

## **SYLLABUS**

COURSE TITLE: DHBS 3501 Clinical Practice II  
SEMESTER: Summer  
CREDIT HOURS: 3.0

REVISED: 2007  
REPRINTED: 2007

COURSE DIRECTOR: Ann O'Kelley Wetmore, R.D.H., B.S.D.H.

## GOAL

This course will provide the student with information and clinical experience, including ultrasonic scaling and advanced instrumentation skills for scaling and root planing. The student will develop a care plan for providing comprehensive patient care using assessment, diagnosis, planning, implementation, and evaluation data. Rotations to other departments in the Dental Branch will be introduced to enhance the student's dental hygiene clinic experience. Patient management and professionalism are stressed in this stage of clinical development.

This course will also provide a learning environment as close to "real world" dental hygiene practice as possible with supervision and facilitation by clinic faculty. Practice of dental hygiene procedures for Class III and Class IV calculus/debris cases will be introduced. Through rotations to other departments in the Dental Branch, the student will be introduced to dental hygiene practice in environments other than the dental hygiene clinic.

## OBJECTIVES

1. Complete a personal learning contract for your clinic learning experience using template provided by instructor (see Appendix A).
2. Demonstrate standard precautions in infection control before, during and after all patient contact.
3. Integrate patient management and professional behavior into all patient contact experiences.
4. Apply all knowledge gained in previous and concurrent course work in conducting a comprehensive medical and dental history interview on all patients.
5. Report all patient medications, herbals and supplements and their drug classification, indications, dental and local anesthetic contraindications and drug interactions to instructor.
6. Summarize patient's medical and dental history for instructor feedback.
7. Adapt patient care according to physical and dental assessment.
8. Identify and describe all normal and abnormal findings during assessment phase of total patient care.
9. Recognize and describe hard and soft deposits based on UTDB criteria.
10. Recognize and describe healthy and unhealthy gingival and oral tissues.
11. Classify periodontal status using AAP guidelines for the dental hygiene diagnosis.
12. Demonstrate periodontal assessment procedures:
  - 12.1 determine probe depths
  - 12.2 identify free gingival margin
  - 12.3 identify and classify furcations using Nabor's probe
  - 12.4 determine mobility
  - 12.5 calculate clinical attachment level
13. Develop an individualized patient education regimen based on patient needs assessment.
14. Identify and record hard tissue dental findings.
15. Become proficient in calculating the O'Leary plaque score.
16. Relate knowledge gained in the interpretation of radiographs when determining the dental hygiene diagnosis of a comprehensive patient care plan.
17. Determine an evidence-based comprehensive patient care plan for all patients using the ADPIE dental hygiene process of care and instructor feedback.
18. Demonstrate proficiency at entering a treatment plan in the EPR using a correct sequence and appointing patient accordingly.
19. Demonstrate proper instrumentation techniques and tissue management as determined by the patient's treatment plan.

20. Practice instrumentation techniques using advanced techniques introduced in this course and clinic seminar.
21. Identify root morphology and tooth anomalies that require advanced instrumentation.
22. Implement all aspects of treatment to provide total patient care in accord with current research and evidence based principles
23. Evaluate total patient care using patient response, self-assessment and instructor feedback.
24. Provide all aspects of dental hygiene care in a timely manner, considering patient's needs above yours.
25. Record all aspects of patient care in the EPR and on pertinent paper evaluation forms.
26. Perform polish, floss and fluoride procedure in accordance with patient needs.
27. Demonstrate application of pit and fissure sealants as determined by DDS examination and treatment plan.
28. Value instructor feedback and synthesize into future clinic experiences.
29. Enhance the clinical learning experience through student faculty post-clinic conferences
30. Reflect weekly in online blog about clinical experiences through self-assessment and reflection.

## CRITERIA FOR CLINICAL EVALUATION

Given clinic instruction, audio-visuals, seminar discussions, simulation laboratory experiences, the *School of Dental Hygiene 2006-2007 Student Handbook (Student Handbook)* and the "Clinic Procedure Checklist" in the *Student Handbook*, the student should demonstrate competence in the following areas:

(Note: For specific criteria for clinical evaluation, refer to the levels of competence described under "Evaluation Methods" and "Competency Demonstrations" in the syllabus and the "Clinic Procedure Checklist" in the *Student Handbook*.)

- A. Infection Control  
Demonstrate infection control protocol as outlined in the Safety and Infection Control Section of the *UTDB Clinic Manual* and the Aseptic Technique Checklist in the *Student Handbook* prior to patient arrival, during the appointment and after patient dismissal.
- B. Medical/Dental History  
Conduct a thorough medical/dental history on all patients. Proper clinical procedure will be dictated by the type of data collected and assessed. The medical history must be reviewed with the patient and the instructor at the beginning of each consecutive appointment. Students will use a medical history rubric to self-assess and gain instructor feedback.
- C. Extra/Intraoral Examination  
Complete an Extra/Intraoral head and neck examination on all patients. Identify all normal structures or conditions as well as any abnormal conditions. Describe findings using notations in the EPR. The examination will be reviewed at the beginning of each consecutive appointment.
- D. Case Classification and Gingival Description  
Classify the patient's calculus/debris status based on amount and locations of hard and soft deposits. Describe and assess gingival present condition and history, presence of bleeding, bone loss, and other factors within the oral cavity as defined in the *Student Handbook* using the gingival description record in the EPR.
- E. Treatment Planning  
Determine the complete oral health needs of patients using the assessment, diagnosis, planning, implantation and evaluation model of the dental hygiene process of care. Reflect those needs in the dental hygiene treatment plan. Present the plan to the patient using appropriate patient management techniques. Dental services, treatments, and referrals will be confirmed with the instructor.
- F. Instrumentation  
Utilize the proper instrument in an appropriate manner to remove all deposits with no unnecessary tissue trauma. The sharpness, original shape and design of the instrument will be maintained.
- G. Patient Education  
Determine the educational needs of the patient following proper data collection and assessment. Provide education and instruction to the patient, based on ongoing patient assessment, to fit his/her individual needs. Individualized patient education includes: plaque control, nutritional counseling, tobacco cessation and information regarding the oral and systemic link to health.
- H. Time Management  
Manage all aspects of the patient's case. Provide individualized services to the patient in an efficient and effective manner.

- I. Record Keeping  
Accurately complete all forms in the patient's EPR, clinic evaluation forms and other clinic paperwork with non-erasable black ink.
- J. Ethics and Professionalism  
Demonstrate ethical and professional behavior.
- K. Dental/Periodontal Charting  
Review and accurately record dental and periodontal conditions on all patients as outlined in the Student Handbook. Complete periodontal charting prior to scaling unless the case is to be perio charted by quadrant throughout treatment as designated by instructor. A full mouth periodontal charting noting six probe depth measurements, free gingival margin measurements, bleed on probing notations, mobility classification, and furcation grade per tooth is to be completed annually. If the patient presents with a full mouth periodontal charting within the past year, you will update the EPR periodontal chart by noting readings in areas previously recorded as 4 mm. or above and/or bleeding points.  
  
You are to consult the instructor in identifying which patients will require a periodontal re-evaluation appointment (ADA code 4132). If you treatment plan a patient to receive scaling and root planing followed by a periodontal re-evaluation appointment, at the re-evaluation appointment you will need to record all six probe readings per tooth in the SRP quadrant/s and record only readings of non-SRP quadrants that were previously 4 mm. or above and/or bleeding points. Note: The clinical attachment level is to be calculated and recorded on the periodontal chart of all patients.
- L. Calculus Removal  
Remove all calculus deposits on all patients without causing undue tissue trauma.
- M. Polish/Floss/Fluoride Treatment  
Remove all remaining extrinsic stain and plaque after scaling. Determine the evidence based method fluoride delivery method appropriate to the patient and administer accordingly, as outlined in the *Student Handbook*.
- N. Pit and Fissure Sealants  
Place sealants on appropriate teeth as outlined in the *Student Handbook*.
- O. Radiographs  
Expose and process diagnostic radiographs.

## RESOURCES

### I. Required Texts

*Clinical Practice of the Dental Hygienist*, Wilkins, E.M., Lippincott Williams & Wilkins, 9<sup>th</sup> Edition, 2005.

*Dental Hygiene, Concepts, Cases and Competencies*, Daniel, S.J. & Harfst, S.A., Mosby, St. Louis, Missouri, 2002.

*Fundamentals of Periodontal Instrumentation & Advanced Root Instrumentation*, Nield-Gehrig, Jill S., Lippincott Williams & Wilkins, 5<sup>th</sup> Edition, 2004.

*The University of Texas Health Science Center at Houston Dental Branch Clinic Operations and Procedures Manual (UTDB Clinic Manual)*.

*The School of Dental Hygiene Student Handbook* referred to as the *Student Handbook*; latest edition; "Clinic Procedure Checklist" which is found in the Student Handbook.

*Oral Lesions: An illustrated quick reference guide to diagnosis and treatment*, by Drs. Chas Dunlap & B.F. Barker, Colgate/Hoyt Lab.; latest edition.

*Dental Drug Reference*, Lexicomp. latest edition.

*The Chairside Instructor*, American Dental Association

### II. Human Resources

Ann O'Kelley Wetmore, R.D.H., B.S.D.H.  
Phone: 713-500-4394, Room 1.085  
Email: Ann.Wetmore @uth.tmc.edu

Student Advisers and Facilitators: As assigned

Dental Hygiene Dept Secretary  
Tonya Alvis  
Phone: 713-500-4086  
Room 1.085

### III. Electronic Resources

Blackboard  
UTDB Email

*Please check BlackBoard and your UT email account on a daily basis for course updates.*

## STUDY PLAN AND REQUIREMENTS

Clinic Time: Monday, Wednesday and Thursday 9:00 am - 11:45 am and 1:00 pm - 4:45 pm.

*Prerequisite: Successful completion of DHBS 3201 Clinical Practice I is the prerequisite of this course.*

### **A. Attendance**

**Clinic attendance is required.** In the event you are unable to attend clinic as scheduled, it is your responsibility to:

1. Notify the Clinic Coordinator, Ms. Wetmore, at 713-500-4394 and the Dental Hygiene Department Secretary at 713-500-4084 by 8:30 a.m. (Leave a message.)
2. **Notify patients for appointment changes that may be needed.**  
You must attend a minimum of 90% of clinical time to receive credit for Clinical Practice II. The margin of 10 percent absence is provided to accommodate only unavoidable absences due to illness, delayed registration, or approved causes. It is not contemplated that this accommodation shall apply to other than exceptional cases. More information is provided in this handout under the "Evaluation Methods" section.

### **B. Appearance Guidelines**

You are to wear a clinic gown over misty green colored hospital scrubs when providing clinical services to patients or working in the clinic area. The gown is to be changed after each patient. If appearance guidelines are not followed, you will be dismissed from clinic. Use the rubric in the Appendix to determine if appearance is within the guidelines for professionalism. (Refer to *Student Handbook* for dress code.)

### **C. Patient Scheduling**

**Your first responsibility in clinic is to have a patient.** Keep a list of patients who are available on short notice so that you can appoint one if a cancellation or no-show occurs. Make open clinic times the exception, not the rule, as they deny you valuable experience and can result in a deduction of points off your final course grade. Check your family of patients regularly. Patients may be assigned to you at the time they are accepted for treatment in the Assessment Clinic however the Assessment Clinic does not provide you with every type of patient and/or specific patients you must have for competency exams and boards. You must supplement your patient family with those from "friends and family" sources. You are expected to complete all patients assigned to you in the EPR system. Should you have an open appointment, inform your instructor and make the proper notation on the clinic board if you leave the clinic area to look for your patient, make a phone call or go to a rotation site, etc.

### **D. Patient Charts/Radiographs**

All charts/radiographs that are used in the day must be returned to the appropriate desk by 4:45 p.m. each day. Patient charts are not to be taken out of the building.

### **E. Personal Property**

To protect your personal property, keep all books, purses, jackets, etc., in your locker rather than in unlocked areas of the clinic and the classroom. **No personal property should be left in the clinic area. Anything left in the clinic may be confiscated.**

### **F. Equipment Maintenance**

Any remaining iodophor must be run through the suction daily to maintain clean vacuum lines. Please report any equipment problems to your instructor as soon as they occur. Please report any computer

problems immediately to your instructor and call extension 4848 to report problem.

**G. Clinic Schedule**

Clinic and Rotation Schedule will be posted on Blackboard and DHII bulletin board and sent via UTDB e-mail. Changes may occur considering institutional requirements. It is your responsibility to be aware of the course schedule and any changes that may occur.

Dental hygiene clinic patient treatment hours are 9:00 am-11:45 a.m., and 1:00 pm – 3:45 pm. Patients may not be treated during any other hours. (Patients arriving late or from the assessment clinic should not be seated in the clinic after 11 for morning sessions or after 3 for afternoon sessions.)

Clinical Conferences will begin by 4:00 pm. Students treating patients in the DH clinic in afternoon clinic sessions must attend that afternoon's Clinical Conference to be counted present for the clinic session. The Clinical Conference will be held by the student's bay instructor.

**H. Indices**

O'Leary Plaque Score: An O'Leary Plaque Score must be completed and properly noted in the PHOTEN of the treatment history in the EPR at each appointment following check-in and prior to instrumentation. After determining the O'Leary Plaque Score, you should follow-up with patient education.

**I. Calculus Removal**

At the discretion of the clinical instructor, Class I and Class II cases will be evaluated for calculus removal after a quadrant or half mouth has been completed and Class III and Class IV cases are evaluated several teeth or one quadrant at a time. **Student should inform instructor if they would like an instrumentation technique demonstrated. It is more important during this course to practice skills in removing deposits rather than attaining perfection.**

**J. Rotation Assignments**

Rotation assignments are scheduled for specific days and times. Refer to the "Rotation Schedule" for assigned days. If you are unable to attend a rotation when it is assigned, contact the Clinic Coordinator and rotation supervisor prior to the absence from your assignment. If you miss all or part of an assignment or receive an unsatisfactory evaluation, you will be required to make it up using your own clinic time as soon as the reassignment can be made by the Clinic Coordinator. In the event that the rotation cannot be rescheduled, an equivalent experience, as decided by the Clinic Coordinator, will be required in place of that assignment using your clinic time.

**K. Appointment Planning**

Appointment scheduling will be done by the student and should follow the patient's consent of an approved treatment. As soon as the treatment plan has been approved by the instructor at the initial appointment, it should be entered into the student scheduler. All consecutive appointments should have planned treatment placed in the scheduler.

**L. Emergency Treatment**

A limited number of patients are accepted for emergency treatment on a first-come, first-serve basis. Patients should arrive at the Dental Branch by 6:30 a.m. carrying at least \$60 on days the Urgent Care Clinic is open.

**M. Pediatric Dental Patients**

It is not recommended that patients under three (3) years be treated in the dental hygiene clinic.

**N. Daily Progress/Learning Contract**

Evaluate and determine your personal goals for the clinic session based on your learning objectives and course evaluation tools. *This should be an ongoing process.* Prior to or at check-in time, you and the instructor will determine what treatment is to be provided and, if indicated, which area is to be

scaled during the appointment. At the end of the appointment the instructor will briefly check the area completed. The instructor will record comments concerning your progress on the CEF form. The instructor will discuss your personal learning objectives with you and make suggestions to enhance your experience. This brief review will serve only as a feedback mechanism to let you know your progress toward completing the patient.

**O. Final Appointment Sequence**

The final appointment will serve as a good measure of your organizational and clinical skills, and your time management skills. It is suggested that scaling and root planing be completed prior to the last appointment. Prior to polishing, a final scale check will be performed on all areas of the mouth regardless of scale checks at previous appointments. You must reassess previously scaled areas for any remaining deposits and tissue response at each subsequent appointment.

For patients not requiring a periodontal re-evaluation appointment, a comprehensive assessment of the patient's oral health will be done at the final appointment. Definitive scaling is to be performed at this time, if needed. Following the comprehensive assessment and final scale check by your instructor, you may proceed with the polish/floss which will be evaluated prior to the application of fluoride. Appropriate recare should be determined and presented to patient.

For patients requiring a periodontal re-evaluation appointment, the comprehensive assessment of the patient's health will be done at the re-evaluation appointment, as well as scaling of residual calculus as necessary, followed by polish/floss/fluoride. You are to consult your instructor in identifying the need for a re-evaluation appointment. A periodontal referral, if needed, should be requested at this appointment. Appropriate recare should be determined and presented to patient.

**EVALUATION**

**P. Non-graded Demonstrations**

(\*2) Medical History

This demonstration is a product evaluation. Faculty will review the medical/dental history with you and the patient after you have completed the interview and have made appropriate notations in the EPR at the patient's initial appointment with you (this may be a patient in progress transferred from the graduating class). The medical/dental history rubric will be used in evaluating your competency. One rubric will be completed as a self-assessment and one rubric will be completed as a faculty evaluation. Both are non-graded and need to be completed at your initial visit appointment on two different patients. (See example of a rubric in Appendix B.)

(\*1) Extra/ Intra Oral Examination

This demonstration is a product evaluation. At the patient's initial appointment with you (this may be a patient in progress transferred from the graduating class), you will complete an extra/intraoral examination. Note normal and abnormal structures and/or conditions. They must be identified and/or described thoroughly in the EPR. The extra/intraoral examination rubric will be used in evaluating your competency. One rubric will be completed as a self-assessment and one rubric will be completed as a faculty evaluation. Both are non-graded and need to be completed at your initial visit appointment on two different patients.

(\*2) Dental Charting

This demonstration is a product evaluation. Instructor will give feedback and demonstrate findings. It is highly recommended to use radiographs for this demonstration. Any patient over six may be used for this demonstration. Student will keep a record in order to self-assess knowledge of identifying existing dental findings. These findings may be on student's patient or colleague's patient either in dental hygiene clinic or on rotations. While there are no limits to how many finding the patient has to have, you will enhance your clinic experience and gain

more knowledge that will be tested in a skill evaluation as you are exposed to more types of dental findings.

- (\*2) Initial/Residual Calculus Detection (one quad\*\* on Class II or III)  
You will use a white reproduced copy of the anatomical dental chart to mark the tooth surfaces where remaining supra **and** subgingival deposits are found. It is not necessary to identify how many mm. subgingival the deposit is. Rough areas of calculus should be noted in red and obvious deposits (clicks) should be noted in blue. The following describes the type of calculus to be noted in blue: a significant deposit readily discernible or detectable, "jump" felt with explorer, definite vibration that sometimes binds explorer, interproximal deposit felt from lingual and/or buccal and/or marginal ring, ledge or partial ledge encircling tooth.

You will identify calculus using the above method. The instructor will give feedback through demonstration. You will then be asked to remove the calculus to the best of your ability. (Depending on the time and type of deposits a reduction in teeth to be scaled or a time limit may be assigned by instructor.) Upon completion of scaling use the above method to identify residual calculus, if any. Instructor will give feedback on detecting skills as well as discuss any areas that may have been missed while scaling. This demonstration should be an opportunity for learning the very basic part of the practice of dental hygiene, to detect and remove calculus. Please take feedback accordingly.

- (\*1) Ultrasonic Demonstration  
Using the ultrasonic rubric, self-assess and gather feedback on the use of ultrasonic scalers.
- (\*1) Naber's probe Demonstration  
You will demonstrate the use of the Naber's probe in determining furcation involvement. Self-assess using the Naber's probe rubric.

\* *Designated number of times a non-graded demonstration must be performed.*

\*\* *Definition: In Clinical Practice II, a quadrant is defined as a minimum of 6 natural teeth (can be restored, but must have root/s that can be scaled), three of which are posterior teeth. Faculty members may use discretion in combining quadrants to represent a qualifying quadrant.*

#### **Q. Competency Demonstrations**

Competency Demonstrations will take place throughout the semester. They will consist of in-depth observation and feedback to provide information on your clinical strengths and weaknesses. After assessment, faculty will discuss with you methods to correct any identified deficiencies and praise success. This is a time for you to ask questions about anything to help develop your skills. It is essential that the exchange be objective and maintained at a professional level.

Competency Demonstrations may not be done on dental hygiene students or patients under the age of 16 (exceptions: Polish/Floss/Fluoride Competency may be performed on any patient 6 years or older and Periodontal Charting must be performed on an adult 18 years or older or on any case deemed appropriate by the faculty). Competency Demonstrations are to be performed without the assistance of peers. In evaluation of these procedures, Competency Demonstrations, the "Clinic Procedure Checklist" in the *School of Dental Hygiene 2006-2007 Student Handbook (Student Handbook)* is used as a guide to critical errors.

Competency Demonstrations compose twenty percent (20%) of the final Clinical Practice II course grade.

Faculty will record evaluations of your performance of Competency Demonstrations attempted for the Competency Demonstration portion of the course grade by indicating your performance level on your Competency Demonstration Sheet along with the patient's DH list number, faculty member's signature/initial and date. Evaluation performance levels are 5, 4 and 1. Once you have achieved a

level of competence (level 4 or 5) the designated\* number of times for course DHBS 3501, you must continue to perform that procedure in a competent manner in order to maintain your skills.

*Note: For specific criteria for clinical evaluation refer to the levels of competence described under "Evaluation Methods" and "Competency Demonstrations" in this syllabus, and the "Clinic Procedure Checklist" in the School of Dental Hygiene 2006-2007 Student Handbook (Student Handbook).*

- (\*2) Periodontal Charting  
one quad; must have probe depths > 3mm. on 3 or more teeth. Record 6 probe depths per tooth as well as the free gingival margin, bleed on probe, furcation grades, mobility classification. You must be record all data in the EPR.
- (\*2) Scaling or Scaling and Root Planing  
one quad\*\* (may use a quad plus up to 4 additional teeth to qualify for scale competency demo) on Class II or III; minimum of six deposits of calculus; competency is to be completed and evaluated within one clinic session. Each area of tissue trauma constitutes one error. Cavitron allowed on Class III quadrants.
- (\*2) Polish/Floss  
must be completed within 45 minutes using rubber cup, selective polishing technique followed by flossing on patient's final appointment; any case Class with a minimum of 16 teeth allowed. This is a product evaluation.

\* *Designated number of times a Competency Demonstration performed for evaluation toward the Competency Demonstration course grade must be performed at a 4 or 5 level:*

\*\* *Definition: In Clinical Practice II, a quadrant is defined as a minimum of 6 natural teeth (can be restored, but must have root/s that can be scaled), three of which are posterior teeth. Faculty members may use discretion in combining quadrants to represent a qualifying quadrant.*

YOU MUST SUCCESSFULLY DEMONSTRATE COMPETENCE IN TREATMENT PROCEDURES DESIGNATED AS "COMPETENCY DEMONSTRATIONS" FOR CLINICAL PRACTICE II AND CONTINUE TO PERFORM THE PROCEDURES AT A LEVEL OF COMPETENCE IN ORDER TO BE ELIGIBLE FOR GRADUATION.

#### **R. Time Constraints**

Two Time Constraints are required in Clinical Practice II. Each of these procedures is a timed 60-minute test that faculty evaluate and assign a numerical grade according to the following criteria. The average of the two Time Constraint grades comprises fifteen percent (15%) of your Clinical Practice II course grade. **A Time Constraint that is not completed by the end of the regularly scheduled clinic semester will be assigned a grade of "0" in calculating the clinical course "Time Constraint" portion of the grade.**

#### Patient Qualifications

Utilizing one quadrant plus up to 4 additional teeth anywhere in the mouth, you must submit a patient meeting the following criteria:

- 1) A minimum of eight qualifying surfaces of calculus (Class II or III calculus) must be present. At least one of the eight qualifying surfaces must be located on a molar. A maximum of four of the eight qualifying surfaces may be located on the mandibular anterior teeth (central incisor to cuspid or cuspid to cuspid). There can be more calculus on the mandibular anteriors but only four can count toward the eight needed.
- 2) It is suggested that probe depths not exceed 6 mm.

### Testing Information

Cavitron is allowed. You will have 60 minutes to scale the assigned area. You will be evaluated on calculus removal and tissue trauma. Five (5) points per error is deducted from 100 points. If no errors are noted and the patient's tissue does not hinder calculus detection, you may receive a final scale check on the quadrant at the discretion of your instructor. Otherwise, consult with your supervising faculty to determine the time of final evaluation of each quadrant.

YOU MUST COMPLETE THE REQUIRED TIME CONSTRAINTS FOR CLINICAL PRACTICE II IN ORDER TO BE ELIGIBLE FOR GRADUATION.

### **S. Quadrant Requirements**

You must complete a minimum of 12 quadrants of Class I or Class II type calculus. Class III type calculus will be equal to two (2) quadrants of Class I or Class II. Class 0 counts for .5 points. Extra points will be added for each extra quadrant completed.

### **T. Case Study**

Select one patient to provide comprehensive patient care. (See requirements below, may be a patient that was seen previously by a student for WREB.) The scaling requirement cannot be attempted until the **Wednesday June 13, 2007**. All other requirements of the Case Study may be completed prior to this date.

### Assess

- Obtain vital statistics: age, ethnicity, sex, occupation, and socioeconomic status.
- Complete a medical/dental history.
- Complete a extra/intraoral examination.
- Complete gingival description.
- Complete dental charting.
- Complete perio charting. (You will use one quadrant to submit for evaluation of perio charting competency.)
- Complete the Comprehensive Patient Assessment Findings Form.
- Complete the Oral Risk Assessment Form.
- Complete radiographic interpretation.

### Diagnose

Using the above data, provide a summary of the following:

- the patient's medical and dental history
- the patient's dental, psychosocial, and dietary needs
- the extra/intraoral, caries and periodontal assessment
- the patient's periodontal and caries diagnosis
- the patient's prognosis

### Treatment Plan

Based on this summary develop a dental hygiene care plan/treatment plan using the dental hygiene process of care. Include the following:

- Oral Risk Assessment
- Preventive Education
- Dental Anxiety Assessment and Pain Management Strategies
- Non-Surgical Periodontal Therapy

### Implement

- Provide rationale for appropriate instrumentation for one qualifying quadrant of Class II, III or IV calculus
- Using calculus detection method documented previously identify areas of calculus on the submitted quadrant

- Remove all calculus in a timed 60-minute test that faculty will then evaluate.

#### Patient Qualifications

Utilizing one quadrant plus up to 4 additional teeth anywhere in the mouth, you must submit a patient meeting the following criteria:

- 1) A minimum of eight qualifying surfaces of calculus must be present. At least one of the eight qualifying surfaces must be located on a molar. A maximum of four of the eight qualifying surfaces may be located on the mandibular anterior teeth (central incisor to cuspid or cuspid to cuspid). There can be more calculus on the mandibular anteriors but only four can count toward the eight needed.
- 2) It is suggested that probe depths not exceed 6 mm.

#### Testing Information

Cavitron is allowed. You will have 60 minutes to scale the assigned area. You will be evaluated on calculus removal and tissue trauma.

You will evaluate your patient for residual calculus and note areas that still need further instrumentation. Instructor will provide feedback on residual and demonstrate/facilitate methods of removal.

#### Evaluation

Evaluate total patient care:

- Determine effectiveness of your care.
- Determine future patient dental hygiene needs.
- Evaluate patient oral self-care.
- Determine future dental needs.
- Discuss referral needs.

#### Grading

A Case Study rubric will be used for diagnosis, plan, and evaluation worth a total of 75 points. Implementation will be worth 25 points with 2 points for each error of calculus and tissue trauma.

#### **U. Clinic Journal/Blog**

You will reflect on your clinic experiences using a Web-based tool such as a blog. A guiding question will be posted each week in BlackBoard to guide your self-assessment and reflection. You are required to post to your blog by Friday of each week of summer clinic. Eight blog entries are required to fulfill this portion of your clinic grade. A self-assessment rubric will be provided to evaluate authenticity of reflection.

## EVALUATION METHODS

The clinic grade will be computed as follows:

### **Patient Treatment/Attendance**                      **10%**

Engagement in patient treatment is critical in this course. It is your responsibility to have a patient in the chair at each appointment. Attendance will count 10% of the course grade. For each clinic session that you do not treat a patient, five points will be deducted from your Patient Treatment/Attendance portion of the course grade. Assisting peers in the clinic and FMS Interpretations do not count as patient contact. You may elect to complete medical history, charting and/or calculus exercises during two non-patient contact clinic sessions to avoid loss of points in Patient Treatment/Attendance; completing exercises and having your instructor check them will allow you to count these sessions as being present and count as if you have patient contact. Your instructor will determine how many exercises will be required during the clinic session.

You must set up your cubicle prior to the beginning of the clinic session; by 9:00 am for the morning session and by 1:00 pm for the afternoon session or you will be counted absent. Set up even if no patient is scheduled as there may be a patient referred to the student by the Clinic Coordinator or other faculty member. Attendance is taken by the instructor at the beginning and end of the clinic session.

If patient treatment is not provided during the scheduled clinic time, report your non-patient status to the instructor as soon as possible. You may be dismissed by the instructor at 11:00 am in a morning session. Students assigned to afternoon clinic sessions must attend that afternoon's Clinical Conference to be counted present for the clinic session. In the case there will be no Clinical Conference, you may be dismissed at 3 pm.

### **Non-graded Demonstrations**

*All demonstrations must be completed by end of Summer Clinic in order to receive an "A" in the course.*

Evaluation of non-graded demonstrations is strictly for feedback. Self-assessment is an integral part of being a dental hygienist and is a demonstration of critical thinking and life-long learning. Completion of ultrasonic observation will carry over to Fall requirements.

### **Competency Demonstrations**                      **20%**

Evaluation of Competency Demonstrations will be recorded by the instructor during the clinic session. Competency Demonstrations may be completed during any clinic session with the approval of the instructor.

Evaluation Performance Levels are defined as:

- 5        =        during this observation, your performance of the procedure surpasses that of entry level competency in judgment and skill. No critical or non-critical\* errors occur at this level of performance. (\*Refer to *Handbook*, Competency Sheet and Syllabus to identify Competency Demonstrations that may have allowable non-critical errors for a level 5 evaluation.)
  
- 4        =        during this observation, your performance of the procedure is at entry level competency in judgment and skill. No critical errors occur at this level of skill performance. (Refer to *Handbook*, Competency Sheet and Syllabus for allowable non-critical errors.)
  
- 1        =        during this observation, your performance of the procedure is below entry level competency in judgment and/or skill. Critical errors and/or non-critical errors occur at this level of performance. This evaluation indicates that you need more practice in order to become competent in performing this procedure. (Note: In determining the Competency Demonstration portion of your Clinical Practice II course grade, each evaluation of 1 results in the subtraction of one point from the total of your evaluation points.)

Once you have successfully demonstrated competence in a treatment procedure, it is important that you continue to perform that procedure in a competent manner in order to maintain your skills and to provide your patients with high quality care.

To assess a numerical grade to be used in calculating the Competency Demonstration portion of your course grade, add competency evaluation scores of 4 and 5. Non-attempted/incomplete Competency Demonstrations and all 1 level evaluations are added as "-1". Use the following scale to determine the competency grade that corresponds to your total.

Evaluation points = Comp grade

30 = 100	15 = 37.5
29 = 96	14 = 33
28 = 92	13 = 29
27 = 87.5	12 = 25
26 = 83	11 = 21
25 = 79	10 = 17
24 = 75	9 = 12.5
23 = 71	8 = 9
22 = 67	7 = 5
21 = 62.5	6 = 1
20 = 58	5 = 0
19 = 54	4 = 0
18 = 50	3 = 0
17 = 46	2 = 0
16 = 42	1 = 0

**Time Constraints** 15%

**Quadrant Requirements** 10%

**Case Study** 20%

75 points possible for Assessment, Diagnosis, Plan and Evaluation

25 points possible for Implementation

100 Total points possible

**Clinic Journal Blog** 5%

**Learning Contract Reflection** 5%

*This is the final assignment for this course.* You will review your learning contract after completion of all competencies, requirements and skill evaluations. You will write a two-page, double-spaced paper that reflects on your clinical learning experience. There is a fair amount of evidence that considers reflection to be a very important part of learning, especially in higher education. The purpose is true reflection. You will be graded on whether your paper meets the following criteria:

- *at least two-pages in length*
- *written using a double-spaced format*
- *free from spelling or grammatical errors*
- *a representation of a true reflection of your clinical learning experience*
- *A HARD COPY must be turned in to me no later than **July 12, 2007 at 4:00 pm.***
- **Late submissions will not be accepted.**

**Dental Charting**

Simulation Skill Evaluation 5%

**Medical History**

Simulation Skill Evaluation 5%

**Rotations***(All must be completed satisfactorily during the assigned semester)***Daily Clinic Evaluation** 5% (EPR average)Daily Clinic Evaluation Criteria

Listed in each category of Daily Clinic Evaluation are the specific objectives you must demonstrate to be successful. (These objectives will also be referred to as grading criteria.) This evaluation is assessed each appointment and is reflected on the lower left area of the Clinical Evaluation Form and is posted on the EPR at the final check out. Successful demonstration of the objectives in each category during an appointment of patient will result in a grade of 5. Errors in any category will result in a 1-point deduction each per occurrence. For example, a student does not perform the appropriate oral hygiene instruction with the patient. If there are no other Daily Clinic Evaluation errors during that appointment, the Daily Evaluation grade is 4. In this example, if the student does not begin clinic on time nor dismiss the patient on time, two additional points are deducted resulting in a Daily Evaluation grade is 2. Please note that any infraction in infection control or professionalism results in an automatic grade of 1.

All of the Daily Evaluation grades are averaged for the semester by the EPR. The following are the grades equivalences on a scale of 100:

- 5 = 100
- 4 = 87.5
- 3 = 75
- 2 = 50
- 1 = 0

Categories of Evaluation within Daily Clinic Evaluation

- A. Medical/Dental History  
For grading criteria, refer to the appropriate Clinical Procedure Checklist in the *Student Handbook*.
- B. Head/Neck Examination  
For grading criteria, refer to the appropriate Clinical Procedure Checklist in the *Student Handbook*.
- C. Case Classification and Gingival Description
  - 1. Classifies the patient's occlusion.
  - 2. Classifies the patient's prophylaxis status; prophy class.
  - 3. Classifies the patient's periodontal status, AAP Classification.
  - 4. Describes the gingival condition of the patient.

Base these classifications and descriptions on gingival history and present condition, amount of soft and hard deposits present, presence of bleeding, bone loss, and other factors within the oral cavity as defined in the *Student Handbook*.
- D. Treatment Planning  
For grading criteria, refer to the appropriate Clinical Procedure Checklist in the *Student Handbook*.
- E. Instrumentation
  - 1. For grading criteria specific to the use of different types of instruments, refer to the

- appropriate Clinical Procedure Checklist in the Student Handbook.
- 2. Utilizes the proper instrument in an appropriate manner with no unnecessary tissue trauma.
- 3. Maintains the sharpness, original shape and design of each instrument.

F. Patient Education

- 1. For grading criteria specific to the use of different types of patient education, refer to the appropriate Clinical Procedure Checklist in the *Student Handbook*.
- 2. Determines the educational needs of the patient following proper data collection, including assessing plaque with O'Leary Plaque Score.
- 3. Provides education to the patient including:
  - a) Plaque relationship to dental caries and periodontal disease.
  - b) Appropriate brushing method/s.
  - c) Selection of proper toothbrush and auxiliary plaque control measures.
  - d) Appropriateness of fluoride treatments.
  - e) Tobacco Cessation
  - f) Dietary counseling.
  - g) Phase contrast microscope.
  - h) Diagnostic radiographs.

G. Time Management

- 1. Prepares cubicle in advance so patient is seated at the scheduled appointment time.
- 2. Initiates principles of effective time and motion management.
- 3. Is familiar with procedure(s).
- 4. Is prepared for the procedure(s).
- 5. Completes procedures in a timely manner.
- 6. Utilizes clinic time effectively and efficiently.
- 7. Dismisses patient at proper time.
- 8. Cleans cubicle and leaves clinic at noon and afternoon closing times.

H. Infection Control

- 1. Practices standard precautions.
- 2. Follows good principles of personal hygiene on a daily basis.
- 3. Follows proper hand washing guidelines.
- 4. Keeps fingernails short.
- 5. Wears approved clinic attire.
- 6. Does not wear jewelry when in clinic.
- 7. Keeps hair pinned up, pulled back away from face.
- 8. Practices proper disinfection protocol.
- 9. Changes iodophor disinfectant on a daily basis.
- 10. Verifies sterile instruments.
- 11. Uses appropriate barrier techniques-i.e. gloves, mask, protective eyewear.
- 12. Removes gloves or put on overgloves when leaving the cubicle, writing in the chart or opening drawers.
- 13. Wears heavy duty, vinyl utility gloves when cleaning contaminated instruments.
- 14. Follows environmental surface asepsis.
- 15. Provides a needle cap holder when a needle and syringe are present.
- 16. Manages hazardous waste properly.
- 17. Limits contamination.
- 18. Keeps patient chart in noncontaminated area.
- 19. Does not leave items on any cubicle surface while treating patients.
- 20. Refer to "Aseptic Technique" in the Clinical Procedure Checklist in the *Student Handbook* for a detailed description of procedures.

I. Record Keeping

1. Documents all patient information required in EPR
2. Displays radiographs on view box, where they are accessible.
4. Documents review/update medical history in EPR.
5. Documents review/update head and neck exam in EPR.
6. Documents all procedures and required information in the EPR
7. Completes all appropriate forms (i.e. Clinic Evaluation Form from "Student Name" through "Last Assessed") and completes all EPR forms including PHOTEN by clinic check-out time.

J. Ethics and Professionalism

Refer to "Ethics and Professionalism" in the Clinical Procedure Checklist in the *Student Handbook* for a detailed description of procedures.

1. Introduces patient to faculty.
2. Asks for clarification when uncertain of instructions or task.
3. Works independently yet recognizes his/her limitations.
4. Demonstrates ability for self-evaluation according to criteria presented in manuals and lectures.
5. Provides pertinent, individualized, appropriate information to the patient regarding treatment and the prevention of dental disease.

**Patient Case Study E-Portfolio/Presentation**

The student will be required to submit the case study completed in Summer Session as an E-Portfolio. Student will present the E-portfolio using a Power Point Presentation to the class. E-portfolio and oral presentation rubric will be used for evaluation. Course director will provide feedback. Use evidence based information in determining your patient's care needed. Be creative and use patient photos and pictures of radiographs. There are several resources available for this.

The following information **must** be recorded in the E-portfolio:

Assess

- Obtain vital statistics: age, ethnicity, sex, occupation, and socioeconomic status. **"No Name" in accordance with HIPAA.**
- Summary of patient's medical and dental history.
- Summary of the patient's dental, psychosocial, and dietary needs.
- Summary of extra/intraoral examination findings and gingival description.
- Copy of dental charting.
- Copy of perio charting.
- Copy of the Comprehensive Patient Assessment Findings Form.
- Copy of the Oral Risk Assessment Form.
- Summary of radiographic interpretation.

Diagnose

Using the above data, provide a summary of:

- the patient's periodontal and caries diagnosis
- the patient's prognosis

Treatment Plan

- Provide a copy of the treatment plan
- Include the following:
  - a. Oral Risk Assessment
  - b. Preventive Education
  - c. Dental Anxiety Assessment and Pain Management Strategies

d. Non-Surgical Periodontal Therapy

Implement

Provide a description of the treatment you provided

Evaluation

Summarize the effectiveness of your treatment and make recommendations for the patient's future needs

**Possible Course Grades: A, B, C and F**

Course Grading Scale:

93 -100	A***
84 - 92	B
75 - 83	C
0 - 74	F

\*\*\* *All Demonstrations, Competency Demonstrations and Requirements must be completed within the regularly scheduled Summer 2007 Clinic Session to earn an "A" in Clinical Practice II.*

## Appendix A

### *Learning Contract Example*

#### **DHBS 3501 CLINICAL PRACTICE II Summer Session 2007**

#### **LEARNING CONTRACT**

<b>Learning Objective</b>	<b>Learning Resources and Strategies</b>	<b>Evidence of Accomplishment</b>	<b>Evaluation Criteria and Validation</b>
Become proficient with the use of Nabor's Probe	Sim Center demonstration and clinic practice	Complete positive demonstration in clinic	Rubric and instructor feedback

## Appendix B

*Example of Self-assess / Faculty Feedback Rubric*

### DHCT 2301 CLINICAL PRACTICE II Summer Session 2007

#### MEDICAL/DENTAL HISTORY RUBRIC

Student Name \_\_\_\_\_

Instructor \_\_\_\_\_ Date \_\_\_\_\_

Objectives	Novice 1 point	Emerging 3 points	Competent 5 points	Earned Points
Apply all knowledge gained in previous and concurrent course work and conduct a comprehensive medical and dental history interview on all patients.	Requires instructor prompting to complete a summary of patient medical and dental history.	Summarizes medical and dental history, identifying special needs related to dental hygiene care with prompting from instructor to identify special needs regarding dental hygiene care.	Summarizes medical and dental history, identifying special needs related to dental hygiene care.	
Report all patient medications, herbals and supplements and their drug classification, indications, dental and local anesthetic contraindications and drug interactions to instructor.	Incomplete reporting of all patient medications, herbals and supplements and their drug classification, indications, dental and local anesthetic contraindications and drug interactions to instructor.	Report all patient medications, herbals and supplements and their drug classification, indications, dental and local anesthetic contraindications and drug interactions with instructor prompting.	Report all patient medications, herbals and supplements and their drug classification, indications, dental and local anesthetic contraindications and drug interactions to instructor.	
Reviews vital statistics and edits in EPR	Forgets to review vital statistics	Reviews vital statistics and edits in EPR Medical History	Reviews vital statistics and edits in EPR Medical History and Demographic Data	

Take and record all vital signs in the EPR medical history form and treatment history PHOTEN note.	Takes all vital signs. No EPR notation.	Take and record all vital signs. Requires instructor prompt to record in both EPR medical history form and treatment history PHOTEN note.	Take and record all vital signs in the EPR medical history form and treatment history PHOTEN note.	
Conduct interview using face to face contact and explaining/probing all areas that patient gives unsure answers to	Conduct interview using face to face contact. Does not probe or explain areas that patient are unsure of. Has difficulty pronouncing words on medical history.	Conduct interview using face to face contact. Does not probe or explain areas that patient are unsure of. Cannot pronounce all words on medical history.	Conduct interview using face to face contact and explaining/probing all areas that patient gives unsure answers to. Uses correct pronunciation.	
Identify medical conditions which require a medical consult or alert. Inform patient of reason for alert. Demonstrate how to write a medical consult.	Requires direct order to: Identify medical conditions which require a medical consult or alert; Inform patient of reason for alert; Write a medical consult.	With Instructor prompt: Identifies medical conditions which require a medical consult or alert; Informs patient of reason for alert; Writes a medical consult.	Identify medical conditions which require a medical consult or alert. Inform patient of reason for alert. Demonstrate how to write a medical consult.	
Fill in EPR Medical/Dental History completely. Record information in EPR regarding all positive responses.	Fill in EPR Medical/Dental History missing more than two responses. Completely records information in EPR regarding all positive responses after instructor prompt.	Fill in EPR Medical/Dental History missing less than two responses. Completely records information in EPR regarding all positive responses after instructor prompt.	Fill in EPR Medical/Dental History completely. Record information in EPR regarding all positive responses.	
Listen to instructor feedback and synthesize into future clinic experiences Ask questions pertinent to enhancing clinical learning experience.	Argues with instructor about feedback and does not ask questions that will enhance learning.	Unable to listen to instructor feedback and synthesize into future clinic experiences. Ask questions that are not pertinent to enhancing clinical learning experience.	Listen to instructor feedback and synthesize into future clinic experiences. Ask questions pertinent to enhancing clinical learning experience.	

Integrate empathetic patient management and professional behavior in all patient contact experiences.	Shows narcissistic behavior and displays unprofessional conduct.	Conducts self in a professional but non-empathetic manner.	Integrate empathetic patient management and professional behavior in all patient contact experiences.	
Synthesizes knowledge gained from medical/dental history into needs assessment.	Unaware to synthesize knowledge gained from medical/dental history into needs assessment.	Synthesizes knowledge gained from medical/dental history into needs assessment with instructor prompt.	Synthesizes knowledge gained from medical/dental history into needs assessment.	
<b>Score:</b>				