badge and a special lead apron to protect the developing embryo/fetus when exposing radiographs.

**Pregnant Patients**
Radiographs will be postponed on pregnant patients. If radiographs are necessary and can not be postponed the patient will be referred to the community.
Lost dosimetry badges will be replaced at the students’ cost. Faculty lost dosimetry badges will be replaced at the faculty cost.

Ionizing Radiation Procedures

Exposure of Patients, Faculty and Students shall always follow the principles of ALARA (As Low As Reasonably Achievable).

1. Deliberate exposure of an individual to dental diagnostic radiographic procedures for training or demonstration purposes shall not be permitted unless there is a documented diagnostic need for the exposure by a licensed dentist.

2. Operator Safety:
   a. Operators will wear radiation monitoring badges at all times while in the clinic.
   b. Pregnant students and faculty will wear a fetal radiation monitor.
   c. Only the patient, with operator visibility, is permitted in the operatory when radiographs are taken. (Children of adult patients must remain in the reception area).
   d. The operator of the x-ray equipment will remain a minimum of 6 feet away from the tube head at an appropriate angle from the tube head during exposure.
   e. The operator will not, under any circumstances, hold films in a patient’s mouth during a radiographic exposure.
   f. The operator will not, under any circumstances, hold or stabilize the x-ray tube head during a radiographic exposure. If the equipment is not stable notify a faculty member and note in the Equipment Repair Log. Move to an x-ray unit that is stable.
   g. The operator will not stand in direct line with the central beam.
   h. The operator will not, under any circumstances, expose a radiograph when another patient, student, faculty member or any other person is within 6 feet of the central beam, this includes being in the hallway.
   i. The operator may, only under exceptional circumstances and with faculty permission, allow someone to hold a film in a patient’s mouth (never on a manikin). When these circumstances arise, the patient’s guardian or parent may be used to assist in holding the film in a patient’s mouth IF they are draped with a lead apron. Faculty, students, and staff will not under any circumstances be asked to hold film in a patient’s mouth.
   j. The operator will not expose a panoramic radiograph if any person is within 4 feet of the tube head.

3. Patient Safety:
a. The medical history must be reviewed prior to exposing radiographs.

b. All radiographs taken for a given patient should meet the **Criteria for Prescribing Dental Radiographs** and must be documented in the patients chart under *Radiograph/Photo History* in the *Clinical Assessments (Initial)* note and *Treatment Rendered Today* in the *Student Treatment Notes*, noting prescription by a DDS designating radiographs needed or the standing order we have with our dentist.

c. Digital radiographs will be the standard radiographs taken, but if analog films must be used then the highest speed film available will be used.

d. When available, square collimator will be used.

e. A thyroid collar and lead apron will be used on each patient, for all intra-oral radiographic procedures, regardless of age. *Do not bend the thyroid collar down; this creases the lead in the apron making it ineffective for thyroid protection.*

f. For panoramic radiography only, the panoramic lead apron will be used and it will be positioned in such a way so that it will not interfere with the diagnostic value of the radiograph.

g. The patient must always remain in view of the operator during all exposures.

h. A record of radiation exposure of each patient will be documented in the patient’s chart.

i. Radiographs will be postponed on pregnant patients. If radiographs are necessary and cannot be postponed the patient will be referred to the community.

j. Retakes on a patient **must** only be taken when the radiograph is **undiagnostic**. All retakes on a patient must be supervised by a faculty member. If the retake is not successful, a faculty member will retake the radiograph.

4. Quality Assurance is utilized to assure the production of high-quality diagnostic radiographs which minimize patient exposure.

a. Projection Technique

1. Before students take a FMX of intraoral radiographs on a patient, they must successfully pass a written test on radiation hygiene and safety and demonstrate competency on technique for all intraoral and extra orbital films on a manikin.

2. There will be direct supervision on the radiographs taken on all patients until the student can demonstrate competency on 3 consecutive patients.

3. There will be direct supervision of all students during retake exposures.

4. All radiographs are reviewed by the student and a faculty member for errors immediately after they are processed. The need for retakes is then determined by the diagnostic quality of the film, and the retakes are taken or the patient is scheduled for the retakes.

5. Retakes taken by students are limited to 5 films for a FMX, 2 films for HBW’s or VBW’s, and 1 panoramic radiograph or occlusal films. **Retakes must be supervised.** Films above and beyond the limits established above, which are needed for diagnosis and treatment, shall be taken by a Faculty
6. Students who demonstrate less than a minimum competency (75%) on 2 consecutive FMX, HBWX, VBWX, Occlusals, or panoramic radiographs will be remediated on a manikin until proficiency is improved.

7. Film holders and alignment devices will be used to aid students in the correct alignment of the x-ray PID and area of interest.

b. Evaluation of Dental X-Ray Machines

1. All x-ray machine performance standards are monitored through annual procedures performed by the Radiation Safety Manager to meet New Mexico statutes.

2. The student is responsible for bringing to the attention of the clinical faculty member immediately any deviation from normal. The problem should then be logged in the Equipment Repair Log.

c. Identification of Processing Problems:

d. 1. All PSP series will be evaluated for defective (scratched, bent) receptors as they are processed. If defects are found in the series all of the PSP receptors used in that series will be pulled from circulation and given to the Clinic Manager for further evaluation.

1. All analog film is to be stored in the darkroom. Film will be stored in a safe temperature and used according to age sequence. Out-of-date film will never be used on patients.

2. Instructions for processing analog radiographs and process maintenance procedures are displayed in the darkroom. If the films are too dark or too light, the exposure technique and/or processing procedure for that particular machine will be evaluated and corrected. It should also be noted on the Equipment Repair Log. If a machine is in question, it should be posted as “Do Not Use” until the problem has been identified and corrected.

3. A radiology certified individual will check the processing system on all radiology clinic days. A log is kept for routine monitoring of processor maintenance and solution changes.

4. Annual quality assurance tests on the darkroom will be recorded and any irregularities will be noted in the Equipment Repair Log.

e. Other:

1. Annual quality assurance tests will be conducted and results recorded on the following: screens and cassettes, x-ray machines, and the darkroom. Any deviations from normal must be brought to the attention of the Radiation Safety Officer and the Program Director immediately.

2. The faculty person teaching radiology is responsible for assuring that the x-ray procedures are in compliance with all governmental agencies. Any discrepancies noted should be reported to the Clinical Dental Assistant and the Program Director immediately.

3. All students and faculty are required to wear dosimetry badges when engaged in taking radiography or working in the immediate vicinity of radiographic exposure.
5. **Infection Control** – Intraoral Films

PPE, gloves, mask and a lab coat with name tag, radiation monitor must be worn when taking radiographs on patients. Operators must wash hands prior to and after removal of gloves.

**Infection Control for Radiography**

Appropriate infection control measures will be used throughout all radiographic procedures.

**Before Exposure of Intra-Oral Films:**

**Unit Preparation:**

1. Disinfect the dental unit, chairs, counters and x-ray unit using appropriate surface disinfectant wipe or spray.

2. Place barrier covers on the tube head and chair. Make sure all controls and handles are covered. Be very careful when placing and removing plastic on the x-ray unit to avoid causing excess static electricity. Static electricity can cause artifacts to appear on the film and short circuit the control panel. Plastic can also cause dials to read incorrectly.

3. Place a clean tray cover or patient bib on the counter. Lay out mask, gloves, patient bib, labeled plastic cups with patient name (to receive exposed films), paper towel or gauze to dry exposed film, clean cotton rolls, gauze and 6” cotton tip applicator.

4. Lay out and set up, sterilized, XCP Kit; bitewing tabs, soft covers for film edge on a tray cover or paper towel on the counter.

5. Select appropriate films for the series to be taken and prepare initial films with bite wing tabs, soft edge materials if desired.


7. Turn on the x-ray unit and select initial exposure readings.

8. Disinfect the lead apron.

**Patient Preparation:**

The following must be performed prior to placing gloves:

1. Adjust chair

2. Adjust headrest

3. Place lead apron

4. Remove objects/ jewelry, glasses
After placing gloves:

1. Remove intra-oral appliances (partials, etc) from the arch to be x-rayed.
2. Remove films from mount, place in film holders, and place for desired projection and expose the film. Be sure to double check the machine setting prior to pushing the button.
3. Transfer film-holding devices from protected work area (paper covers) to mouth and back. Do not lay it on unprotected counters.

After Exposure:

1. Dry film with gauze or paper towel and drop in labeled cup to take to the darkroom. In the case of digital radiographs, dry the PSP envelope with gauze and wipe with cavi wipes before taking it to the ScanX machine. Do not use disinfectant rinse. It may soak into the film pocket and ruin the film. Do not handle the cup with contaminated hands.
2. Prior to removing gloves, dispose of all disposable items and move film holders to sterilization after all retakes have been made. Return intra-oral appliances to patient.
3. After glove removal, wash hands, remove lead apron and hang it flat. Return jewelry, glasses etc to patient, take labeled cup with exposed films to the darkroom to have them processed.
4. While wearing gloves remove plastic barrier from film. Drop analog film onto clean paper towel taking care not to touch film with gloves. Dispose of plastic and paper liner in trash, but place lead foil in lead foil container. Drop PSP receptor into light protected transfer box taking care to not touch receptor with gloves. Dispose of plastic in trash.
5. Remove glove and load film/receptor into processor.

**Dark Room Infection Control/ Safety**

1. Clean and disinfect counter tops, handles and knobs of cabinets, light switches, and equipment.
2. Follow procedure for processing intraoral films to ensure the processors do not become contaminated.
3. Turn on the vent while in the darkroom.
4. Use safe light only while processing. If you enter a dark darkroom call out to see if someone is processing film before turning on the light.

**ScanX Infection Control/ Safety**

1. Follow procedure for processing intraoral films to ensure the ScanX processor does not become contaminated.
2. Feed PSP through ScanX
3. Once all PSP has processed and images are saved, place the PSP on Eraser
4. Desinfect all areas touched.
5. Return PSPs to boxes.

**Steps for Operatory Cleanup**

Wearing gloves or over gloves:

1. Remove all plastic barriers and place in trash bin
2. Disinfect the lead apron, chair, counter, and machine controls.
3. Turn off x-ray unit, dental unit, computer and view box.

**Copies/Duplication of Radiographs**

If copies/duplicates are needed, it is the student’s responsibility to copy/duplicate the films. Patients should be told it will take 1 week to get films copied/duplicated. After films are copied/duplicated and labeled the patient is notified that their radiographs are ready to be picked up. There must be a consent form, a HIPAA form, and a radiograph release form present in the chart and a note must be made in the patient’s chart that the radiographs were given to the patient.

**Copying Procedure:**

1. In EagleSoft in the patient’s chart open *View Images*.
2. Make sure photo paper is in the copier. (Photo paper may be found in the business office. It is located in the stackable shelves to the right hand side of the printer on the 3rd shelf.)
3. Select the series from which you want to print the radiographs.
4. Select File.
5. Select Print All.
6. If the only a few radiographs for a series need to be copied then:
   a. Highlight the radiographs needing to print.
   b. Select File.
   c. Select Print instead of Print All.

**Duplicating Procedure:**

1. Clean plate (view screen) with soft, clean, moist cloth and dry. Try to avoid creating static electricity.
2. With the rocker switch pressed down on the side that shows duplicate pages (1-> 2); set the timer window to “12” to duplicate good quality/good density films. Use the + or – rocker switch on the left side of the panel to increase or decrease time. To darken a duplicate, decrease exposure time. To **lighten** a duplicate, increase exposure time. (This is just the opposite of what you do when exposing x-ray film.)
3. Place mode switch in the “VIEW” position. (Press down where you see the symbol for the eye) Do not use the view light when others are developing films. It may damage their film.
4. Remove radiographs from mounts and arrange on the screen in the proper position with the raised dots facing up.

5. Set the mode switch to “duplicate.”

**NOTE:** Steps 1-5 maybe done with the safelight (or) overhead light if others are not processing films. *At this point, proceed with the safelight only.*

6. In safelight condition, remove duplicating film from box and place over film arrangement with the notched corner of the film to the upper right. Replace the cover on the box of duplicating film and return to the drawer.

7. Close cover on duplicator, press down firmly and close the latch.

8. Depress the exposure button located in the center of panel above the timer window.

**CAUTION:** Never depress the exposure button unless the cover is closed and securely attached. *The UV rays emitted may damage other films in the dark room.*

9. When the red exposure light turns off, raise the cover and remove the duplicating film.

10. Process the duplicating film. Insert film into processor (short side first) so it will “track” straight. Do not bend the film.

11. Label the film with patient name, date film were taken, DACC Dental Clinic and clinicians name. Mark the patient’s right side on the duplicate film.

12. Remount the original films and return them to the patient’s chart.

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**Requirements for Proficiency in Radiology**

All students must demonstrate continuing practice and proficiency throughout their educational career. You are required to keep a list of all radiographic patients listing, the type of series taken, and the grades for technique and interpretation. This will be tracked in Foliotek through the *REF.*

**Graduation Requirements for Radiographs**

The minimum number of radiographic surveys presented for graduation requirements include the following and they should represent films taken each semester. To meet graduation requirements both the techniques score and the interpretation score must be ≥ 75% Pre-clinic, Clinic I and II, ≥80% Clinic III and ≥ 85% Clinic IV.

- 8 Full Mouth Surveys: (known as FMS/FMX or CMRS)
  - 4 Digital minimum outside of radiology class
- 6 Panoramic Radiographs
- 6 Sets of Horizontal Bite wing films—in addition to those taken as part of FMX
  - 3 Digital sets minimum
- 4 Sets of Vertical Bite Wing films—in addition to those taken as part of FMX
2 Digital sets minimum

- 3 Sets of PEDO or Mixed Dentition Bite Wing films.
  - Digital allowed using PSP only

- 3 Sets of Occlusal Films
  - Digital allowed using PSP only

**Digital Radiographic Procedures**

Digital Sensors and Phosphorous imaging plates will be used for digital radiographic system. Phosphorus plates are exposed as regular intraoral films using the setting on the X-ray machine for digital films. Special film holders for Digital Sensors are used to facilitate accurate film/tube head positioning and for paralleling technique.

The Phosphorous imaging plates can be used in any operatory. Phosphorous imaging plates are loaded into the ScanX scanner and scanned into the Eaglesoft on the computer. This sends the images to the patient’s electronic chart.

The Clinic has four (4) Schick/Sirona Digital Sensors which are used with Patterson Imaging to view the images on the computer in the operatories. Currently, Operatories 1-2, 7-8, and 11-12 have sensor compatibility.

The Program is currently developing guidelines for use, and these will be provided to students as soon as they become available.

**Student Responsibilities:**

When taking and documenting radiographs, *the student has the following responsibilities:*

- Determines appropriate radiographic survey for patient following “Guidelines for Prescribing Dental Radiographs”.
- Takes radiographs using infection control and radiation safety measures.
- Processes films with no handling or processing errors.
- Mounts, labels, and evaluates all radiographs then store them properly.
- Records radiographic surveys in the patient’s chart under Radiograph/Photo History in the Clinical Assessments (Initial) note and in the Student Treatment Notes under Treatment Rendered Today including: date of exposure, type of film, type and number of radiographs taken, number of retakes taken, clinician’s name along with any variations in exposure settings.
- Records the exposure information on Foliotek in the REF.
- Evaluates all radiographs for technical quality and for signs of pathology and enters all radiographic findings on the appropriate patient chart forms.
- Ensures that dental faculty interprets the films for radiographic findings.
- Arranges for supervision of all re-takes.
Arranges for and follows through with all referrals related to radiographic findings.

Records all retakes on Foliotek in the REF.

**Faculty Responsibilities:**

When taking and documenting radiographs, *the faculty has the following responsibilities:*

- Verifies appropriateness of survey selection.
- Evaluates technical quality of all radiographs and verifies/corrects student’s radiographic findings.
- Ensures that related student evaluation forms are complete (*Radiographic Evaluation Forms (REF’s), Radiography Clinical Skill Evaluation (CSE’S), - Exposure variance logs in clinic x-ray units*).
- Supervises student’s retakes
- Verifies/corrects chart entries and signs them off. *This includes: Radiographic Consent, Radiographic Prescription, Treatment Notes, Referral – with duplicate of radiographs, Dentist’s ‘to be evaluated’ log, and Retake documentation in REF.*

**Dentist Responsibilities**

When taking and documenting radiographs, *the dentist has the following responsibilities:*

- Prescribe radiographs and signs *Radiographic Prescription.*
- Evaluates all radiographs for technique and verifies/corrects student’s chart entries
- Interpret radiograph and signs chart entries related to radiographic findings. *This includes Treatment Notes, Dental Charting, Referral, and Retake documentation in REF.*
- Prescribe and supervises retakes
- Facilitates referrals with copy or duplicate of radiographs.

**DACC Radiographs and Pregnant Patient**

The most recent evidence-based scientific data released by the American Dental Association (ADA) and the American College of Obstetricians and Gynecologists (ACOG) states that radiographs are not contraindicated during pregnancy. However, the DACC Dental Clinic has chosen to take the position that *no radiographs will be exposed on pregnant patients.*

Preventive oral health care is a critical component of over-all health during pregnancy. While radiographs will not be taken during pregnancy here at DACC, a limited exam may be performed, along with other preventive services, such as a prophylaxis. It is highly recommended that the patient return for a comprehensive exam after the pregnancy, in order to rule out disease that may be identified in radiographs.

Please see the “U.S. Nuclear Regulatory Commission’s Regulatory Guide 8.13 on the following pages for further information concerning prenatal radiation exposure for student clinicians and faculty.
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SECTION 12. DENTAL HYGIENE THERAPY

Education
Every patient will receive a comprehensive educational presentation tailored to meet the individual’s preventive, therapeutic, and personal needs. All presentations will be based on sound educational principles—presented at the patient’s level of understanding—and provide for patient interaction and participation in the process. Appropriate pre-educational assessments will be conducted (e.g. plaque recorded, patient questioned, etc.) and the lessons reinforced. The outcomes of the educational program will be evaluated and documented.

Plaque Control
Each patient may be given one toothbrush, floss, or other plaque control aid at no cost, in addition to the basic treatment fees. Pamphlets and occasionally free samples of toothpaste, mouth rinse etc may be given at no cost. If a patient requires additional instruction with an aid that has already been given out, models may be used.

Tobacco Education
Tobacco is a major threat to oral and general health. Therefore, patients who use tobacco must be counseled to quit and if appropriate, a referral to community education and support groups will be made. Instructional materials and referral cards are kept at the teaching station and in the hallway. Additional information may be found in the lateral file in the lockerroom.

Nutritional Counseling
Patients who will benefit from formal nutritional counseling will be given a food diary to complete. The diary will monitor their food intake to ensure that they are receiving adequate amounts of nutrition in the basic food groups; that they are not consuming too many caries contributors (e.g., frequent sugars); and that they are eating in a manner that contributes positively to their overall oral health.

Counseling will be based on scientific knowledge and no supplemental vitamins, dietary compounds, or other “special diets” will be recommended. Patients with an obvious breach in sound nutritional intake or dietary practices will be referred to appropriate health care practitioners.

Other Education
A broad range of educational programs related to oral health may be implemented for individuals or groups and may include such topics as, infant and child oral health care, fluoridation or other appropriate topics. Students are encouraged to consult with faculty when planning special educational programs. Audio-visual aids may be checked out of the department for such programs. Educational or counseling needs of the patient beyond the scope of dental hygiene and dentistry will be referred to appropriate professionals.

Preventive Procedures
Fluoride Therapy
Fluoride therapy is a highly effective preventive measure for both children and adults. It is a heavily researched, yet, at times, controversial topic. The type of fluoride (topical and/or systemic therapy) provided in the DACC Dental Clinic must be selected based on the patient’s fluoride history, current fluoride use, and the most current recommendations of the Centers for Disease Control and Prevention and the American Dental Association.

Clinicians must inform the patient about fluoride and must provide educational emphasis on the benefits of fluoride therapy.

An ADA accepted fluoride dentifrice should be recommended for routine brushing. Topical fluoride rinses available over-the-counter or prescription strength rinses or brush-on fluoride gels should be recommended to supplement routine brushing when the patient’s caries susceptibility warrants enhanced fluoride therapy (e.g., caries active, orthodontic appliances, xerostomia, difficulty in maintaining optimal oral hygiene, etc.).

Children
Supplemental fluoride will be recommended for children in fluoride deficient areas, unless their intake is estimated to be at optimal levels through other sources. Supplements may be prescribed as drops, tablets, or lozenge. The American Academy of Pediatrics recommends systemic fluoride therapy through age 16 (US GPO 1986-621-077). These recommendations are still current as of Aug. 2004. Recommended supplemental fluoride dosages* are based on the child’s age and the amount of fluoride in the water.

<table>
<thead>
<tr>
<th>Age</th>
<th>Level Of Fluoridated Water (ppm)*</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>&lt; 0.3 ppm</td>
</tr>
<tr>
<td>Birth—6 mo.</td>
<td>None</td>
</tr>
<tr>
<td>6 mo.—3 yrs.</td>
<td>0.25 mg/day**</td>
</tr>
<tr>
<td>3—6 yrs.</td>
<td>0.50 mg/day</td>
</tr>
<tr>
<td>6—l6 yrs.</td>
<td>1.0 mg/day</td>
</tr>
</tbody>
</table>

*1 part per million (ppm) = 1 milligram/liter (mg/L)

**2.2 mg sodium fluoride contains 1 mg fluoride ion.

Topical fluoride therapy may be instituted for children as soon as teeth erupt by using fluoride varnish applications. A variety of materials are available and it is important to follow manufacturer’s recommendations. Care should be taken to prevent the ingestion of the fluoride.
Sodium Fluoride **varnish**, which is painted on the teeth, is also available. Patients /guardians are instructed not to brush for the rest of the day and to not let the patient eat or drink for at least thirty minutes following application.

Beginning at two years of age, or as soon as the patient is able to co-operate, standard procedures for brushing on fluoride may be implemented. This early initiation is recommended because research has shown that the surface enamel of newly erupted teeth is not completely calcified and therefore is most susceptible to caries. Periodic professional application of fluoride should continue quarterly, semiannually, or annually depending on the patient’s caries susceptibility and the fluoride system used. Preferably, professional applications should be continued throughout life to maintain cariostasis and reduce dentinal hypersensitivity in exposed root surfaces.

Sodium fluoride, (NaF1), stannous fluoride (SnF2), and acidulated phosphate fluoride (APF) systems for professional application have all been evaluated and approved for safety and effectiveness by the American Dental Association and the Food and Drug Administration.

APF and neutral NaFl gels are available in the clinic and should be carefully **measured so each tray contains no more than 2 ml for small patients and 2.5 ml for larger patients with permanent teeth.** Fluoride gels can also be applied with an applicator or brush. Patients should be instructed not to eat or drink for 30 minutes after application.

For best uptake of fluoride the teeth should be dried carefully prior to application. Application time for topical fluoride should be **four minutes** unless the patient cannot cooperate. Then, a shorter application period and a modified application technique should be used.

Young children and patients who cannot expectorate on request should **not** have a fluoride rinse used and they must be very carefully supervised during topical application to ensure that they do not swallow the fluoride.

**Adults**

Fluoride toothpaste or a prescription topical fluoride agent will be recommended for adults with decalcification, incipient caries, new decay, loss of attachment with exposure of root surfaces, extensive restorative dentistry, orthodontic appliances, xerostomia from radiation therapy or prescription drugs.

Some research indicates that **acidulated phosphate fluoride may not be appropriate** for patients with porcelain restorations, or other esthetics restorations such as bonded or laminated restorations or for patients who have had etching/bleaching procedures.

Patients undergoing radiation therapy of the head and neck must be carefully evaluated before treatment and be put on appropriate topical fluoride therapy to help preserve their teeth.

The fluoride content in wells and city water systems varies greatly in the southern half of New Mexico. Check with the Public Health Department to determine what level of fluoride is in the water. See [http://apps.nccd.cdc.gov/mwf/index.asp](http://apps.nccd.cdc.gov/mwf/index.asp) for additional information.

Professionally applied fluoride treatments **must be fully documented** in the patient’s chart. Include:

- Type of fluoride, (APF, neutral NaFl, etc.) and % ion, e.g., 1.2%;
- Method of application (tray, brush on, etc.);
- Flavor, if applicable;
- Dose (approximate total ml applied); and
- Patient reactions, if any.

**The clinical dentist or clinical coordinator must sign all fluoride prescriptions.** A copy of the prescription for supplemental fluoride or prescription-strength home applications must be attached to the patient’s chart. If prescription fluoride products are dispensed from the clinic, a special fee will be collected from the patient.

For further information on fluoride use, prescription information, etc., see the texts and drug references available in the clinic.

**Sealants**

While the use of fluorides has dramatically reduced smooth surface caries, it has done little to reduce pit and fissure caries. Therefore, the application of pit and fissure sealants is recommended as a preventive measure. Special fees will be charged for sealants.

The following guidelines developed by the U.S. Department of Health Sealant Task Force in 1986, will be used to help determine when sealants should be applied:

- Ideally, patients receiving sealants should be on an appropriate fluoride regimen to reduce the risk of smooth surface caries. However, the absence of optimal fluoride is not a contraindication to the application of sealants.
- Teeth to be considered for sealing include:
  1. Occlusal surfaces of 1st and 2nd primary molars;
  2. Occlusal surfaces of 1st and 2nd premolars and 1st, 2nd, and 3rd permanent molars;
  3. Buccal pits on mandibular molars;
  4. Lingual grooves on maxillary molars;
  5. Lingual pits on maxillary incisors.
- All children and adolescents should receive sealants if they meet the indications described below in the chart: Tooth Criteria for Application of Pit and Fissure Sealants.
- Adults may have sealants if they are at risk for developing lesions in pits and fissures that were previously caries free. This may be true for patients with xerostomia or orthodontic appliances. Sealants would be placed in teeth meeting the criteria described below.
- Before sealants are placed, a diagnosis for caries must be made using visual and tactile evaluation of the dried teeth with a sharp explorer and a mirror. The Diagnodent and the Midwest Caries I.D. may be used to help detect potential caries. Usually, bitewing radiographs are taken to evaluate the teeth for proximal caries. However, if the tooth is newly erupted, it can be assumed that the proximal surfaces are caries free and the tooth may be sealed without taking radiographs.
Tooth Criteria for Application of Pit and Fissure Sealants

<table>
<thead>
<tr>
<th>DO NOT SEAL:</th>
<th>SEAL:</th>
</tr>
</thead>
<tbody>
<tr>
<td>❖ Surfaces with frank caries. These teeth should be restored.</td>
<td>3. Deep, narrow pits and fissures with sound surface enamel or slightly questionable surfaces. No proximal caries.</td>
</tr>
<tr>
<td>❖ Teeth with proximal caries. Patients will be referred to their dentist for restorative care.</td>
<td>4. Sound pits and fissures separated by a transverse ridge from a small carious area may be sealed.</td>
</tr>
<tr>
<td>❖ Broad, well coalesced, pits and fissures.</td>
<td>5. Slightly questionable “sticky” enamel surfaces. Incipient carious lesions are ideal candidates for sealants.</td>
</tr>
</tbody>
</table>

Prior to placing sealants, tooth surfaces should be thoroughly cleaned. Using the Air Powder Polisher is the preferred method of cleaning tooth surfaces prior to etching the teeth. Careful technique must be used following the manufacturer’s directions. A 20-second etch time may be used, as research has demonstrated it is effective.

After placement of sealants the occlusion will be evaluated using articulating paper. “High places” will be adjusted using polishing burs/stones. Sealants should be evaluated for efficacy at each re-care appointment. Sealants placed at the DACC Dental Clinic will be replaced at no charge if they are lost within six months of placement.

Other Preventive Measures
Other preventive measures may be appropriate and will be introduced to students on an individual basis to help meet patient needs.

Dental Hygiene Therapy
A variety of therapeutic procedures are discussed in this section. However, this section is not meant to be all-inclusive. As new procedures are validated in evidence based literature, or become part of nationally recognized guidelines (such as the Center for Disease Control) they will be added.
All therapeutic procedures provided for a patient must be justified by clinical assessments and diagnosis and documented in both the *Treatment Plan* and the *Treatment Notes*.

**Pre-Procedural Rinse**

As an infection control procedure, each patient prior to any intraoral procedure must perform a thorough oral rinse. This may be water or a mouth-rinse. The mouth-rinse may be an over-the-counter product or prescription. Be sure to take the patient’s medical history into account. Non-alcohol rinses are recommended and other rinses must not contain any component that may complicate the patient’s oral or general health. The pre-procedural oral rinse has been documented to help reduce the bacterial count in any aerosols that may be produced. The rinse should be vigorous for 30-60 seconds and be evacuated with a saliva ejector or high-speed suction. The patient should **not** be allowed to expectorate into a sink.

If gross soft deposits are present, the teeth should be brushed and flossed by the patient under supervision and an antimicrobial mouth-rinse should be used (e.g., Listerine or Peridex) before other procedures are implemented.

**Scaling/Root Planning (NSPT)**

Every patient with hard deposits on their teeth will be evaluated for possible scaling procedures SRP/NSPT presented to them as part of the treatment plan, along with the appropriate pain management strategies. If root planning is appropriate, it will be included in the plan.

If the patient refuses to have either scaling and/or root planning procedures completed when they are indicated or they refuse the appropriate pain management procedures, the patient will be referred to other dental professionals for care. Such situations must be thoroughly discussed with faculty and the patient before a referral is made. All such situations must be completely documented in the patient’s record.

There are a variety of electromagnetic instruments that can be used before the use of hand instrumentation. There is a Cavitron JET plus ultrasonic scaler located in each operatory in the clinic. The Symmetry IQ 4000 and the EMS mini Piezon are located with instructions in the cart.

Since we are a teaching institution, all students and faculty will follow best practices. If a patient presents with moderate or severe supragingival and subgingival calculus, the patient will receive a dental hygiene care plan that indicates the appropriate procedures to be followed which might include but not limited to scaling and root planning of one quadrant at a time or SRP of 1-3 teeth at a time as deemed necessary by the student and supervising faculty. It is much desired to proceed with few teeth a time and provide optimal care, rather than debride a full mouth and perform fine scaling at later appointments. Therefore, students will not perform debridement and fine scaling procedures.

Dental hygiene faculty or dentists will evaluate all procedures with special training in dental hygiene or periodontal procedures. Multiple *Clinical Skill Evaluations* and/or *Clinical Competency* forms and evaluation procedures are available for assessment of these procedures.

**Coronal Polish**

Coronal polishing will be performed on a selective basis, depending on the patient’s soft deposits and stain. If tooth brushing and flossing will remove all soft deposits, the patient should remove them under the clinician’s supervision. If deposits cannot be adequately removed using these procedures, a coronal polish will be performed using the least abrasive polishing agent that will accomplish the task.
Either prophy paste with **hand-piece polishing** or **air powder polishing** may be used dependent on the type of stain, type of restoration and the skill level of the clinician. Selection of prophy paste should include consideration for remineralization requirements and the abrasiveness of the materials and its effect on tooth structure and restorations. Remember, air powder polish should NOT be used on porcelain, gold, or other esthetic restorations. Contraindications in the patient’s medical history must be considered due to amount of sodium found in the powder used for polishing.

A coronal polish should be followed by a topical fluoride application to help replenish fluoride in the enamel/root surface. A coronal polish may be performed prior to removing hard deposits in order to improve visualizations of calculus. This may be especially helpful when working with children.

Care must be taken when polishing around orthodontic and other fixed appliances but it is important to remove all plaque and as much stain as reasonable. Disclosing solution should be applied following coronal polish to identify areas that may need to be re-polished. This may be done prior to instructor checkout of the procedure.

**Desensitization**

Dentinal hypersensitivity may be a problem when recession occurs, such as after root planning. It may be triggered by thermal, mechanical, or chemical stimuli. Self-care, including excellent plaque removal using a soft, polished-bristle brush, floss, fluoride dentifrice and/or home desensitizing toothpastes should be recommended as the primary means of controlling sensitivity. Elimination of spicy, acidic and sour foods and minimal use of fermentable carbohydrates may also be recommended.

Professional desensitization may be attempted using a topical application of an agent such as Gel-Kam Root Desensitizer, Protect, or fluoride varnish. Follow the manufacturer’s instructions and document thoroughly in the **Treatment Notes**.

**Appliance Care**

A patient’s removable appliances will be cleaned and polished as part of the prophylaxis and the patient will be taught an appropriate routine for home care of the appliance. While the appliance is out, oral tissues hidden by the appliance should be carefully evaluated and cleaned with a gauze sponge or soft brush.

The following guidelines may be used to help determine an appropriate plan for professional cleaning of oral appliances:

- Prepares all supplies in advance (2 covered trays with 2 zip lock bags - one with stain and tartar remover, and one with diluted mouthwash, denture brush)
- Wear protective clothing, gloves, masks, and glasses when working with removable appliances.
- Give the patient a tissue and ask him/her to remove the appliance.
- Carefully inspect the appliance for damage, loose teeth, cracks etc. and report these to the faculty. Place the appliance in the zip lock bag containing stain and tartar remover and zip the bag closed. The bag is then placed on a tray and carried to the sterilization area while wearing PPE.
- Place the sealed bag into the appliance ultrasonic containing water, submerging the majority of the zip lock bag into the ultrasonic cleaner and leaving zip seal section hanging over edge of ultrasonic cleaner. **[The machine to be used is identified for appliance cleaning only]**. Place the lid on the machine and turn the ultrasonic on for about 8-10 minutes.
- Return to sterilization area with second tray containing zip lock with mouthwash. Inspect appliance for
compelte stain and tartar removal- complete a second run through the ultrasonic if needed. Remove zip-lock bag from the ultrasonic unit and discards tartar/stain remover down the sink and sip lock bag in regular trash. Rinse thoroughly under tepid running water (placing towels in the sink or filling the bottom of the sink with water decreases the chance of damage if the appliance is accidentally dropped). Use a clean denture brush to remove any remaining debris. (The denture brush may then be given to the patient after thorough rinsing.)

- Place the appliance and denture brush in zip lock bag of mouthwash to store it until it can be replaced in the patient’s mouth. (Denture brush is given to patient in zip lock to take home at no charge.)

- Prior to returning appliance to patient inspect all oral tissues adjacent to the appliance. Rinse the appliance with clear water prior to placement in the mouth.

- Review and educate patient on appliance home care.

**Adjunctive Dental Hygiene Services**

**Antimicrobial Applications**

Topical applications of antimicrobials may be indicated when the patient presents with periodontal infections. These require a dentist’s prescription, which must be noted and signed off in the patient’s chart.

Antimicrobials may be applied with a syringe, an oral irrigator or other device. Research provides no definitive guidelines for in-office antimicrobial use. Determination for the use and type of irrigant or other type of vehicle (chip, microsphere, etc.) will be made on an individual basis through consultation between faculty, student and patient. There are various antimicrobial agents available in the clinic. Mixing and application directions are located with the agents.

Localized delivery of antimicrobial agents may be indicated in areas that do not respond to typical dental hygiene therapy. In other words, these agents are not utilized until the patient has completed all initial therapy and it is determined that specific periodontal sites require additional therapy. This assessment usually happens at the six-week re-evaluation appointment.

The antimicrobial agents must be prescribed by dentists and then placed only after discussion with the patient about risk/benefits and fees. Initially, faculty will closely supervise use of these products. The guidelines below should be followed.

- The area to be medicated should be carefully evaluated for its periodontal condition **after appropriate healing time following dental hygiene treatment** and for access for the type of local antimicrobial being considered for placement.

- The patient’s medical history must be evaluated for contraindications to the medication.

- Manufacturer’s directions for placement must be followed

- Procedure must be documented including: diagnosis of the periodontal condition presenting at time of placement of the medication; type of medication used; technique used; any complications which may have occurred; date and signatures of student and attending faculty.

**Margination**

Overhanging restorations collect plaque and pose a threat to periodontal health. Therefore, all patients will be evaluated for the need to have existing restorations marginated, or replaced, to help maximize the effectiveness of plaque control measures the patient performs.
Visual, tactile, and radiographic evaluation will be used. If the restoration requires replacement or the margination is beyond the skill level of the student clinician, the patient will be referred to his/her dentist.

**Margination is indicated for:**
- Overhanging proximal or other margins on amalgam restorations that are intact with no recurrent caries, fractures, or voids;
- Over-contoured, bulky contact areas and occlusal/gingival embrasure areas of amalgam restorations;
- Overhanging margins and over-contoured surfaces of composite restorations;

**Contraindications for margination procedures include:**
- Caries, fractured restorations, and voids at the margin of the restoration;
- Restorations with large overhangs and extremely bulky restorations generally need to be replaced because they are time-consuming to recontour and often present other problems during the margination procedure;
- Laminates, gold and bonded restorations will NOT be marginated due to the potential for removing the restoration or for damaging it beyond repair.

**Implant Care**
Dental implants require special care to maintain them calculus and plaque-free. There are a variety of different types of dental implants. Some are titanium alloys; others are metal with ceramic or hydroxyapatite coating, while others are made of different, unique materials. The systems used for implanting the apparatus into bone and for attaching the superstructure of dental appliances are varied and complex.

If a patient presents with a dental implant, the following guidelines may be used to help plan appropriate therapy:
- If possible, contact the clinician who placed the implant to help determine the type of appliance used and the correct procedure for proper maintenance.
- If it is not possible to discuss maintenance procedures with the clinician responsible for the implant, attempt to determine the type of implant placed by discussing it with the patient and completing a visual examination. Then, follow the manufacturer’s directions and/or the following suggestions for care.
- **Examination:** The condition of the implant and the surrounding tissue should be evaluated and recorded at each maintenance visit. Criteria for implant success include:
  - No clinical mobility;
  - No radiographic evidence of peri-implant radiolucency;
  - No pain, infection or parathesia;
  - Implant is useful for prosthesis.

Visual examination should evaluate peri-implant tissue for signs of inflammation: changes in color, size,
shape, and consistency.

**Probing may be contraindicated for certain implants.** If it is not, it should be done very gently to determine bleeding tendencies. A plastic probe is available.

Disclosing for plaque is permitted and the gingival surface of the prosthesis should be included in the plaque evaluation.

- **Radiographs:** It is suggested that radiographs be taken every three months after initial placement of the implant. After the first year, radiographs should be taken once every twelve months. Additional diagnostic radiographs should be obtained more frequently if the implant exhibits mobility.

- **Instrumentation/Polishing:** The use of metal instruments, sonic and ultrasonic instruments, and air-polishing devices are generally contraindicated due to the potential for scratching or marring the surface of the implant. Vibrations produced with sonic/ultrasonics may dislodge the dental implant from the bone. However, some research has suggested use of a modified plastic tip in an ultrasonic unit as a means of successfully cleaning certain types of implants.

Plastic or titanium hand instruments (which are available in the clinic) can be used to remove calculus and a wooden tip porte polisher or floss and non-abrasive polishing agent may be used to remove stain from most types of implants.

If the implant has a perimucosal tissue ring that can be removed, it may be cleaned in the ultrasonic cleaner and replaced. The implant prosthesis and all natural teeth should be scaled and polished using routine procedures to remove calculus and stain.

- **Self-Care:** Meticulous plaque removal must be accomplished on a daily basis. Removable dentures or partials may be cleaned in the usual manner, with care being taken not to scratch or mar the surface.

Posts, abutments or other protruding portions of the implant must be carefully cleaned without damaging either the appliance or the surrounding tissue. Soft, smooth, tip-rounded toothbrushes may be used and are usually further softened with warm water. Floss, tufted-floss, gauze, yarn, wooden tips or smooth plastic tips may be used. Implements without wire components, such as interdental brushes or pipe cleaners, may also be used.

- Oral irrigators may be used to help clean around implants.
- Antimicrobial rinses may be used when implants are present.
- Topical fluoride may be applied directly to adjacent remaining natural teeth and will not adversely affect the implant. The implant itself does not benefit unless stannous fluoride is used as an antimicrobial.

- **Maintenance Schedule:** Immediately following placement of implants, a series of weekly evaluation appointments is scheduled to follow healing and patient compliance with home care. Once these are
stabilized, maintenance appointments are scheduled at one- to three-month intervals for the first year postoperatively. After that, three-to six-month intervals may be scheduled, depending on the patient’s periodontal condition. Students and faculty are expected to review these schedules with patients and encourage compliance.

**Mouth Guards**
Plastic mouth guards may only be made for patients requiring protection during athletic activities. A dentist must evaluate the patient for contraindications to the procedure and evaluate the fit of the appliance at the time of delivery. A *Parental Release* form is required and special fees will be charged for appliances. Fees must be paid **before** the appliance is given to the patient. (See the *Fee Sheet* in Section 15: Clinic Business Operations). Information about procedures for making mouth guards during special clinics where the patient is a “limited care patient” along with appliance care information and special treatment notes using during these clinics.

**Night Guards**
For the management of bruxing or clenching **will not** be part of DACC services these require continuous monitoring by the treating dentist.

**Polishing Restorations**
Amalgam restorations may benefit from surface polishing or re-contouring to minimize plaque retention or occlusal interferences. If polishing procedures are implemented proper personal protective barriers must be worn during the procedure and high-speed suction should be used to help minimize aerosols in the environment.

Amalgams may be polished with finishing burs, shofu cups, pumice or other polishing agents such as tin oxide or amalgloss.

Tooth-colored restorations should be polished only with appropriate agents selected according to the type of material in the restoration. Shimmer polish and tin oxide are available.
Faculty must evaluate the restoration prior to and following the polishing procedure and it must be well documented in the *Treatment Notes*.

**Tooth Whitening**
Senior students who have met clinical requirements may perform tooth-whitening procedures on DACC patients of record following completion of dental hygiene therapy. If a patient is not of DACC record the patient must present to DACC with a prescription from their regular dentist and it must include the information of the last dental hygiene therapy. (The dental hygiene therapy must be within 3 months of visit for whitening services.) It is important to discuss the risks and benefits and special fees associated with the procedure with the patient before commencing with the procedure.
A special patient information form and consent form must be completed. Student must follow the Tooth Whitening checklist that requires several faculty signatures.

All tooth whitening product manufactures’ recommendations must be followed carefully and appointments for follow-up evaluation should be made with the patient.
Post-Operative Care
Post-operative care should be provided following procedures that require special follow up by the patient, such as root planning, treatment of Acute Necrotizing Ulcerative Gingivitis or periodontal abscess, suture placement or any other procedures that may require special care to ensure proper healing.

When providing post-operative care, consider the following as part of a treatment regimen:

- Gentle but thorough plaque removal;
- Soothing rinses (warm water mixed with salt or baking soda);
- Application of topical antiseptic or antibiotics as a swab, irrigation or rinse;
- Systemic antibiotics;
- Pain relief;
- Control of hemorrhage;
- Control of dentinal hypersensitivity;
- Alterations in nutritional intake or diet consistency.

Preferably, instructions should be given in written form. All recommendations should be documented in the patient’s chart.

Suture Removal
If any patient requires sutures, qualified faculty will place them. If a patient requires the removal of sutures, a student clinician may remove them, after faculty evaluates the area for proper wound healing.

Prescriptions/Dispensing Drugs
Clinical dentists may dispense prescriptions for patients. Pre-typed forms developed by manufacturers of prescription compounds used for dental hygiene therapy or by phone calls to a pharmacy. A copy of the prescription must be placed in the patient’s chart and/or a complete rotation of the prescription called in must be entered in the Treatment Notes.

Certain prescription drugs, Peridex, and prescription-strength fluoride, are kept in the clinic for direct dispensing. Neither antibiotics nor prescription pain relievers are kept in the clinic. When these drugs are dispensed, a prescription must be completed and a copy placed in the chart. A notation must be entered in the patient’s Treatment Notes.

In 2012 the New Mexico legislation expanded the scope of practice for licensed Dental Hygienist to include limited prescriptive authority. Therefore it will be important for students to learn as much as possible about pharmacology and prescription writing.

Prescription (Rx) Writing Protocol
1. Student is to review chart and determine need for the prescription, EG antibiotic premedication, fluoride, etc. Student will research and determine the correct prescription.
2. Student will present to the Dr. for review.
3. Dr. will ensure the Rx is correct and approve by signing the Rx in Eaglesoft.
4. Student will either:
   - Call in the Prescription under the supervision of the Dentist:
     - Rx itself will be annotated with
       - Date Rx was called in.
       - The name of the pharmacy to which the Rx was called in.
       - The phone number of the pharmacy.
       - The signature of the student who called in the Rx.
       - The annotated Rx will be kept in the chart.
   - Give the Rx to the patient when a pre-typed prescription is used.
     - A copy of the prescription will be kept in the chart.
5. Student will annotate the Treatment Notes with:
   - Date of the note entry and the date of the Rx.
   - Whether the Rx was called in or given to the patient.
   - Name and phone # of pharmacy if the Rx was called in
   - Rx: Name of the Drug and dosage unit (mg) or (mg/ml for liquids).
   - Disp: Quantity dispensed (number of tablets or ml of liquid).
   - Sig: Directions to the patient.
   - Refill: number of refills allowed.
   - Name of the Rx Dr.
   - **Student and Dentist signature must be entered in the Treatment Note.**

See the Clinic **Unit Reference Notebook** for additional details on prescription writing.

**Re-Evaluation and Re-care Maintenance**
At the completion of active therapy an evaluation will be made to determine the appropriate interval for an appointment for Re-evaluation and Recare Maintenance. Re-evaluation appointments are made 2 to 6 weeks following completion of active therapy. These appointments are to evaluate such things as plaque control and/or healing of soft-tissues at the Re-evaluation appointment. Additional educational and/or treatment may be provided. Once the patient self-care and oral conditions are under control the patient will be scheduled for Recare Maintenance appointment. **Intervals between active and maintenance phases of therapy must be based on scientific rationale, patient motivation and needs, NOT on tradition.**
The “active phase” of dental treatment may be considered complete when healing of periodontal tissues has occurred, optimal tissue health has been achieved, plaque control is maintained and other oral disease such as caries is under control.

Intervals of two to four months may be necessary for periodontally involved patients, medically compromised patients, patients with special oral conditions (caries, orthodontic appliances, etc.) and patients with poor plaque control.

Three to six months may be appropriate for patients with good plaque control and well-controlled periodontal conditions or other oral conditions.

Re-care intervals must be noted in Foliotek on the Case Management forms and in the Treatment Notes of the patient chart.

**Objectives**

Maintenance appointments are to prevent oral disease in healthy patients and continue therapy for patients who have been treated for periodontal and other oral diseases. Other objectives include the maintenance of plaque control, the opportunity to evaluate results of active treatment and to implement additional treatment such as additional root planing, desensitization, and reinforcement/continuation of education.

**Procedures** will vary at maintenance intervals. However, the following would be standard:

- Update medical/dental history;
- Review radiographs or secure new films for evaluation;
- Update intra-oral and extra-oral evaluations;
- Reevaluate dental conditions;
- Complete periodontal evaluation including gingival assessment and periodontal charting;
- Review plaque evaluation and home care regimen;
- Full-mouth scale, root plane and curettage if indicated and polish as needed;
- Provide additional adjunctive therapy as needed;
- Establish new interval for maintenance/supportive therapy;
- Refer for periodontal, restorative or other care as needed.
SECTION 13. PAIN CONTROL & ANXIETY MANAGEMENT

Introduction
To maximize patient comfort and minimize stress and anxiety all patient must be evaluated for the benefits and risks of using local anesthesia and/or nitrous oxide sedation. Local anesthesia will be used as a pain management strategy whenever it is indicated. Nitrous oxide/oxygen sedation will be used only for anxious patients. A careful evaluation of the patient’s medical/dental history must be accomplished at each visit. Vital signs must be taken and recorded before local anesthetic or nitrous oxide is administered.

Health Professional CPR Certification is required prior to administration of local anesthetics. Students must have successfully passes their CSE for specific injections on a student partner in the Pain and Anxiety Control course prior to performing that injection on a patient. Three successful procedures in nitrous oxide/oxygen sedation are also required prior to using it on clinical patients. Certified faculty will closely supervise Nitrous Oxide sedation procedures on all occasions. A faculty instructor will closely supervise all injections administered by students until competency has been established both didactically and clinically as evidenced by successful completion of the Pain and Anxiety Control course DHYG 218-219 and passing the WREB local anesthesia written exam. Copies of student’s local anesthesia certificates must be maintained on file in the Program Director’s office.

Local Anesthetic
Selection of anesthetic shall be based on the following criteria:

- Length of time for which pain control is necessary – this includes not only the duration of the procedure but also any postoperative pain control needed.
- The need for hemostasis.
- Absolute and relative patient contraindications to local anesthetics, vasoconstrictors, and/or preservatives used in dental local anesthetics.
  - Absolute contraindications – true, documented reproducible allergy
  - Relative contraindications:
    - Atypical plasma cholinesterase – ester anesthetics contraindicated. Use amide local anesthetic
    - Methemoglobinemia – Prilocaine contraindicated
    - Significant liver dysfunction (ASA III or IV) – Amide local anesthetics may be used judiciously
    - Significant renal dysfunction – (ASA III or IV) - Amide local anesthetics may be used judiciously
- Significant cardiovascular disease – Avoid epinephrine if possible. Epinephrine may be used if the total epinephrine dose does not exceed 0.04 mg. For a concentration of 1:100,000 epi., this corresponds to a maximum of 2 carpules (1.8ml/carpule).
- Clinical hypothyroidism (ASA III or IV) – avoid epinephrine
- Cardiac dysrhythmias unresponsive to medical therapy – epinephrine and other catecholamines may provoke further cardiac irritability leading to potentially more serious, possible lethal dysrhythmias. Therefore epinephrine should be avoided in patents with unresponsive cardiac dysrhythmias.
- Hypertension – patients with systolic > 200 mm Hg or diastolic > 115 mm Hg shall not receive elective dental care and receive a referral for an immediate medical consultation.
- Pregnancy – represents a relative contraindication to elective dental care, particularly during the first trimester. Local anesthetics and vasopressor are not to be used on patients within the clinic. Patients who are nursing shall not receive local anesthetics with vasoconstrictor due to its FDA lactation category of NS (not safe for nursing infants; medication contraindicated or requires cessation of breast-feeding) Pregnant and/or lactating patients needing local anesthesia shall receive:
  - Lidocaine without epinephrine.
    - FDA pregnancy category B – (caution advised) animal studies show no risk or adverse fetal effects, but controlled human first trimester studies not available. Fetal harm possible but not likely.
    - Lactation category of S – safe for nursing infant; medication usually compatible with breast-feeding
- Drug-Drug interactions:
  - Tricyclic antidepressants (TCA’s) – There is an increased risk of hypertensive crisis due to the interaction of TCA’s and vasoconstrictors. *Norepinephrine and levonordefrin shall be avoided in patients receiving TCA*. Epinephrine may be used if the total epinephrine dose does not exceed 0.05 mg. For a concentration of 1:100,000 epi, this corresponds to a maximum of 2 carpules (1.8ml/carpule). TCA’s include but not be limited to the following:
    - Amitriptyline (Elavil)
    - Nortriptyline (Aventyl, Pamelor)
    - Imipramine (Tofranil)
    - Doxepin (Sinequan)
    - Amoxapine (Asendin)
    - Desipramine (Norpramin)
    - Protriptyline (Vivactil)
Clomipramine (Anafrnil)

- Nonselective β-blocker- There is increased risk of hypertensive crises combined with reflex bradycardia. Vasopressor containing local anesthetics should be avoided in patients taking nonselective β-blockers.

If vasopressors are necessary, epinephrine may be administered if the total epinephrine dose does not exceed 0.04 mg. For a concentration of 1:100,000 epi, this corresponds to a maximum of 2 carpules (1.8 ml/cartridge). Preoperative vital signs shall be recorded and vitals shall be monitored every 10 minutes after administration of local anesthetic for a minimum of 90 minutes.

- Cocaine – there is significant risk of myocardial ischemia, potentially lethal dysrhythmias, myocardial infarction, or cardiac arrest in patients with high cocaine blood levels when a local anesthetic containing a vasopressor is accidentally administered intravascularly. Whenever possible, local anesthetics containing vasopressor should not be administered to patients who have used cocaine within the last 24 hours.

- Unusual genetic or acquired medical and/or mental conditions must be carefully researched to determine if local anesthetics are contraindicated.

Monitoring
All patients receiving local anesthesia shall be continuously monitored and will NOT be left unattended.

Stress Reduction
Stress reduction protocols will be followed throughout treatment.

- Sedation if necessary and prescribed by the attending dentist – typically the evening before and the morning of the dental appointment.
- Effective pain control
- Iatrosedation techniques
- Morning appointments for severely apprehensive patients
- Limit appointment duration in accordance with the patient’s tolerance level
- Provide a calm, cool and comfortable atmosphere
- Proper postoperative pain control

Topical Anesthetics
The use of topically applied local anesthetics is an important component of the Pain Control armamentarium. Conventional topical anesthetics are unable to penetrate intact skin but do diffuse through abraded or compromised skin (e.g. sunburn) or any mucous membranes.

The concentration of a local anesthetic applied topically is typically greater than the same anesthetic administered by injection. The higher concentration facilitates diffusion of the drug through the mucous membrane. Higher concentration also increases the risk of toxicity, both locally to the tissues and systemically. Because topical anesthetics do not contain vasoconstrictors and local anesthetics are inherently vasodilators,
vascular absorption of some topical formulations is rapid, and blood levels may quickly reach those achieved by direct IV administration. The base forms of Benzocaine and Lidocaine are slowly absorbed into the cardiovascular system and therefore are less likely to produce an overdose reaction.

**Benzocaine** is the most popular topical anesthetics. It is an ester local anesthetic. The likelihood of occurrence of allergic reactions to esters is significantly greater than that to amide topical anesthetics. Because Benzocaine is not absorbed systemically, allergic reactions usually are localized to the site of application.

**Lidocaine**, an amide, possesses topical anesthetic activity in clinically acceptable concentrations. The risk of overdose with amide topical anesthetics is greater than that with the esters and increases with the area of application. Unmetered sprays of topical anesthetics are potentially dangerous and are not to be used in this clinic. Metered sprays that deliver a fixed dose with each administration, regardless of the length of time the nozzle is depressed, are preferred.

As a rule, topical anesthesia is effective only on surface tissues (2 to 3 mm).

For effectiveness, topical anesthetic should be applied for 2 minutes. Topical anesthetic applied according to the manufacturer’s instructions (approximately 10 to 15 seconds) has no greater value than that of a placebo. **Oraqix** is a non-injection intra-pocket anesthetic commonly used for periodontal scaling/root planing procedures. It provides anesthesia after an application time of 30 seconds, with duration of action of about 17-20 minutes. Generally, subgingivaly applied topical anesthetics (Oraqix) do not cover broad surface areas, so the risk of toxicity is decreased. However, Oraqix contains both active ingredients lidocaine and prilocaine base (25 mg/g of each substance). Consequently, clinicians should use caution when using this form of anesthesia and ensure that appropriate dosages are calculated.

**Complications**

**Local complications**

A number of potential local complications are associated with the administration of local anesthetics

- **Needle breakage**

**Prevention**

- Use the largest appropriate gauge needle, 25 or 27 gauge for Inferior Alveolar Nerve Block, Posterior Superior Alveolar, and Infraorbital Block. Use 27 or 30 gauge for Middle Superior Alveolar, Anterior Superior Alveolar, and Incisive Block injections.
- Use a long needle for injections greater than 18 mm
- Do not intentionally bend a needle.
- **DO NOT HUB A NEEDLE**
- Do not redirect a needle that is fully inserted into the tissue
Management

Remain calm

♦ Notify Faculty immediately
♦ Instruct patient not to move – do not remove your hand from the patient’s mouth, keep their mouth open. If possible place a bite block
♦ If the fragment is visible have an instructor try to remove it with a small hemostat
♦ If the needle is lost

- Inform the patient and allay fears
- Note the incident in the chart
- Keep the remaining needle fragment
- Perform a panoramic radiograph
- Refer the patient to an oral surgeon for consultation
- Have business office administrator notify insurance carrier immediately

- **Persistent anesthesia or paresthesia Prevention**
  - Strict adherence to injection protocol and proper care and handling of dental anesthetic cartridges minimize the risk of paresthesia. Nevertheless, cases of paresthesia may still occur despite care taken during injection

Management

Most paresthesias resolve within 8 weeks without treatment.

Reassure the patient

- Patient should be asked to come in for consultation with the attending dentist if possible.
- Ensure that the patient has spoken directly with the attending dentist.
- Explain that paresthesia is not uncommon.
- The attending dentist shall examine patient.

- Reschedule for reexamination by the attending dentist every 2 months as long as the deficit remains.
- If deficit remains after 6 months, refer to an oral surgeon for consultation.
- Dental treatment may continue, however avoid readministration of local anesthetic into the region of the previously traumatized nerve.

  - **Facial nerve paralysis**
Prevention

- Transient facial nerve paralysis is almost always preventable by adhering to protocol with the inferior alveolar nerve block. A needle tip in contact with the bone on the medial aspect of the ramus before deposition of local anesthetic solution virtually precludes the possibility that anesthetic will be deposited into the parotid gland during an IA nerve block.

Management

- **Trismus**

Prevention

- Within seconds to minutes after deposition of local anesthetic into the parotid gland, the patient senses a weakening of the muscles on the affected side of the face.
- Reassure the patient. Explain that the situation is transient, will last a few hours, and will resolve without residual effect.
- Contact lenses should be removed from the patient until muscular movement returns.
- An eye patch should be applied to the affected eye until muscle tone returns.
- Record incident on patient’s chart.
- Forgo further dental care at this appointment and until muscular movement returns.
- Use a sharp, sterile, disposable needle.
- Properly care for and handle local anesthetic cartridges.
- Use aseptic technique. Contaminated needles shall not be used. Change contaminated needles out immediately.
- Practice atraumatic insertion and injection technique.
- Avoid repeat injections and/or multiple insertions into the same area.
- Use minimum effective volumes of local anesthetic

Management

- Arrange an appointment for examination of the patient.
- In the interim, prescribe;

Warm saline rinses

1 tsp salt to 12-oz warm water held in the mouth on the involved side and then spit out Hot moist towels to the affected area 20 min every hour
Analgesics

Ibuprofen: 800 mg is usually sufficient. Muscle relaxants if necessary. Diazepam, 10 mg bid (twice daily)

- Record the incident and any therapy prescribed in the patient’s chart.
- If pain and dysfunction continue unabated beyond 48 hours, consider possibility of an infection and add antibiotics to the treatment regimen.

**Soft tissue injury**

**Prevention**

- Use a local anesthetic of appropriate duration.
- Warn the patient and guardian against eating or drinking anything hot and against biting on the lips and tongue.
- A self-adherent warning sticker should be used on children.
- A cotton roll may be placed between the lips and teeth. Secure the roll with floss wrapped around the teeth to prevent aspiration.

**Management**

Management of the patient with self-inflicted soft-tissue injury secondary to lip or tongue biting or chewing is:

1. Analgesics as needed for pain
2. Antibiotics as necessary if infection results
3. Lukewarm saline rinses to aid in decreasing any swelling that may be present.
4. Petroleum jelly or other lubricant to cover a lip lesion and minimize irritation.

**Hematoma**

**Prevention**

- Be aware of the normal anatomy.
- Modify injection techniques as dictated by the patient’s anatomy (i.e. decrease the depth of penetration in a patient with smaller facial characteristic).
- Use a short needle for the PSA nerve block to decrease the risk of hematoma.
• Minimize the number of needle penetrations into tissue.

• Never use a needle to probe the tissue.
Management

The PSA nerve block usually produces the largest and the most esthetically unappealing hematoma. The infratemporal fossa, into which the bleeding occurs, can accommodate a large volume of blood. When swelling becomes evident direct pressure should be applied to the site of bleeding for not less than 2 minutes.

**IA** – pressure is applied to the medial aspect of the mandibular ramus.

**ASA** – pressure is applied to the skin directly over the infraorbital foramen.

**Incisive** – pressure is placed directly over the mental foramen.

**Buccal** – Place pressure at the site of bleeding.

**PSA** – Digital pressure can be applied to the soft tissues in the mucobuccal fold as far distally as can be tolerated without eliciting the gag reflex. Apply pressure medially and superiorly. It is difficult to apply pressure to the site of bleeding because of the location of the involved blood vessels. The PSA artery, the facial artery, and the pterygoid plexus are located posterior, superior and medial to the maxillary tuberosity. Bleeding usually ceases when the external pressure on the vessels exceeds the internal pressure or when clotting occurs.

- Note the hematoma in the patient’s chart.
- Advise the patient about possible soreness and trismus.
- Prescribe analgesic if necessary for soreness – Ibuprofen 800 mg is usually sufficient.
- Prescribe ice applied to the region immediately on recognition of the developing hematoma.
- DO NOT prescribe heat to be applied to the area for at least 4 – 6 hours.
- Prescribe “tincture of time” (usually resolves in 7 – 14 days).

### Infection Prevention

- Use only sterile disposable needles.
- Properly care for and handle needles to avoid contamination.
- Properly care for and handle anesthetic cartridges.
- Use cartridges only once.
- Store cartridges in original container until use.
Management

Prescribe antibiotics
PenV 500 mg, 41 tabs, T stat (Statim or immediately) then T QID (quarter in die or four times a day) until gone
Clindamycin 300 mg, 41 tabs, T stat then T QID until gone. (If patient is allergic to Penicillin) Begin treatment for trismus, if necessary

- **Post anesthetic intra-oral lesions**

Prevention

Unfortunately, there is no means of preventing these intraoral lesions from developing in susceptible patients

Management

Primary management is symptomatic. Pain is the major initial symptom developing approximately 2 days after injection.
Consider:
Viscous Lidocaine
Equal mixture of Diphenhydramine and milk of magnesia rinsed in the mouth to coat the ulcerations Orabase paste
Zilactin applied topically

Analgesics
- Note lesions on patient’s chart.
- Reassure the patient that the situation is not due to a bacterial infection secondary to the local aesthetic solution but is in fact an exacerbation of a process that was present in latent form in the tissues before the injection.

Systemic Complications

Adverse drug reactions generally fall into three categories.

1. **Overdose** the signs and symptoms, which manifest as a result of an absolute or relative over-administration of a drug leading to elevated blood levels.

2. **Allergy, which is a hypersensitive state,** acquired through exposure to a particular allergen, re-exposure to which brings about a heightened capacity to react.

3. **Idiosyncrasy** which is a qualitatively abnormal unexpected response to a drug differing
from its pharmacological actions and thus resembling hypersensitivity

- **Overdose**
- **Prevention**
  - Do not exceed the maximum MRD (Minimal Reacting Dose) based upon the patient’s weight, age, health and the drug being used
  - Be aware of, and reduce dosages as needed, when other medications are concomitantly being taken which can increase blood levels of local anesthetics
    
    Meperidine (Demerol)
    Phenytion (Dilantin) Quinidine
    Despramine Cimetidine

  - Aspirate in at least two planes before injection to prevent intravascular injection.
  - Inject slowly – The rate at which a drug is injected is the single most important factor in preventing overdose. Under no circumstances should the rate of drug deposition be less than 60 seconds for a 1.8 ml cartridge
  - Use vasoconstrictors whenever possible and indicated.

**Management**

- **Position**

  Unconscious – supine with feet elevated slightly
  Conscious – based on patient comfort

- **Circulation**

  Unconscious – assess and provide external cardiac compression if necessary
  Conscious – assess circulation

- **Airway**

  Unconscious – assess and maintain airway
  Conscious – assess airway

- **Breathing**

  Unconscious – assess and ventilate if necessary
  Conscious – assess breathing

- Reassure the patient if conscious
• Protect patient during the potential convulsive phase 5-15 mg diazepam IV if convulsive period is prolonged

• Monitor and record vital signs

• Administer oxygen (10L/min)

• Treat bradycardia with Atropine 0.4mg IV [with Advanced Cardiac Life Support (ACLS) training]

• Transport to emergency room – if patient becomes unconscious activate EMS by calling 911.

### Allergy

### Prevention

• Properly review the medical history and never use any drug to which a patient claims to be allergic until the allergy can be absolutely disproved.

• Questions for the Patient with an alleged allergy to local anesthetics
  1. describe your reaction – itching, hives, faint, dizzy, lightheaded, perspiration, shaking, palpitation
  2. How was your reaction treated? - epinephrine, histamine blocker, corticosteroid, oxygen, spirits of ammonia, no treatment necessary
  3. What position where you in at the time of the reaction? – supine, upright, partially reclined
  4. what is the name, address, and telephone number of the doctor in whose care you were under when this reaction occurs

### Management

• **Assume that allergy exists. Do not use local anesthetics until allergy has been absolutely disproved**

• Elective dental treatment requiring local anesthesia should be postponed until a thorough evaluation of the patient’s “allergy” is completed.

 Suspected allergy

-Refer patient for consultation with their physician for allergy testing. Inhalation sedation with nitrous oxide and oxygen is an acceptable alternative until this is completed. Acute pain should be managed with oral analgesics and infection with oral antibiotics

 Confirmed allergy

-If the allergy is limited to ester anesthetics, amide anesthetics may be used provided they do not contain a paraben preservative which is closely related to the ester (no dental cartridges manufactured in the U.S. since Jan 1984 contains methylparabens)

-If, in the extremely unlikely case, a documented allergy to an amide local anesthetic exists, other amide
local anesthetics may be employed because cross-allergenicity between amide local anesthetics does not occur.

-On occasion, it is reported that a patient is “allergic” to all ‘caine’ drugs. Such a report should provoke close scrutiny and the method by which this conclusion was reached should be reexamined.

Mild reaction

- Administer oral Diphenhydramine (25-50 mg)
- Repeat dose q6h (every 6 hours) for 2 days
- Patient should remain in the clinic under observation for 1 hour before discharge to ensure that the reaction does not progress.

Severe reaction

- Activate the Emergency Medical System (EMS) by calling 911
- Administer epinephrine 0.3 mg SC or IM
- Repeat every 5-10 min prn
- Administer oxygen (10 L/min)
- Monitor and record vital signs
- Perform Basic Cardiac Life Support (BCLS) if needed

Idiosyncrasy

- This describes a qualitatively abnormal, unexpected response to a drug. An example is stimulation that occurs in some patients after administration of a CNS-depressant. Unfortunately, it is virtually impossible to predict which persons will have such reactions or the nature of the resulting idiosyncrasy.
- It is thought that virtually all instances of idiosyncratic reaction have an underlying genetic mechanism. These aberrations remain undetected until the individual receives a specific drug.

Management

Specific management of idiosyncratic reactions is necessarily symptomatic. Position, Circulation, Airway, Breathing, and Definitive care

Documentation

All local anesthesia procedures will be fully documented in the patient’s record, including:

- Date and Time of administration
- Pre operative and post operative vital signs (including Blood Pressure (BP), Pulse, Respiration, and Weight)
Injection (i.e. IANB, PSA etc.)

- Needle used (gauge and length)
- Type of anesthetic administered and concentration (i.e. 2% Lidocaine)
- Vasoconstrictor used and concentration (i.e. 1:100,000 epi)
- Dose in mg
- Patient’s reaction (i.e. normal or any adverse reaction noted)

**Nitrous Oxide/Oxygen Sedation**

The following guidelines for patient selection, administration, monitoring, and recording the use of nitrous oxide/oxygen (N2O+O2) analgesia will be followed.

**Patient Selection**

- Determine patient’s need for conscious sedation.
  - Review medical history to determine conditions that may **contraindicate** use of Nitrous Oxide and Oxygen conscience sedation. These include:
    - Chronic obstructive pulmonary diseases (e.g., emphysema, chronic bronchitis or any patient with hypoxic drive)
    - Pregnant patient: Pregnant patients needing N2O will be given a referral to be treated at another clinic
    - Pregnant clinicians will not be administering N2O to a patient that needs it: the patient will need to be referred to another clinician
    - Patients with cystic fibrosis may incur bullae as a complication of the disease. Because of the expansive nature of nitrous oxide, it is contraindicated in this case
    - Current upper respiratory tract infection (Head cold, nasal obstruction)
    - Current or recovering substance abuse
    - Inability to communicate/follow instructions (e.g., very young children, mentally disabled)
    - Psychologic impairment.

The patient will be asked to sign a consent form.

**Monitoring**

All patients receiving nitrous oxide and oxygen sedation shall be continuously monitored and will NOT be left unattended.

**Documentation**

All nitrous oxide procedures will be fully documented in the patient’s record, including:

- Date and Time
- ASA Classification
- Indication for nitrous oxide
- Preoperative and postoperative vital signs (including BP, pulse, respirations, SPO2)
- Patient’s tidal volume (L/min)
- Peak % of nitrous oxide delivered (%)
- Time postoperative 100% Oxygen was delivered (min)
- Recovery (pt comments)
- Adverse Reactions/Comments

Preparing the N2O + O2 Unit
- Check-out equipment with the Clinic Lab Manager.
- Equipment is located across from Operatory #1.
- Forms with the tanks need to be completed. Determine that tanks are full and there is a back-up tank of oxygen available.
- The preoperative and postoperative pressures on the “In Use” tanks should be checked and recorded on the “In Use” card
- Nitrous oxide units shall not be used without the scavenger system properly attached, operating and adjusted.

Administration of Nitrous Oxide
- In order to adequately titrate the dosage, a full minute shall expire between each dosage change.
- Patients shall never be left unattended while being administered nitrous oxide.
- All patients will be given a postoperative oxygenation period following the termination of nitrous oxide flow. The patient will receive pure oxygen for 5 minutes after Nitrous Oxide has been turned off.

Nitrous Oxide Unit Clean-Up
- Grey autoclavable masks will be properly bagged and autoclaved for reuse. Disposable masks will be placed in a ziplock bag with the patient’s name and given to the patient. Patients will be instructed to bring the mask back if they are planning to receive nitrous oxide sedation at another visit.
- Check tanks for pressure of gas left in each. Arrange for reordering, if necessary.
SECTION 14. STUDENT EVALUATION

Philosophy of Grading/Evaluation
Grading and evaluation give both student and faculty a measure of skill and knowledge development. They also give faculty a means to provide input that should be helpful in students’ professional growth and development.

This program is based on the philosophy that the quality of dental hygiene care must be of the same high
standard regardless of who provides the care. Therefore, the goal is to develop competent dental hygienists; people who are well qualified to practice their profession because they have mastered the necessary knowledge, attitudes and skills.

If you are judged competent, it implies that your knowledge, attitudes, and performance have been judged against standards that the people in the profession believe to be acceptable. The competencies (standards of performance) expected of DACC Dental Hygiene Program graduates have been determined by experts in dental hygiene education and practice. They have defined the criteria that determine competent performance of essential tasks, and thus effectively define “Acceptable Performance” for the beginning practitioner.

The DACC Dental Hygiene Program employs a fractional grading scale, which allows faculty to assign plus or minus grades. Plus or minus designations carry grade points. These grade points will impact a student’s overall GPA.

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<tr>
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<tr>
<td>99-100</td>
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<tr>
<td>79-80</td>
<td>C+</td>
</tr>
<tr>
<td>75-78</td>
<td>C</td>
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</table>

** A final grade below a (75%) will interrupt a student’s progress through the Program and may result in non-compliance with the program’s established protocol. Please refer to our section on Consequences for Non-Compliance of Standards of Conduct and if needed, refer to the Health Sciences Student Handbook for more information. If you are having trouble with this course and your grade has fallen below 75%, it is your responsibility to contact the professor immediately and arrange for tutoring or other assistance. You are expected to maintain a minimum of 75% at all times while in the Dental Hygiene Program. Failing to do so, can result in non-compliance with program’s protocols.

Successful completion of this course does not guarantee that the student will pass state, regional or national dental hygiene exams.

**REMEDIATION:**

- If a student does not successfully complete the designated clinic requirements by the end of a semester, deductions related to the delinquencies will be calculated into the final semester grade. (See Division of Course Grade in this syllabus for deductions.) If the student has a passing grade (75% or greater) AFTER deductions have been included, the student will be allowed to enter remediation time to complete requirements not previously completed. Requirements must be completed prior to the beginning of the next semester. If the student does NOT have a passing grade after deductions have been included, the student will not be able to enter remediation and may not be
able to proceed in the program. See guidelines in the Student Clinic Manual for readmission procedures. Please refer to our section on Consequences for Non-Compliance of Standards of Conduct and if needed, refer to the Health Sciences Student Handbook for more information.

- All patient requirements must be completed in order to receive the full grade percentage portion. If one or more patient requirements are missing, the student will receive a zero (0) for that category of the course grade.

- The grades received during remediation time will need to be passing grades. The passing grades will be calculated at 50%, and added to the final grade.

- Students who do not successfully complete remediation time and requirements or who receive a non-passing grade (74% or lower) may not be able to proceed in the program. Please refer to our section on Consequences for Non-Compliance of Standards of Conduct and if needed, refer to the Health Sciences Student Handbook for more information.

- In very special circumstances, with approval from faculty and program director, the student will be allowed to enroll into a special course (at the student's expense) to complete requirements not met during remediation; the time to complete these requirements may not exceed a total of 15 hours of instruction prior to the next course in sequence. If for any reason, the student does not complete the requirement(s) or requires more than 15 hours of instruction to complete requirements, the student may not be able to proceed in the Dental Hygiene Program. Please refer to our section on Consequences for Non-Compliance of Standards of Conduct and if needed, refer to the Health Sciences Student Handbook for more information.

**Time Required for Study and Self-Reflection**

College students, in general, are expected to study three (3) hours each week for every credit they are registered for. For students in health-care and other professional programs the expectation is for four (4) or five (5) hours per credit hour each week. **Therefore, if one is registered for fifteen (15) credit hours a semester, this means a minimum of sixty (60) hours of study, in addition to the time spent in class and clinics.** Classes usually require 10-13 hours of attendance each week and clinic and labs take 12-18 hours a week. This totals 22-30 hours a week in class. Together with study time, this means 90 hours/week or ~ 12 hour days, 7 days a week while in the program. This makes for a very busy two (2) year commitment in the professional program! It is imperative that students have the support of family and friends while engaged in this endeavor.

As a student enrolled in the DACC Dental Hygiene Program, the above expectations stand. If you are having trouble committing this time, or need help with study tips to make you more efficient and effective you need to contact your supervising faculty or the Program Director as soon as possible. We can and will assist as much as possible to help you succeed. Ultimately though, it is your hard work and perseverance that will make you successful.

**Evaluation/Grading: General Information**

A variety of evaluation instruments and procedures will be used to give students and faculty a means to measure skill and knowledge development. They will also be used to help faculty (and peers) give students constructive feedback on their decision-making, application of professional ethics, efficiency and effectiveness
and a myriad of other important factors.

Classroom Evaluation
Students are expected to attend all scheduled classes, laboratories and specified extra-curricular activities identified in the course syllabi. Active participation is essential to the learning process and is often part of the grading system.

Course syllabi will explain the components to be graded and the criteria for assigning grades. Components to be graded may include:

- Quizzes
- Exams
- Written Papers
- Oral Presentations
- Group Projects
- Others as Assigned

Criteria will be different for each graded component, and will be totaled to provide a final grade. Dental Hygiene students are required to pass every course in the curriculum with at least a “C” grade of 75% or higher to remain in the Program.

Classroom and clinical learning require critical thinking, problem solving and the ability to apply theory in practical situations. It is not just rote learning. Many of the quizzes and exams will require the application of information in new situations.

Faculty will meet with students periodically to review their progress. Generally this is a midterm conference where all courses and clinical classes are discussed and a Student Progress Report is developed. If necessary, a plan for improving performance will be designed and implemented.

Competency Based Evaluation
DACC Dental Hygiene academic and clinical courses are graded. Grading is competency-based, which means that the essential skills, knowledge and attitudes expected of students at a given point in the curriculum are specified and the conditions under which students are expected to perform, as well as the criteria for evaluation, are defined. This program is a competency-based program which includes a process of learning of psycho-motor skills that envelop certain stages of development.

Both process and products are evaluated using a variety of clinical checklists, and other evaluation forms. Students are not graded “on the curve” comparing students’ performance. This should help students focus on their professional development, and feel at ease in providing assistance and encouragement to their peers.

Stages of Learning
Recognize that to reach competency in a new skill the learner goes through several stages of development.

**Novice**

This is the beginning stage of learning. The novice tries to follow “rules” and to mimic what is observed. The novice tries to pair his/her actions with visual and sensual cues provided by the environment. For example: *Do you remember when you learned to ride a bike or drive a car? Learning how to balance, or judge the width of the road took lots of concentration, paying attention to all the physical sensation and visual cues you were told about.*

**AND**

*Learning to use a dental instrument, to “feel” the tooth surface, you have to keep the instrument tip on the tooth and sense the relative hardness and contours of the surface to help you discover deposits you may need to remove.*

*It takes thought, practice and time! Good learning means following the rules and being patient with yourself. But, also, it means taking chances and learning from your mistakes!*

**Developing (Intermediate) Level**

Both rules and experience guide behavior as some elements in the learning environment are recognized as being relevant to performance even though the learner may not be able to define them or their importance.

*Perhaps you line the nose of your vehicle up in the center of the road or peak over your shoulder to be sure you were “within the lines.” Perhaps you dream about making smooth shifts between gears.*

**AND**

*When “exploring” a tooth with an instrument, you may visualize the anatomy of the area, then try to sense the tactile differences between deposits found on a tooth.*

*Widely varied, repetitive practice and reflection (time to think between performances) seem to be required to move through this stage to competency.*

**Competent**

Judgment and choice enter as controlling elements in behavior. The large number of potentially relevant rules and experiences must be organized, and performance is guided by learner-chosen plans.

*Once competent at driving, you can shift through several gears without even thinking about it! And can turn a corner without worrying about whether you will stay in your own lane. You finally figure out how to get where you are going without running off the road and you do it with a certain amount of ease and efficiency.*

**AND**

*When “exploring” teeth you know without looking whether you have found decay or deposits that must be removed.*
A sense of responsibility begins with learner choice and develops as one’s experience broadens. The level of “Competent Performance” is generally the level at which dental hygiene students’ graduate, though a few may advance to higher levels of proficiency in some skills.

Proficient
With practice, one becomes proficient at a skill. A large repertoire of experience makes possible the analysis of the whole context of performance. The practitioner is able to match sets of information and skills and choose appropriate patterns of performance even though the circumstance may differ from the usual. Rules are no longer consciously applied.

When driving, you can think about something other than where you are headed and still get there. Or find an address without running a stop sign or hitting something while you look.
Most clinicians develop true proficiency only after graduation and an opportunity to spend time in practice.

Expert
The expert demonstrates fluid, reflexive responses to entire situations. Experience with a broad variety of circumstances helps one to develop skills and knowledge to a very high level.

Faculty will use a variety of teaching and learning strategies to help students move from the Novice stage to Competence.

Clinical Competencies
The American Dental Hygienists Association and the American Dental Educators Association with input from a variety of communities of interest developed the following competencies. These Standards are the basic expectations for all accredited dental hygiene programs and for all practicing dental hygienists. The DACC curriculum and expectations for performance are derived directly from these Standards. Note that the following are related to the Professional Competencies found in Section 2 of this Manual.

Standards for Clinical Performance
The professional groups that help develop the competencies for entering Dental Hygienists identify a variety of core skills and concepts that all dental hygienists should have. Our standards explain how these skills and concepts will be attained and assessed.

Clinical Skill Evaluations (CSE’s)
Clinical Skill Evaluation forms are essentially checklists that identify important components of clinical skills. A rating scale is included and is the same on every form. CSE forms may be used for independent learning and practice, peer and faculty feedback on skills and for grading specific components of clinical performance. CSE’s help identify a student’s level of achievement. For example:

- Novice means the clinician is in the beginning stages of learning, follows “rules” and mimics what is observed. (at or above 75%)
- Developing means the clinician is in an intermediate level of learning, applies knowledge but some improvement/guidance is needed. (75 - 84%)
- Competent means that the clinician can accurately and efficiently perform the procedure, no
guidance or assistance is needed, applies knowledge and judgment. (>85%)

Students are responsible for knowing and understanding all elements of the skill they are required to perform before they request a formal evaluation. Two attempts are allowed, however, the final scores will be averaged.

For radiography CSE, students cannot pass a competency using “Retake” films. “Retakes” are obliviously correcting a problem with the original set of films.

Faculty will grade CSE forms that are identified for a given semester course. During the graded evaluation, there will be NO faculty instruction or intervention unless it is clear that the student is not capable of performing to a satisfactory level.

Before taking a CSE, students must be well prepared and have read their lecture materials and CSE requirements.

Completed “CSE” forms will be kept in student’s “Graduation tracking in Foliotek” and will be retained through the two-year curriculum to help document progress toward meeting graduation requirements.

Format Design and Criteria for Completion of CSE Forms

1. Title: Identifies the skill to be observed and rated.
2. Student Name: Enter the student’s full name and date.
3. Faculty Signature and Date: The individual who is rating performance should sign and date the evaluation.
4. All CSEs are completed electronically using Foliotek Assessment Plus.

Increasing Competency Levels
Each semester the type of situation or difficulty of the case on which a given procedure is to be evaluated will be identified for grading purposes. As students gain experience, situations will become more complex. In general, Juniors are expected to perform at 75% accuracy while Seniors are expected to perform at 85% or higher on the same skills.

Clinical Curriculum Map
The following is a list of clinical skills that are sequenced in the general order in which they are first introduced and formally evaluated. CSE’s may not be required for all skills.
<table>
<thead>
<tr>
<th>Clinical Procedures</th>
<th>DHYG 110 PRECLINIC</th>
<th>DHYG 112 CLINIC I</th>
<th>DHYG 132 CLINIC II</th>
<th>DGHYG 210 CLINIC III</th>
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<td>Emergency Protocols</td>
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An instrumentation competency exam may be given at anytime during the semester as a learning tool and formative evaluation. These are used as part of the course evaluation.

At the end of each semester a final clinical competency exam will be given. Both Junior and Senior students will take “Clinical Competency Exams”. The content of these exams will be discussed with the students if changes are made. The exams may include a variety of CSE’s, mock patient interviews, demonstration of emergency procedures, specific instrumentation procedures, etc. Descriptions and grading information for these competencies will be included in clinical course materials.

**Case Management**

A student evaluation *Case Management* form will be completed for each client a student works with in the DACC Clinic. This form will be started when the patient is first seen, and will be continued until the patient is complete, or care is otherwise terminated. Faculty each time the student provides care for the patient should fill out this form. Faculty should sign each component at the time the evaluation is made. Written comments should be used to guide learning and identify essential information about patient care. The patient’s health status; whether Medically Compromised or Special Needs must be checked in the Case Management form.

It is critical that this form be completed accurately, since it is essentially the grade sheet for patient care and the documentation of Mini-Mock Boards. Students will not be given credit for cases unless the Case Management form is completed and signed off and the patient has paid all fees. Faculty will meet with the Clinic Administrator and Administrative Assistant weekly to determine whether fees have been paid. If not, the student will be asked to contact the patient to remind them they must pay outstanding balances.

**Mock Boards**

Mock Boards are a tool to help students identify areas where they need instruction or practice, and to provide students with experience in patient selection and all aspects of taking clinical dental hygiene board examinations.

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Senior students will take at least one Mock Boards to help prepare them for the clinical exams they must take to get licensed.

Mock Boards should be considered “Clinical Exams”. The exams are anonymous in that the evaluating faculty teams do not know who the clinician is, whose work they are evaluating. The procedures used in the Western Regional Examining Board (WREB) / Central Regional Dental Testing Service (CRDTS) are followed with a few modifications to the criteria for patient selection, assessment and treatment planning phases.

Because this exam has no direct faculty observation or instruction, all CSE’s, Clinical Competency exams must be successfully completed prior to taking the Mock Boards. If these evaluations are not completed by the deadlines stated in course syllabi, students will NOT be allowed to take Mock Board exams.

- Mock Boards will be completed in the fall semester of senior year according to the grading evaluation information distributed prior to the Mock Board exam. A Mock Board may be given in the spring semester of senior year if the Clinical Coordinator deems it appropriate.
- Students must make all attempts to find WREB/CRDTS acceptable cases for these exams. Junior students will assist in identifying appropriate patients from their spring semester patient pool.
- Senior students will differentiate WREB/CRDTS clickable calculus from lighter calculus when evaluating a potential board case, using the Key on the form.
- Junior students will assist faculty during Mock Boards. This is an opportunity to see “behind the scenes” in these anonymous examinations.

**Rotations**

Students will be assigned to several educational rotations including:

- Office Assistant;
- Sterilization Duty;
- Radiology Duty;
- External Clinical Rotation. (Community Health Clinic Rotation, St. Lukes Medical clinic, Nursing Home Rotation; Etc) if available.

Many of these rotations will be assigned during clinical time; some will be assigned during other times of the day or week depending on schedules available at the rotation site. All rotations are supervised by qualified professionals and provide opportunities to learn special facets of dental hygiene practice.

All students are required to participate in assigned rotations to fulfill clinic requirements. Students may not “switch” rotations without the consent of the supervising clinical dental hygiene faculty. The number and type of rotation will vary semester to semester and will be identified in each course syllabus. Assignments will also be posted in the clinic on special forms.

Transportation to and from external rotation sites and expenses incurred while at the site (e.g., lunch etc.) are the responsibility of the student.
Evaluation of student performance while on rotation will be documented and an *External Rotation Evaluation* form to be initialed by supervising hygienist or dentist for each external rotation. Rotation evaluation forms will be recorded and returned to the student to be kept on file in Graduation tracking in Foliotek. These forms will be used in the clinical grading process.

**Students on rotations are expected to arrive at least 15 minutes before the start of clinic and stay after clinic at least 15 minutes to complete all procedures.**

The purpose or goal for each rotation follows:

**Clinical Assistant**
The purpose of the Clinical Assistant Rotation is to provide students with an opportunity to learn chair side assisting skills, clinic management skills, and an opportunity to critically analyze a variety of clinical skills. It is expected that students will practice effective interpersonal skills, engage in cooperative decision making, act as role models and provide peer teaching during this rotation. Students who are unable to have a patient in their chair will be assigned to this rotation. However, all efforts must be made for the student to have a patient for the clinical time. These rotations will only be implemented for students who have no patient on the chair.

**Office Assistant**
The purpose of the Office Assistant Rotation is to provide students with an opportunity to implement fundamental clinical management skills including: patient management, telephone etiquette, appointment control, financial record keeping and collections, recall maintenance, basic computer record keeping and inventory control. It is expected that the student will practice effective interpersonal skills and develop management and leadership skills during this rotation.

They will assist with fee sheets, prepare appointment schedules, and other business related activities. If time permits they will provide other types of assistance to faculty and students.

**Sterilization Duty**
The purpose of the Sterilization Duty is to provide students an opportunity to practice infection control, hazard control and clinic management skills in a large, busy dental clinic. Students will be responsible for instrument preparation and sterilization for multiple operators, maintain all sterilization equipment, maintain inventory control, and monitor sterilization effectiveness.

Students may also have an opportunity to assist clinicians with other types of clinical procedures.

**Radiology Duty**
The purpose of the Radiology Duty Rotation is to provide students with an opportunity to practice film processing and duplication, film mounting, maintaining infection control and hazard control in the radiographic area, and operating and maintaining all radiographic and darkroom equipment. It is expected that the student will have experience with inventory control, appointment control and patient management skills and will provide peer support and teaching as appropriate.

**External Rotations**
Faculty of the DACC DH Program will arrange for external rotations (when possible). Community Dental or Medical Clinics will be used as external rotation sites when it is possible to contract with various sites. This will help broaden student’s experience with culturally diverse populations and to provide a variety of health care experiences in a Public Health setting. Students will be challenged to work relatively independently on a variety of clients and will be expected to develop and use appropriate patient management skills. In some settings such as Ben Archer Health Clinic, students may be providing dental hygiene therapy. In other settings
such as St. Lukes Medical Clinic students may be providing oral health screening, education, and referrals. In most situations students will work under the supervision of staff at these sites. A separate evaluation form will be completed and signed off by the site staff. These should be turned in to the senior clinic coordinator. Instructions on how to prepare for this rotation will be given prior to going out. Portable equipment may be used and in most cases students will be required to bring their own personal protective equipment (PPE) and instruments.

If weather or illness prevents a student from attending the scheduled rotation, the student must notify BOTH the rotation site and DACC supervising faculty by 8 am. Remember, patients and the office staff are depending on the clinician. One should be willing to help out dental staff in sterilization, exposing x-rays, etc., when not working with a patient.

Requirements: The number of external rotations varies each semester and will be identified in clinical course materials. In the case of cancellation due to weather or illness, the day must be made up.

Chart Audits
To assure the quality of patient care, charts are audited periodically. Two types of chart audits will be conducted: 1. Student chart audit with fee reconciliation. These help to verify that all treatment was necessary, appropriate, and completed in a timely manner. Client records are analyzed for completeness and legibility of records including signatures, fees, referral and consultation records, radiographs, chart entries, maintenance interval, etc. The chart audit protocol is directly related to quality assurance standards mandated by ADA Accreditation and the standard of care for the profession. (See Section 9: Clinic Procedures for complete details.)

If problems are identified, the student will be asked to correct all records and turn them in to the Clinical Coordinator to be signed off. No credit will be given for patients completed unless all records are complete and accurate.

Patient Satisfaction Survey
At the completion of patient treatment, every patient will be asked to complete a survey indicating their level of satisfaction with treatment, clinical procedures and the student, staff interactions.

Surveys are labeled with a student code and date of service so that if the survey reveals unfavorable comments, faculty can contact the student involved. If the information is significant it may affect the student’s clinical grade. The grading process is determined by the clinical co-ordinator.

Student Progress Report
At least once in each semester, students will meet with the Clinical Coordinator to review academic coursework, clinical progress, achievements and any areas of concern. It is the student’s responsibility to schedule the conference. If necessary, more than one conference may be scheduled. During these sessions, student’s progress and concerns will be discussed. If special tutoring or other accommodations are needed for any course, options will be discussed and it is up to the student to make all final arrangements and keep the Clinical Coordinator apprised of progress.

A report will be generated for each individual student’s progress and a copy provided to the student during the meeting with the Clinical Coordinator.
Graduation Requirements
Dental Hygiene students are expected to meet all requirements for graduation including the following patient caseload. Patient Treatment Plans must be comprehensive, complete and all fees must be paid. Faculty reserves the right to modify these requirements based on availability of patients, difficulty of patients or other extenuating circumstance. Students will be notified, in writing, if the Dental Hygiene Programs makes a decision to alter the requirements.

CASE LOAD
(Minimum of 40 patients for graduation)

Each student must see the following categories of patients:

- At least Thirty (30) AAP Class 0, I, II
- At least Ten (10) AAP Class III -IV periodontally involved patients

Of the above requirements, students must have:

- At least three (3) Geriatric Adults
- At least three (3) Medically Compromised
- At least three (3) Special Needs Patients
- At least three (6) Youths age 12-17
- At least three (5) children under the age of 12
- At least (10) degree of difficulty Level B or greater

Degree of Difficulty
In order for each student to experience the wide range of patient conditions and different states of disease, the following degree of difficulty, based on the amount of calculus present, shall be incorporated into the criteria for the patient case-load. See individual course syllabi for specific semester requirements. The levels of difficulty are defined below:

Degree of Difficulty

Level A: Slight

Generalized light supragingival calculus and/or localized light subgingival calculus on ≤ 30 % of teeth present; calculus will be limited to the cervical third, and be of the fine, granular type; will transmit a ‘gritty’ sensation to the explorer; not apparent on radiographs.
Level B: Moderate

Localized moderate supragingival calculus and generalized moderate subgingival calculus on >30% of teeth present; calculus is of the spicule type; there will be an obvious raised ‘bump’ when moving the explorer over the calculus; may be apparent on radiographs.

Level C: Heavy

Generalized or localized moderate-heavy supragingival and generalized heavy subgingival calculus on >30% of the teeth present; typically involving 2-3 surfaces of most teeth; calculus will be of the nodule, ledge, and/or ring type, and will be obvious after 1-2 exploratory strokes; may be tenacious; calculus will ‘bind’ the explorer; usually apparent on radiographs.

RADIOGRAPHS

(Graded for both Technique & Interpretation)(See Section 12 for more details)

- 8 Full Mouth Surveys: (referred to as FMS/FMX or CMRS)
- 6 Panoramic Radiographs
- 6 Sets of Horizontal Bite wing films—in addition to those taken as part of FMX
- 4 Sets of Vertical Bite Wing films—in addition to those taken as part of FMX
- 3 Sets of PEDO or Mixed Dentition Bite Wing films.
- 3 Sets of Occlusal Films All radiographs will be graded.

Of these, the following may be taken during Radiology Class (DHYG 118) and applied toward Graduation Requirements (not on dexter).

- 1 Digital FMX
- 1 set 4BW
- 1 Panoramic film

Total of 3 Patients in addition to the student partner needed for radiology class

Adjunct Clinical Services

Students must complete the following adjunct clinical services to clinical competency.
1. Apply chemotherapeutic agents/ antimicrobials
2. Tooth whitening procedures.
3. Local Anesthetic (Type and number of injections will be specified in the local anesthetic course.)
4. Nitrous Oxide Sedation (3 evaluated procedures on different patients)
5. Care of Removable Appliances
6. Anti-microbial placement.

SECTION 15. EQUIPMENT AND SUPPLIES

Responsibilities for Maintenance
Everyone working in the clinic facility is responsible for the care and maintenance of all equipment and the surrounding areas in order to ensure a safe and healthy environment. Supplies are to be restocked as needed to help maintain efficiency.

Read Instruction Manuals

Most dental equipment is very expensive. It must be handled with care, used only as recommended by the manufacturer and repaired according to the manufacture’s instructions. It is the student’s and faculty’s responsibility to familiarize themselves with written instructions prior to using and/or repairing any piece of equipment.

The following major pieces of equipment & supplies are available for use in the Dental Clinic. Instruction manuals for each piece of equipment are filed in three ring notebooks at the teaching station in the center hallway of the clinic.

Equipment Sign-out

Specialized equipment that is kept in the locked silver cart must be signed out and signed back in using the log kept with the cart. The security of expensive items such as digital x-ray sensors, cameras, and diagnostic equipment is everyone’s responsibility.

Dental models are to be signed out on the sheet posted on the inside of the cupboard door where the models are kept. Skulls and anatomical models may not be taken off campus.

Equipment needed to operate clinic

- **Compressor**: can be turned on in sterilization lab on specialized key board next to cubbies
- **Vacuum**: can be turned on in sterilization lab on specialized key board next to cubbies
- **Water**: can be turned on with light switch plate located underneath dosimetry badges

ALL UNITS NEED TO BE TURNED OFF AFTER END OF CLINIC SESSION.

Unit Maintenance

The dental unit will not operate until the water, air compressor, and vacuum systems are turned on at the panels in the sterilization area.

1. Check unit brackets, tray arm and light stand. Tighten screws when necessary, and replace missing screws. Be careful to move the assistant’s arm without twisting the arm in a full circle, as this will crimp the internal air/water lines.
2. Check pressure for hand-piece; it should be at 20-40 when tested with gauge.
3. Use the brake on the unit arm to raise and lower the tray to avoid stripping the internal gears.
4. Light should not be cycled on and off more than necessary. Lights should turn on with the unit and off when the unit is turned off at the end of the day.
5. To replace a unit light bulb, take the light shield off carefully and remove the burned out bulb. Use a 2 x
2 gauze pad to remove the spare bulb from the back of the light arm. This shields the bulb from fingerprints and oils that will cause the bulb to burn out quickly. Carefully replace the bulb and the light shield and notify the Clinical Lab Manager that a new replacement bulb is needed.

6. Maintain the unit water system in the following manner:
   a. Prior to patient care, place a water bottle **filled with reverse osmosis water** from the sterilization room on the water bottle hook-up on the unit stand add a Bluto tablet to the water bottle. Run this water through all water systems for at least one minute. It may require that you replenish the water prior to use if significant water is eliminated from the bottle.

7. Maintain the unit traps in the following manner.
   a. At the end of the week, replace the filter under the assistant’s arm of the unit. Wear personal protective barriers and place the used filter in the bio-hazardous wastebasket under the counter.
   b. At the end of the month, replace the gauze filter under the back of the unit tray. Wear personal protective barriers and place the used gauze in the biohazard wastebasket under the counter.

8. **Chair position in the unit space # 1-6 must NOT be moved.** Chairs have been positioned to accommodate both the utility box and cords and the chair position in relation to the unit hand-piece and other hose and the x-ray tube head. Chairs are heavy and constant movement risks injury or damage to the chair/equipment.

9. Chair position can be changed using either the foot control or the touch pads on the unit
   a. By touching the function buttons (0, 1, 2, 3) the chair moves to a preset position.
   b. **This is for informational purposes only. Do Not Re-Program The Chair.** However if one were permitted to re-program a chair your would adjust automatic stop positions, use the following codes (function buttons) as seen on the controls:

   - 0 = Exit
   - 1 = Operate
   - 2 = Operate second position
   - 3 = Upright

   First, put the chair back and seat to the desired position, press and hold “learn button” (which looks like a stick figure of a person semi-reclined with arrows around it). While holding the “learn button”, press the function button and hold for 2 beeps.
   c. To swivel the toe of the chair to one side of operatory, release the locking lever that is behind the base of the chair seat. Once in position tighten the level to hold the chair in position

10. Chair headrest height and tilt can be changed easily in units 7-12. The knob on the back of the headrest allows adjustment on the tilt. To change the height of the headrest simply pull up or depress the headrest. Chair headrests in unit 1-6 have magnetic attachments and can easily be repositioned on the chair. However: **There is a warning when using magnets around pacemakers.**

11. Check the operator and assistant chairs periodically for floss and debris around wheels and tighten screws
and bolts as needed. At the end of each clinic session, return both chairs to the back of the operatory.

12. When not in use, patient chair should be in the highest position and the dental light aligned with the chair with the foot controls on the side of the base of the chair. Remember to remove these foot controls before attempting to lower the chair!

Unit Cleanup
See Section 7: Infection Control section for detailed information on cleaning up the unit.

Disposable Supplies
Whenever possible, use disposable supplies and single unit dose materials.

Barrier materials, infection control supplies and other materials are stocked in five places:

1. Dental operatory cupboards and drawers and between unit cupboards
2. Central hallway cupboards
3. Clinic Administrative Office
4. Sterilization area
5. Storage Closet

Students are responsible for stocking the operatory to which they are assigned. It is very important to follow the labels on unit drawers and cupboards so that every operatory is identical to the others. This facilitates efficient utilization of all units.

General Clinic Supplies
<table>
<thead>
<tr>
<th><strong>DAILY</strong></th>
<th><strong>WEEKLY</strong></th>
<th><strong>MONTHLY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Clean base of unit chair and all chairs with appropriate disinfectants.</td>
<td>Clean x-ray machine cupboard</td>
<td>Clean unit and all chairs with appropriate cleansers.</td>
</tr>
<tr>
<td>Clean and disinfect plastic light shield, it may be removed for cleaning if necessary</td>
<td>Vac -cleaner</td>
<td>Clean cupboards between units.</td>
</tr>
<tr>
<td>Sanitize light arm and post</td>
<td>Unit Filters</td>
<td></td>
</tr>
<tr>
<td>Disinfect top of cabinets and all door and drawer handles and interior of Cavitron storage shelf</td>
<td>Clean top of cabinets with appropriate cleanser.</td>
<td>Clean and organize cabinet drawers and shelves</td>
</tr>
<tr>
<td>Ensure all equipment and supplies are present and accounted for</td>
<td>Restock drawers and shelves according to the standardized system for stocking disposables.</td>
<td></td>
</tr>
<tr>
<td>Disinfect clipboard, pens/pencils, magnifying glass</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disinfect unit</td>
<td>Clean unit thoroughly including base and foot controls</td>
<td></td>
</tr>
<tr>
<td>Check floor for debris and clean if necessary</td>
<td>Move patient chair and clean floor around chair and unit</td>
<td></td>
</tr>
<tr>
<td>Clean top of control box on floor, make sure the cover is on securely</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sort trash according to bio-hazardous waste regulations.</td>
<td>Ensure that trash is being picked up on schedule</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dust area behind Partitions that are between units</td>
<td></td>
</tr>
</tbody>
</table>
Follow procedures for unit maintenance

The student on clinic assistant rotation is responsible for restocking gloves, cups, paper-towels, mouth rinses and surface disinfectants that are kept near sinks. The clinical Dental Assistant will restock bulk supplies and must be notified when inventory is getting low. Inventory tags and an inventory request form are to be used as instructed.

Supplies for patient self-care such as toothbrushes, floss, interdental cleaners, toothpaste and mouth rinse must be dispensed carefully with the patient only receiving one of each item. The budget will not allow for multiples of any item.

Educational materials and self-care items including toothbrushes, floss, mouth rinse etc. will only be distributed for Health Fairs and community education projects that have been formally identified by the Department faculty.

*Note: Do not store personal hygiene items (tooth or hairbrushes, hair ties, nail files, etc.) in unit drawers.

Equipment Problems

- Report malfunctions immediately to attending faculty and/or the Clinic Lab Manager.
- With faculty or staff supervision you may attempt to fix the problem if you have been trained to do so. (Refer to the instruction manuals on the equipment if necessary)
- Write up the problem (and solution if the equipment was fixed) in the “DACC Dental Programs Equipment Repair Log” using the “Equipment Deficiency Report Form” as follows:
  6. A separate sheet shall be used for each individual piece of equipment affected.
  7. The Clinical Supervisor and Repair/ maintenance personnel should leave the “Deficiency Report” form in the front of the “Equipment Repair Log” for review.
  8. When completing the Equipment Deficiency Report, enter:
     i. Date
     ii. Name of person making report,
     iii. Equipment affected and location,
     iv. Equipment deficiency,
     v. Repair action,
     vi. The person making the repair will print name, initial and will date the report when corrections are completed.
     vii. Once completed, the report will be filed in the logbook under the appropriate section for the equipment affected.
The Clinical Lab Manager periodically reviews the Equipment Repair Log to ensure that all repairs are made documented in a timely manner.

Cavitron Jet Combination

The Cavitron Jet Combination system is both an ultrasonic scaler and an air polishing prophylaxis system. They are located in each operatory either on the counter or in a pull out tray. It operates by converting ordinary AC house current into high frequency current. The ultrasonic system consists of two parts; an insert and the SPS □ (Sustained Performance System□) electronic system that automatically adjusts frequency and the tip stroke of the ultrasonic insert tip. The unit receives water (RO) and chemotherapeutics (both liquids must be manually added) from a Dual Select Dispensing System, which is under the operatory counter. The air powder polishing insert tip allows for an air driven slurry of abrasive powder and water to polish teeth. The mode selection is automatic when the Air-polishing insert nozzle or the 30K ultrasonic tip is inserted into the handpiece.

Cavitron Dual Select: Ultrasonic Scaler and Air Jet Powder Polish:

❖ See Section 7 for details of infection control of this unit.
❖ (Never use the scaler without adequate fluid flow at the instrument tip.)
❖ Manufacturer’s instructions will be found in the clinic Reference Notebooks kept at each unit in the X-ray machine console.

Piezo

❖ Piezo scaler is located in the Clinic File Cabinet
❖ Alternative to Cavitron (Ultrasonic)
❖ Technique sensitive; need to read and follow instructions carefully
❖ Can be used with patients that have a pacemaker.
❖ Manufacturer’s instructions will be found in the clinic Reference Notebooks kept at each unit in the X-ray machine console.

Hand-piece Maintenance

Attach slow-speed handpieces to one of the air hoses on the unit not marked “highspeed”. The “high-speed” hose has a water connection that can flow through the tubing when the toggle on the foot control points to the blue circle. Dental hygiene handpieces are not designed to have water flowing through them.

❖ Do not run slow-speed hand-pieces such as Midwest RDH or NSK Hygiene Pro Air without a chuck or a prophy angle inserted;
❖ Remove surface debris from the handpiece with water-soaked gauze.
❖ Disconnect the hand-piece from the unit hose. Lubricate the Midwest RDH Handpiece with oil provided by the manufacturer. Place 3 drops into the drive air tube (gold) at the base of the handpiece. Reconnect the handpiece to the unit hose and run it until it reaches normal speed. Wipe off excess oil; OR lubricate on the Assistina machine.
❖ Discard the prophy angle;
• Bag and heat-Sterilize. No further oil is needed.

• For all other hand-pieces, read and follow manufacturer’s instructions. If there is a special “chuck” to remove burs from the hand-piece, be sure it remains with the handpiece throughout the cleaning and sterilizing process.

Clinic Computers:

**Teaching Station computers:**
The computers located at the teaching station have Internet access for Foliotek usage only. These computers are not to be used for personal business or leisure.

**Operatory Computers**
All dental operatories have access to a computer that has been loaded with Eaglesoft and Patterson Imaging software. This software can be used to capture intra-oral photographs, access patient charts, and capture and store digital radiographs. Eaglesoft also allows for various types of computerized dental and periodontal charts. See Section 15: Business operations for details.

Some of the computers in the cabinets below the X-ray machines do not fit the space very well. However they are positioned to prevent cords from coming unplugged or jammed. This may result in the cabinet doors being slightly ajar. Do not try to move the computer towers or shut doors.

Before the software can store images properly, the patient must be entered in the Eaglesoft program. At the initial appointment students will enter the patients’ information to establish them as a patient in the Eaglesoft system.

**Turning Computer On/Off:**
When taking intra-oral photographs with the computer wand; plug the wand in to the computer tower then turn on the camera after opening the Eaglesoft program.

Our IT Department has requested that computers be left on. However, you must log off from Eaglesoft or any other system you are logged in using your credentials.

**iPads**
The iPads in the clinic are for instructor use during assessments and clinical instruction. Some iPads can be used to complete patient satisfaction surveys.

**Intra-Oral Cameras**
The DACC Dental Hygiene clinic has a digital camera and two (2) intra-oral cameras, which can be used to take photographs. These are kept in the locked silver cart located in the clinic. **WARNING:** the wand holder for the Imagecam HD is powerfully magnetic. Exercise extreme care and caution around any person with a pacemaker or similar medical device.

The manufactures’ instructions will be found in with the camera and in the clinic Reference Notebook kept in the X-ray machine console.

See Section 10 Guidelines for Dental Hygiene Assessments and Diagnosis for details on how to use the cameras.
Clinic Music System
The music system located at the teaching station can be used during clinic time. The volume must be kept at a low volume and an appropriate station for clinic setting that can be determined by the Clinic Coordinator.

Autoclaves
There are three (3) types of autoclaves in the DACC-Clinic. It is the students’ responsibility to prepare and run all instruments through the autoclaves at the end of clinic sessions. The manufactures’ instructions on the use and care of the machines will be found in notebooks in the sterilization area. Read them thoroughly before using the equipment and follow all safety guidelines.

Midmark M-9 Auto Clave
- **Solution:** Deionized water is used.
  Fill tube inside front door.
  Fills & drains chamber automatically. The Midmark wastewater is automatically drained.
  - **Package Status:**
    Pouches/Cassettes
    - **Time:**
      15 minutes at temperature and pressure + time for heating & drying cycles.
      Generally~40 minutes full cycle.
    - **Temperature:**
      270° F (132° C) - for wrapped instruments
    - **Pressure:**
      27 PSI
    - **ON/Off:**
      Power button located on front panel (On/Standby). Select & Start switch on front panel.
      Door opens automatically at end of cycle.

Statim 2000 - Level bubble must be off center to help drain machine.
- **Solution:**
  Deionized or Distilled water only
  WASTE WATER RESERVOIRS: Before adding water to the Statim the wastewater reservoir must be
emptied. This bottle is under the counter below the machine. To remove the bottle, hold the lid securely and turn the container off the lid. This helps preserve the lid and coils that rest in the bottle. Wastewater is emptied down the sink drain and fresh water is placed in the bottom of the plastic reservoir to help cool the coils.

The gasket on the Statim must be perfectly aligned with the holes in the back of the machine’s cassette. Care must be taken when placing the lid on the cassette to ensure a seal without distorting the gasket.

Fill reservoir nearly to top of chamber.

At the end of each cycle; water drains to bottle that is below the counter on the lower left, it must be emptied before refilling top reservoir.

Put ~2 inches of water in bottom of bottle to help cool coils.

- **Package Status / Time:**

  Wrapped Cassettes: 10 minutes at temperature and pressure + time for warm-up & drying. Warm-up for ~2-4 minutes. Recommend ~ 10 min. drying at minimum unless using immediately

  Unwrapped: 3.5 minutes at temperature and pressure.

- **Temperature:**

  275° F (135° C)

- **Pressure:**

  Pressure specified in manual as 212 kPa

- **ON/Off:**

  Power switch located at left rear.

  Start cycle on front panel with Green diamond icon. Machine beeps when cycle is complete and drying begins.

  Dry cycle may be interrupted with “Off” button (Red circle/triangle icon).

**Adec Lisa Autoclave** (includes a Vacuum phase which helps sterilize hollow instruments)

- **Solution**

  Deionized or distilled water only.

- **Package Status:**

  Wrapped cassettes or packaged instruments.

- **Time:**
Sterilization = 4 minutes. Entire cycle = 30-40 minutes.

- **Temperature:**
  273° F

- **Pressure:**
  31.5 PSI

- **ON/Off:**
  Switch is located inside small door on lower right front.

Follow the instructions for use found in the notebook beside the Autoclave. Learn to recognize all the symbols used to progress through the start up and cycling phases. Learn to fill and empty the water tank on signal. Date stamp packages when removed from sterilizers using appropriate color codes.

**DOOR GASKETS:** Door gaskets are fragile and must be in good condition to allow the autoclaves to work properly. Extra door gaskets for the sterilizers are available in the sterilization area.

**Ultrasonic Cleaners**
The counter-sunk ultrasonic cleaner is filled each morning with water from the sink. Before filling the tank, the drain line must be shut off under the counter. (The red handle on the plumbing line will require a downward position.) Five (5) enzyme tabs are then placed in the water.

To operate the counter-sunk ultrasonic, set the timer on the under counter control box for ten minutes.

At the end of the day, opening the drain line under the counter drains the counter-sunk unit. (The red handle will be up and to the right.) The tank is then wiped out with a surface disinfectant and wiped dry. The rim of the cleaner, the lid and the counter must also be cleaned and wiped dry.

The gray, Patterson Brand, countertop ultrasonic cleaner is used only to clean dental appliances (dentures, partials, etc.). Plain water is used in this unit. Either glass beakers or plastic bags are used to hold the dental appliance and the liquid tarter/stain remover. The unit is drained and cleaned at the end of each day.

The white, HS, ultrasonic cleaner is used to clean small individual dental instruments that are not part of a kit or cassette. Water and an enzyme tablet are used in the unit and a wire mesh basket is used to hold the instruments during cleaning. The unit is emptied and disinfected at the end of the day.

**Radiography & Darkroom Equipment**
See Section 11: Radiology, for information about the operation and care of radiographic and processing equipment and darkroom features. Section 10 also explains infection control procedures to be used with this equipment.

**Laundry**
The equipment manual for washer and drier are in a three-ring notebook in the laundry area. This book also
contains instructions for completing the laundry. The washer and dryer are to be run by the student on clinic assistant/sterilization rotation during and at the end of clinic sessions. However, if the student cannot retrieve clothing from the machines before leaving the clinic a wash or dry cycle should not be started. This will help prevent mildew in the washing machine and on clothing and will keep dried clothes from wrinkling. (See Section 7 Infection Control for more details).

**Oxygen Tanks**
The mobile oxygen tank is an E size tank with a regulator and attachments. The oxygen tank to be used during an emergency is located on the Red Crash Cart. Other tanks are housed with the Nitrous oxide and are located across from Operatory #1. Details of its operation will be reviewed when students learn emergency procedures.

**Nitrous Oxide/Oxygen Units**
The unit is stored across from Operatory #1. Details on the operation and maintenance of this equipment will be found in Section 13: Pain Management and will be covered during DHYG 218-Pain and Anxiety Management.

**Eye-wash Stations**
There are several eye-wash stations in the dental facility. These must be cleaned every month by disinfecting the plastic caps and running water through the system for 10 minutes. The Clinical Lab Manager must keep a log of the maintenance procedure.

**Dental Laboratory Equipment**
Details on the operation and maintenance of the following equipment will be explained during the DHYG 134 Dental Materials:

- Vibrator
- Model Trimmers
- Vacu-Mix & Vacu Former
- Other laboratory equipment (as needed)

It is important to prevent pouring dental materials (stone, impression materials, etc) down the sinks. They have special traps that are periodically changed by DACC facilities staff; however, preventing unwanted build up will help keep sinks functioning properly.

**Diagnostic Equipment**
The manufacturers’ instructions will be found in the clinic Reference Notebook that is kept in the unit’s X-ray machine console, and in the Equipment Reference Manuals in the teaching station.

- A Parknell - pulp vitality tester
- Diagnodent - caries detection unit
- Midwest Caries I.D - caries detection unit
- Trimira Identafi 3000 - oral examination
End of Day Clinic Shut Down
A checklist outlining the procedures to be followed to close the clinic will be found in the Unit Reference Notebook in the X-ray machine console between operatories.

END OF DOCUMENT
Documents from these appendices are located on a separate document. Please ask your clinical coordinator if you need any of these documents.

- Appendix A, Acknowledgement Pages
- Appendix B, Disciplinary Action and Drug Screening Forms
- Appendix C, Immunizations and Exposure Incident Form
- Appendix D, Equipment and Repairs
- Appendix E, Instructor Help Request in Clinic and Chart Audit
- Appendix F, Radiology
- Appendix G, Emergency and Incident Forms
- Appendix H, Foliotek Instructions
- Appendix I, Eaglesoft Instructions