UNIVERSITY OF NEW ENGLAND

Portland Campus

Dental Hygiene Program Policy and Procedures Manual

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DENTAL HYGIENE
PROGRAM POLICIES AND PROCEDURES MANUAL

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DENTAL HYGIENE PROGRAM POLICIES

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1.1 Dental Hygiene Mission Statement

The Dental Hygiene Program endeavors for excellence by preparing oral health professionals intellectually and practically for a broad and robust career in dental hygiene.

1.2 Dental Hygiene Learning Outcomes and Program Goals

The Dental Hygiene Program offers students learning opportunities to:

1. Provide the public with compassionate and competent dental hygiene care founded on evidenced-based scientific knowledge as an essential component of comprehensive interprofessional health care and community-based health care.

2. Demonstrate effective decision-making skills through the use of the critical thinking process.

3. Explore the complexities of ethical decision-making as it relates to professional expectations and social responsibility.

4. Commit to leadership, scholarship, and life-long learning to respond to an ever changing healthcare environment and growing profession.

5. Utilize oral healthcare technology (Health Informatics) and effective communication skills for use in the professional and practical arena.

6. Successfully gain access to dental hygiene licensure in the state of choice by completing the national and regional board examinations.

The Dental Hygiene Program Goals

The dental hygiene program strives to:

1. be a national leader in dental hygiene education.

2. offer opportunities to students that are student centered and interprofessional.

3. be authentically honest and professional in all relationships.

1.3 Technical Standards

Technical Standards are conducted for student review and signature each year.

Introduction

Technical standards are all of the nonacademic functional abilities that are essential for the delivery of effective and safe dental hygiene care. The technical standards listed below identify the skills and behaviors necessary to successfully complete the dental hygiene curriculum and adequately prepare our students for the practice of dental hygiene.

Students who have a documented disability should contact the Office of Student Access as soon as possible. Registration with OSA is required before any accommodation requests will be granted. After registering with OSA, the student and OSA will collaborate to identify to what extent reasonable accommodations may exist that will enable the student to meet both the academic and technical standards of the program without lowering programmatic expectations. Reasonable accommodations will be directed toward providing an equal educational opportunity for students with disabilities while adhering to the standards of dental hygiene practice expected of all students. As stated in the syllabus of most dental hygiene courses, any student eligible for and needing academic adjustments or accommodations is requested to speak with the professor within the first two weeks of class. Under no circumstances will the Dental Hygiene Program waive any essential course requirements or technical standards for any student with or without a disability.

The Dental Hygiene Program's technical standards are as follows, which a student must meet with or without reasonable accommodations:

Motor Skills / Manual Dexterity

Students must have full manual dexterity including adequate functioning of arms, wrists, hands and fingers. Appropriate psychomotor skills, manual dexterity and motor movement skills are necessary to render clinical dental hygiene treatment while possessing the physical strength to move oneself into a position that will enable the student to provide appropriate dental hygiene care.

The student must be able to:

Use personal protective devices (tolerate face mask/shield, safety eyewear, surgical gloves and laboratory coat)
Function in an environment where latex is present
Carry out OSHA infection control procedures using cleaners and chemicals
Perform dental hygiene procedures (scaling, polishing, x-rays) and manipulate dental materials
Access a patient from a seated or standing position
Operate switches, knobs, levers in operation of the dental chair and accessory equipment in all clinics and laboratory settings
Exhibit sufficient motor function to elicit information from a patient by palpation, auscultation, percussion, and other diagnostic modalities
Perceive and interpret tactile vibrations appropriately
Manipulate small objects and materials, paying close attention to fine detail
Perform basic life support including CPR
Transfer and position patients with disabilities

Sensory Skills / Observation Skills

A functional use of all senses is required. Visual acuity and intellectual ability are necessary to acquire information from documents such as charts, radiographs, small print, handwritten notations and computer images. Appropriate depth perception with vision from a distance of 18" with or without corrective lenses is essential.

A student must be able to:

Observe demonstrations at a distance and close at hand
Perform procedures in the classroom, clinic area and laboratory setting
See fine detail, focus at several distances, discern variations in color, shape and texture in order to differentiate abnormal from normal
Discern tactile sensations to perceive and interpret information associated with clinic procedures
Visually assess, bimanually palpate hard and soft anatomic structures
Develop reasonable skills of percussion and auscultation

Intellectual Skills / Conceptual and Cognitive Skills

Consistent, accurate and quick integration of information is required especially in an emergency situation.

The student must:

Possess the ability to learn, interpret, integrate, analyze and synthesize data
Possess the intellectual abilities required to carry out reasoning, analysis, problem – solving, critical thinking, self-evaluation and lifelong learning
Be able to comprehend three dimensional and spatial relationships

Communication Skills

A student must:

Communicate effectively and professionally with patients, colleagues, faculty and guests in verbal, nonverbal, and written form
Possess sufficient command of the English language in order to retrieve information from lectures, textbooks, and exams
Be able to obtain an accurate medical/dental history
Be able to accurately record findings in patients' records

Behavioral / Social / Mental / Emotional Skills

High levels of emotional and mental stability are required on a daily basis.

A student must possess the emotional health and mental stability necessary to:

Demonstrate respect and caring for patients, peers, staff, and faculty
Interact with peers, patients, staff and faculty in an emotionally stable, professional, and ethical manner

Demonstrate respect for the diversity of cultures among clinical patients, college personnel and peers
Demonstrate a team approach in carrying out responsibilities in all settings
Endure physically taxing workloads
Function effectively under stress
Adapt to changing environments by displaying flexibility
Display compassion, integrity, respect and concern for others, and strong interpersonal skills
Be tactful and congenial
Be able to accept criticism and respond by appropriate modification of behavior
Be able to interrelate among colleagues, staff, and patients with honesty, integrity, professionalism and nondiscrimination
Exercise good judgment
Promptly complete responsibilities attendant to the diagnosis and care of patients, and the development of mature, sensitive, and effective relationships with patients
Respect the confidentiality of patient privacy.

Other Skills

Students must demonstrate the ability to arrive at their clinical assignments on time and meet the programmatic requirements in a timely, professional and competent manner.

I attest that with proper training I see no reason why I am not capable of performing the technical standards expected of a student in the UNE Dental Hygiene Program as outlined above with or without reasonable accommodations.

_____

Student Signature Date

1.4 Competencies

PROFESSIONALISM AND ETHICS

1. Apply a professional code of ethics in all endeavors.
2. Adhere to state and federal laws, recommendations and regulations in the provision of dental hygiene care.
3. Provide dental hygiene care to promote patient/client health and wellness using critical thinking and problem solving in the provision of evidence-based practice.
4. Assume responsibility for dental hygiene actions and care based on accepted scientific theories and research as well as the accepted standard of care.
5. Continuously perform self-assessment for life-long learning and professional growth.
6. Advance the profession through service activities and affiliations with professional organizations.
7. Provide quality assurance mechanisms for health services.
8. Communicate effectively with individuals and groups from diverse populations both in writing and verbally.
9. Provide accurate, consistent and complete documentation for assessment, diagnosis, planning, implementation and evaluation of dental hygiene services.
10. Provide care to all patients using an individualized approach that is humane, empathetic, and caring.
11. Pursue continuing education courses and/or higher education that demonstrate a commitment to lifelong learning.

COMMUNITY INVOLVEMENT

1. Provide community oral health services in a variety of settings.
2. Provide screening, referral and education services that facilitate public access to the health care system.
3. Respond to patient or community requests for information about contemporary dental problems.
4. Promote the dental hygiene profession by actively participating in the membership, leadership and / or service in professional organizations.
5. Assess and evaluate community based oral disease prevention strategies that aim to improve the oral health of the public.

HEALTH PROMOTION AND DISEASE PREVENTION

1. Evaluate and utilize methods to ensure the health and safety of the patient and the dental hygienist in the delivery of dental hygiene.
2. Evaluate factors that can be used to promote patient adherence to disease prevention and/or health maintenance strategies.
3. Provide educational methods using appropriate communication skills and educational strategies to promote optimal health.
4. Promote preventive health behaviors by personally striving to maintain oral and general health.
5. Identify individual and population risk factors and develop strategies that promote health related quality of life.

PATIENT CARE

1. Assessment

a. perform a comprehensive examination using clinical, radiographic, periodontal, dental charting, and other data collection procedures to assess the patient's needs

b. Recognize predisposing and etiologic risk factors that require intervention to prevent disease

c. Obtain, review and update a complete medical and dental history

d. Recognize health conditions and medications that impact overall patient care

e. Identify patients at risk for a medical emergency and manage the patient in a manner that prevents an emergency

2. Diagnosis

a. Use assessment findings, etiologic factors and clinical data in determining a dental hygiene diagnosis

b. Identify patient needs and significant findings that impact the delivery of dental hygiene services

c. Obtain the proper consultations as indicated

3. Planning

a. Establish a planned sequence of care based on the dental hygiene diagnosis; identified oral conditions; potential problems; etiologic and risk factors; and available treatment modalities

b. Prioritize the care plan based on the health status and actual and potential problems of the individual to facilitate optimal health

c. Establish a collaborative relationship with the patient in the planned care to include the etiology, prognosis, and treatment alternatives

d. Make referrals to other health care professionals

e. Obtain the patient's informed consent

4. Implementation

a. Utilize accepted infection control procedures

b. Obtain diagnostic quality radiographs

c. Apply basic and advanced techniques of dental hygiene instrumentation to remove deposits without trauma to hard and soft tissues

d. select and administer appropriate chemotherapeutic agents and provide pre and post treatment instructions

e. provide adjunct dental hygiene services that are legally permitted

f. Provide oral health education to assist patients in assuming responsibility for their own oral health

5. Evaluation

a. Evaluate the effectiveness of the patient's self-care and the dental hygiene treatment in attaining or maintaining oral health

b. Determine the clinical outcomes of dental hygiene interventions

c. Develop a maintenance program that meets the patient's needs

d. Provide referrals for subsequent treatment based on the evaluation findings

**** Patient care and community-centered competencies also appear in sections 3.07 and 3.08.***

1.5 UNE Dental Hygiene Program Standards of Clinical Practice

The Standards for Clinical Dental Hygiene Practice are a resource for dental hygiene practitioners seeking to provide patient-centered and evidence-based care

Standard 1: Assessment

The collection and analysis of systematic and oral health data in order to identify client needs.

1. **HEALTH HISTORY**: Data on health status are comprehensive and include information on the patients' general health, oral health, and behavioral patterns.
   - Demographic Information
   - Vital Signs
   - Physical Characteristics
   - Social history
   - Medical history
   - Pharmacologic history

2. **CLINICAL ASSESSMENT:** Planning and providing optimal care require a thorough and systematic overall observation and clinical assessment.
   - Examination of the head and neck and oral cavity, including oral cancer screening.
   - Complete, and diagnostic set of radiographs.
   - A comprehensive periodontal examination
   - A comprehensive hard-tissue evaluation.

3. **RISK ASSESSMENT:** Qualitative and quantitative evaluation based on health history and clinical assessment to identify any risks to general and oral health. Factors that should be evaluated to determine level of risk (high, moderate, low) include but are not limited to:
   - Fluoride exposure, tobacco exposure
   - Nutrition history
   - Systemic disease/conditions
   - Prescriptions/over the counter drugs
   - Salivary function
   - Age, gender, genetics and family history
   - Habit and lifestyle behaviors
   - Physical disability
   - Psychological, cognitive, and social considerations

Standard 2: Dental Hygiene Diagnosis

The identification of an individual's health behaviors, attitudes, and oral health care needs for which a dental hygienist is educationally qualified and licensed to provide. The dental hygiene diagnosis provides the basis for the dental hygiene care plan.

I. Analyze and interpret all assessment data.
II. Formulate the dental hygiene diagnosis or diagnoses.
III. Communicate the dental hygiene diagnosis with patients or clients.
IV. Determine patient needs that can be improved through the delivery of dental hygiene care.

V. Identify referrals needed within dentistry and other health care disciplines based on dental hygiene diagnoses.

Standard 3: Planning

Planning is the establishment of realistic goals and the selection of dental hygiene interventions that can move the client closer to optimal oral health. The dental hygiene treatment plan is derived from the dental hygiene diagnosis and includes goals, priorities, dental hygiene procedures and patient action.

I. Identify all needed dental hygiene interventions.
II. In collaboration with the patient and/or caregiver prioritize and sequence the interventions.
III. Identify and coordinate resources needed to facilitate comprehensive quality care.
IV. Collaborate and work effectively with the dentist and other health care providers and community based oral health care programs to provide high-level, patient centered care.
V. Present and document dental hygiene care plan to the patient/caregiver.
VI. Counsel and educate the patient/caregiver about the treatment rationale, risks, benefits, anticipated outcomes, evidence-based treatment alternatives, and prognosis.
VII. Obtain and document informed consent and /or informed refusal.

Standard 4: Implementation

The act of carrying out the dental hygiene care. Care should be delivered in a manner that minimizes risk; optimizes oral health; and recognizes issues related to patient comfort including pain, fear, and or anxiety.

I. Review and confirm the dental hygiene care plan with the patient/caregiver.
II. Modify the plan as necessary and obtain additional consent.
III. Implement the plan beginning with the mutually agreed upon first prioritized intervention.
IV. Monitor patient comfort.
V. Provide any necessary post-treatment instruction.
VI. Implement the appropriate self-care intervention; adapt as necessary throughout future interventions.
VII. Confirm the plan for continuing care or maintenance.
VIII. Maintain patient privacy and confidentiality.
IX. Follow up as necessary with the patient (post treatment instruction, pain management, self-care)

Standard 5: Evaluation

Evaluation is the measurement of the extent to which the client has achieved the goals specified in the dental hygiene care plan. The dental hygienist uses evidence-based decisions to continue, discontinue, or modify the care plan based on the ongoing reassessments and subsequent diagnoses. Evaluation occurs throughout the process as well as at the completion of care.

I. Use measurable assessment criteria to evaluate outcomes.
II. Communicate to patient, dentist, and other health care providers the outcomes of dental hygiene care.
III. Evaluate patient satisfaction of the care provided through oral and written questionnaires.
IV. Collaborate to determine the need for additional diagnostics.
V. Self-assess the effectiveness of the process of providing care, identifying strengths and areas for improvement.

Standard 6: Documentation

The primary goals of good documentation are to maintain continuity of care, provide a means of communication and to minimize the risk of exposure to malpractice claims.

I. Document all components of the dental hygiene process of care (assessment, dental hygiene diagnosis, planning, implementation and evaluation) including purpose of the patient's visit in the patient's own words.
II. Objectively record all information and interactions between the patient and the practice. (phone calls emergencies, failure to return for treatment, follow through)
III. Record legible, concise and accurate information. (dates and signatures)
IV. Recognize ethical and legal responsibilities of recordkeeping including guidelines outlined in state regulations and statutes.
V. Ensure compliance with HIPPA.
VI. Respect and protect the confidentiality of patient information.

Resource: Adapted from the American Dental Hygienist Association Standards of Applied Dental Hygiene Practice
Retrieved August 2, 2018, https://www.adha.org/resources-docs/2016-Revised-Standards-for-Clinical-Dental-Hygiene-Practice.pdf

1.6 Accreditation

The University of New England is accredited by the New England Association of Schools and Colleges, Inc., which accredits schools and colleges in six New England states. The Commission on Dental Accreditation accredits the Dental Hygiene Program.

1.7 Licensure

The licensing process for dental hygienists includes the successful passing of the written Dental Hygiene National Board as well as the successful passing of all required regional or state licensing examinations. Fees for licensure are determined by individual states.

1.8 Baccalaureate Degree in Dental Hygiene

The University of New England offers students the opportunity to pursue a bachelor of science that fully prepares students to take the licensure examinations to become registered dental hygienists.

Bachelor of Science Degree Completion

The Bachelor of Science completion program includes advanced education in dental hygiene skills and prepares students for a broader range of careers in dental hygiene, community health, administration or research.

1.9 Student Expenses

All students enrolled in the Dental Hygiene Program are **required** to purchase/rent books and other necessary items, such as instruments, as deemed appropriate by the course director. The largest expense for students will occur at the beginning of the fall semester of the junior year. It is at this point students will begin their clinical experiences and will need to purchase the necessary instruments. The cost incurred will be approximately $5,000.

The faculty requires the bookstore to purchase specific, high quality instruments; and the faculty has determined that the items in the bookstore are necessary for skill development as a dental hygiene student.

Additionally, the program has been able to negotiate warranty extensions and generous instrument return policies that are not available to students who purchase outside of this system.

Students must have quality instruments for learning. Students without them will be prohibited from participating in clinical sessions. An organized Board Review is recommended and varies in cost, however, plan for a range of $500-$1,000 for registration, travel and lodging.

Students planning to take board exams in the fourth year should also plan on testing fees of approximately $1,400.

1.10 Student Members of the American Dental Hygiene Association

Students enrolled in clinical dental hygiene courses may become members of the Student Members of the American Dental Hygiene Association (SMADHA). This Association provides the student with the opportunity to be involved in both campuses as well as district activities. Monthly meeting times are posted in advance in the Grace Coleman Dental Hygiene Building.

1.11 American Dental Hygienists' Association Code of Ethics for Dental Hygienists

1. Preamble

As dental hygienists, we are a community of professionals devoted to the prevention of disease and the promotion and improvement of the public's health. We are preventive oral health professionals who provide educational, clinical, and therapeutic services to the public. We strive to live meaningful, productive, satisfying lives that simultaneously serve our profession, our society, the world, and us. Our actions, behaviors, and attitudes are consistent with our commitment to public service. We endorse and incorporate the Code into our daily lives.

2. Purpose

The purpose of a professional code of ethics is to achieve high levels of ethical consciousness, decision-making, and practice by the members of the profession. Specific objectives of the Dental Hygiene Code of Ethics are:

- To increase our professional and ethical consciousness and sense of ethical responsibility.
- To lead us to recognize ethical issues and choices and to guide us in making informed ethical decisions.
- To establish a standard for professional judgement and conduct.
- To provide a statement of the ethical behavior the public can expect from us.

3. Basic Beliefs

The following beliefs guide the practice of dental hygiene and provide context for ADHA Code of Ethics:

- The services we provide contribute to the health and well-being of society.
- Our education and licensure qualify us to serve the public by preventing and treating oral disease and helping individuals achieve and maintain optimal health.
- Individuals have intrinsic worth, are responsible for their own health, and are entitled to make choices regarding their health.
- Dental hygiene care is an essential component of overall healthcare and we function interdependently with other healthcare providers.
- All people should have access to healthcare, including oral healthcare.
- We are individually responsible for our actions and the quality of care we provide.

4. Fundamental Principles

UNIVERSALITY

The principle of universality assumes that, if one individual judges an action to be right or wrong in a given situation, other people considering the same action in the same situation would make the same judgment.

COMPLEMENTARITY

The principle of complementarity assumes the existence of an obligation to justice and basic human rights. It requires us to act toward others in the same way they would act toward us if roles were reversed. In all relationships, it means considering the values and perspectives of others before making decisions or taking actions affecting them.

ETHICS

Ethics are the general standards of right and wrong that guide behavior within society. As generally accepted actions, they can be judged by determining the extent to which they promote good and minimize harm. Ethics compel us to engage in health promotion/disease prevention activities.

COMMUNITY

This principle expresses our concern for the bond between individuals, the community individuals, the community, and society in general. It leads us to preserve natural resources and inspires us to show concern for the global environment.

RESPONSIBILITY

Responsibility is central to our ethics. We recognize that there are guidelines for making ethical choices and accept responsibility for knowing and applying them. We accept the consequences of our actions or the failure to act and are willing to make ethical choices and publicly affirm them.

5. Core Values

INDIVIDUAL AUTONOMY AND RESPECT FOR HUMAN BEINGS

People have the right to be treated with respect. They have the right to informed consent prior to treatment, and they have the right to full disclosure of all relevant information so that they can make informed choices about their care.

CONFIDENTIALITY

We respect the confidentiality of client information and relationships as a demonstration of the value we place on individual autonomy. We acknowledge our obligation to justify any violation of a confidence.
SOCIETAL TRUST

We value client trust and understand that public trust in our profession is based on our actions and behavior.

NONMALEFICENCE

We accept our fundamental obligation to provide services in a manner that protects all clients and minimizes harm to them and others involved in their treatment.

BENEFICENCE

We have a primary role in promoting the well-being of individuals and the public by engaging in health promotion/disease prevention activities.

JUSTICE AND FAIRNESS

We value justice and support the fair and equitable distribution of healthcare resources. We believe all people should have access to high-quality, affordable oral healthcare.

VERACITY

We accept the obligation to tell the truth and assume that other will do the same. We value self-knowledge and seek truth and honesty in all relationships.

A complete copy of the American Dental Hygienists' Association Code of Ethics will be available in the Clinical Resource Library and in the Abplanalp Library.

1.12 Professionalism

Professionalism is inherent to the practice of dental hygiene. The public has an expectation of what the dental hygienists' behavior should be, and therefore it is reasonable that the dental hygienist would behave in such a manner and conform to technical and ethical standards of the dental hygiene profession. Professionalism, generally, is defined as exhibiting a courteous, conscientious, and businesslike manner to all patients, peers and faculty. Other characteristics of the professional dental hygienist are being clean, neat, health and prevention orientated, detail conscious, and motivated by service. It is important to realize that professionalism is a mandatory skill that is continually evaluated during your time here as a student (see section 3.28).

1.13 Social Media

Social media has the potential to harm our patients, ourselves, and our places of work. It is important to understand the HIPAA law and its ramifications. Shared photographs and our words in text messages, tweets etc. have the potential to harm others. Please use discretion and professionalism in all your actions because the public, which we serve, holds our behaviors to a higher standard.

The following are guidelines for UNE Dental Hygiene students/faculty and staff who participate in social media. Social media includes personal blogs and other websites, including Facebook, LinkedIn, MySpace, Twitter, YouTube or others. These guidelines apply whether students are posting to their own sites or commenting on other sites:

1. Follow all applicable UNE Policies. For example, you must not share confidential or proprietary information about UNE and you must maintain patient/client privacy. Among the policies most pertinent to this discussion are those concerning patient/client confidentially, (HIPPA), mutual respect, UNE Student Handbook, dental hygiene program policy of no photography and video in the clinic, and use of patient/client information and likenesses.

2. Where your connection to UNE is apparent, make it clear that you are speaking for yourself and not on behalf of UNE. In those circumstances, you should include this disclaimer: "The views expressed on this [blog; website] are my own and do not reflect the views of UNE/DH.

3. If you identify your affiliation to UNE/DH, your social media activities should be consistent with UNE/DH and Dental Hygiene's high standards of professional conduct.

4. If you communicate in the public internet about UNE/DH or UNE related matters, you must disclose your connection with UNE and your role at UNE.

5. Be professional, use good judgment and be accurate and honest in your communications; errors, omissions or unprofessional language or behavior reflect poorly on UNE/DH, and may result in liability for you or UNE. Course or program dismissal may be a consequence of unprofessional behaviors in all venues.

6. UNE/DH strongly discourages "friending" of patients on social media websites. Students in patient care roles generally should not initiate or accept friend requests except in unusual circumstances such as the situation where an in-person friendship pre-dates the treatment relationship.

7. UNE discourages staff and faculty from initiating “friend” requests with Dental Hygiene students while in the program.

8. Ask UNE/DH leadership for clarification if you have any questions about what is appropriate to include in your social media profile(s).

http://sharing.mayoclinic.org/guidelines/for-mayo-clinic-employees/

1.14 Dental Hygiene Program Full-Time Faculty and Staff

The offices of the faculty and staff of the Dental Hygiene Program can be found in Hersey Hall and the Grace Coleman Building. Students are encouraged to meet with faculty and staff as needed. Office numbers, telephone/voice mail numbers and e-mail addresses are listed below.

NAME	TITLE	ROOM	PHONE/EMAIL
Mary Aube, R.D.H., M.S., Ed	Assistant Clinical Professor	Coleman 103	207-221-4549 Maube4@une.edu
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Lisa Dufour, R.D.H., M.S.	Professor	Hersey 321	207-221-4313 Ldufour@une.edu
Marji Harmer-Beem, R.D.H., M.S.	Program Director, Associate Professor	Coleman 118	207-221-4315 Mharmerbeem@une.edu
Laura Krause, D.D.S.	Associate Clinical Professor	Coleman 112	207-221-4470 Lkrause@une.edu
Janet Lefebvre	Administrative Assistant	Coleman 111	207-221-4471 Jlefebvre2@une.edu
Beverley Litchfield, R.D.H., D.H.Sc.	Assistant Clinical Professor	Coleman 113	207-221-4318 blitchfield@une.edu
Barbara Norton	Administrative Assistant	Coleman 111	207-221-4471 bnorton@une.edu
Danielle Peterson, R.D.H., M.S., Ed	Assistant Clinical Professor	Coleman 102	207-221-4319 Dpeterson8@une.edu
Crystal Petrin	Administrative Assistant	Coleman 109	207-221-4277 cpetrin@une.edu
Charlene Sargent	Office Manager	Coleman 109	207-221-4278 Csargent2@une.edu
Courtney Vannah, I.P.D.H., M.S.	Assistant Clinical Professor	Hersey 324	207-221-4249 cvannah@une.edu

1.15 Dental Hygiene Faculty Advisors

Students enrolled in the Dental Hygiene Program are assigned a dental hygiene faculty member to serve as their academic advisor. Although academic advisors are available to assist students in fulfilling major and graduation requirements, the ultimate responsibility for these matters rests with the student. Students are advised to meet with their advisors at least once per semester. It is the responsibility of the student to initiate the meeting schedule with his/her advisor.

1.16 Tutorial / Learning Assistance

The Student Academic Success Center (SASC) offers a comprehensive tutoring program for the content areas, with emphasis upon the sciences, mathematics, and the health professional curriculum. Every effort will be made to provide appropriate tutorial services. Writing assistance is also available through the Student Academic Success Center.

The SASC is located in the Proctor Center, ext. 4247.

Additional information regarding the Student Academic Success Center can be found in the University of New England Student Handbook.

1.17 Student Access Center (Formally the Office for Students with Disabilities)

UNE seeks to promote respect for individual differences and to ensure that no person who meets the academic and technical standards requisite for admission to, and continued enrollment at, the University is denied benefits or subjected to discrimination at UNE solely by reason of his or her disability. Any student eligible for academic accommodations due to a documented disability is encouraged to speak with the professor in a timely manner. Registration with UNE Student Access is required before accommodation requests can be granted. Student Access on the Portland campus is located in the lower level of Ginn Hall and may be reached by calling 221-4418. Student Access on the Biddeford campus is located in the lower level of Stella Maris Room 131 and may be reached by calling 602-2815.
http://www.une.edu/studentlife/student-access-center

1.18 Student Attendance/Attire

All students are expected to attend all courses for which they have registered. Attendance policies regarding absences are established and announced by the individual instructor for his/her classes. If a student is absent to the extent that his/her work is adversely affected, the instructor will report the student's absence to the department chair/program director with comments on the status of the student in the course.

Whenever a student is specifically reported in writing by an instructor to the department chair/program director as being excessively absent from class, clinic or lab, the instructor, with the approval of the department chair/program director, may drop the student from that course with an appropriate grade. (UNE Student Handbook)

Please refer to the UNE Student Handbook for further information regarding the attendance policy.

Respect for faculty, staff, students, patients and other health care professionals

1. Students are expected to demonstrate respectful behavior at all times toward the faculty, staff, students and patients at the University of New England and other institutions on or affiliated with the University of New England.
2. The student body, faculty and staff represent a diverse group. Respect for and understanding of individuals from diverse backgrounds is a part of a university education. Prejudices against individuals because of race, ethnic or cultural background, gender, disability or other personal characteristics will not be tolerated from UNE Dental Hygiene students.
3. Students are expected to display mature judgment and abide by the reasonable decisions communicated by faculty and staff. Profane language or disrespectful behavior by students is unacceptable. Faculty and staff members work to provide a quality educational program for dental hygiene students. Misunderstandings, changes in curricula or mistakes in administrative aspects of the program will occur from time to time. Appropriate mechanisms exist to communicate student concerns about the operation of the school through dental hygiene faculty members, administrators, student government members and student representatives on school committees.
4. The dignity and respect of all health care practitioners and caregivers must be acknowledged, promoted and upheld.

University of New England Dental Hygiene Program Dress Code

The Dental Hygiene Program recognizes that appropriate personal appearance creates a favorable impression on the College and the dental hygiene profession in general. The dress code is based on the theory that learning to use socially acceptable manners and selecting attire appropriate to specific occasions and activities are critical factors in the total educational process. Understanding and employing these behaviors improves the quality of one's life, but also contributes to optimum morale, as well as embellishes the overall campus image. They also play a major role in instilling a sense of integrity and an appreciation for values and ethics. The continuous demonstration of appropriate manners and dress insures that the dental hygiene students meet the very minimum standards of quality achievement in the social, physical, moral and educational aspects of their lives - essential areas of development necessary for propelling students toward successful careers. As well, faculty, visitors, patients, families, health care sites and accrediting agencies justifiably expect strict standards to be maintained. This dress code applies at all times when the student is on the UNE Campuses and to any situation where patient care activities occur or the occurrence of direct patient or healthcare professional contact can be reasonably assumed. These instances would include but not be limited to all off campus program sponsored experiences. In the absence of a stated policy for an individual course or setting, the following dress code will apply:

A. General Personal Care
1. Maintain good personal hygiene, which includes regular bathing, use of deodorants and regular dental hygiene.
2. Hair should be neat and clean. Hair longer than shoulder length should be secured away from the face if close contact with patients is anticipated. Beards and mustaches must be clean and well groomed.
3. Perfume or cologne is not recommended, as many people are allergic or sensitive to them.
4. Cosmetics should be used in moderation.
5. Fingernails must be clean, neatly trimmed, and short in length.
6. Tattoos must be covered.
7. Jewelry in pierced noses, lips, tongues and other exposed body areas, other than ears is not permitted.

B. Appropriate Attire
1. Clean, business casual styled clothing
2. An undershirt should be worn if undergarments are visible through clothing.
3. Knee-length or longer skirts for women when worn

C. Inappropriate Attire

1. Hats, caps, bandanas, hoods or head scarves (except if considered part of religious or cultural dress)
2. Sweatpants, sweatshirts, pajamas, spandex, exercise attire or jeans with holes, rips, fading or excessive wear or frayed hems.
3. Tank, mesh, halter or tube tops, spaghetti straps, showing of midriff or breast cleavage.
4. Flip-flops, slippers or bare feet
5. Shorts or skorts
6. Shirts with inappropriate or vulgar lettering or messages

The Dental Hygiene Program and its preceptors reserve the right to require students who are in violation of the dress code to remove the inappropriate item(s) or leave the learning or patient care environment. All administrative, faculty and support staff members will be expected to monitor student's behavior applicable to this dress code and report such disregard or violations to Office of the Director.

Provided to you as a professional level dental hygiene student is your clinic name tag to be worn any time you are on the clinic floor. It is your responsibility to keep that tag for identification during labs and patient care. If you lose your name tag you will be responsible for ordering a new one through the Dental Hygiene support staff at a cost to you.

Being able to be recognized as a dental hygiene student is your professional responsibility. If a lost tag is not replaced in a timely manner it will be reflected in the appropriate portion of your clinic/lab grade/s for that semester and every other that it continues to be an issue during.

University of New England College of Dental Medicine Dress Code – 2018

Dress Code

Because the professional appearance and demeanor of all members of the UNE College of Dental Medicine oral health care team contributes to and influences the perception of quality patient care, faculty, students, and staff are required to maintain proper dress, personal hygiene, and a well-groomed professional appearance at all times by following the UNE CDM dress code (below).

All students, faculty, and staff are required to wear UNE identification badges in a visible location. During patient care, the ID badge can be secured under the disposable clinic gown for infection control reasons.

The dress code below serves as a guideline for these standards. When there is a doubt about a particular aspect of the dress code, individuals are urged to make choices that most closely align with the College's mission, values, and vision statements. These guidelines are in effect from 7:30 AM until 5:30 PM, Monday through Friday. Faculty, staff, and students attending or working for weekend events or programs are expected to follow this code.
If a conflict arises between this policy and the College's Infection Control Policies, Infection Control Policies will prevail.

Standard Attire: Campus

Students, faculty, and staff should be appropriately dressed at all times. All clothing should be clean, neat, and in good repair.

Appropriate attire **does** include:

- A visible official school identification badge, worn above the waistline at all times
- Pants/slacks
- Dress shirt with collar and tie (for males)
- Polo shirt with collar
- Sweaters/jackets
- Blouses/tops with modest necklines. Sheer fabrics must be layered.
- Skirts or dresses long enough to allow for modesty and comfortable movement
- Dress shoes, clogs, or boots. Shoes must be a solid material and closed-toe to provide protection against accidental puncture or injury.
- Hats are to be worn outside only
- Body piercing jewelry and all visible body piercings must be removed other than the maximum of 2 holes/earlobes. No bars, dermal anchors, or gauges.

Appropriate attire **does not** include:

- Caps or any type of hat worn inside
- Jeans, leggings, cargo pants, or shorts
- Sweatshirts, sweatpants, or hoodies
- Midriff tops

- T- shirts
- Tank tops, halter tops, exposed bra straps
- Athletic shoes
- Open-toes shoes, sling-backs, sandals, flip-flops, Crocs

Personal Hygiene

Hair

- Hair must be clean and neatly groomed at all times
- Facial hair must be kept neat, clean, and well-trimmed

Personal Cleanliness

- Adequate precautions must be taken to maintain good personal hygiene to prevent body odors
- No perfumes, colognes, or scented body lotions as patients may have allergies

Oral Health Center Attire

Standard attire as described above will be worn in the Oral Health Center. Additional requirements are:

- Men must wear a dress collared shirt and tie
- Shoes must be a solid material and closed-toe, heel, and side to provide protection against accidental puncture or injury.
- Socks, hose, or stockings must cover exposed skin and ankle.
- Students will wear clean, ironed white coats when greeting the patient, while chair-side for patient interviews, and when planned patient contact does not involve a potential for splatter
    - White coats should not be worn out of the Oral Health Center unless for a specific event
- The gown color for the Simulation Clinic shall be yellow (in contrast to the blue or white that is worn in the comprehensive care Group Practices).

Personal Hygiene as described above will be followed. Additional requirements are:

Hair

- During simulated or live patient care, shoulder-length hair must be secured so that it is back and out of the field of operation and does not require handling during the treatment procedure

Fingernails and Hands

- Hands and fingernails are to be immaculately clean, short (nails), and well-maintained
- No nail polish
- Rings that may tear or puncture clinic gloves cannot be worn

Personal Cleanliness

- No gum chewing

All students, faculty, staff, and volunteers are expected to comply with the CDM Oral Health Center's infection control policy by wearing personal protective equipment as described below.

Personal Protective Equipment (PPE)

All students, faculty, staff, and volunteers are expected to comply with the CDM Oral Health Center's Infection Control Policy by wearing appropriate personal protective equipment whenever skin, eye, mucous membrane, or parenteral contact with blood or saliva can reasonably be anticipated.
Determining the proper outer garment PPE typically rests upon whether the planned patient contact involves a potential for splatter. Disposable gowns should be changed for each clinic session or more often if visibly soiled. These gowns must be removed and properly disposed of when departing the patient treatment area.

Scrubs

The University of New England College of Dental Medicine has a no scrubs on campus policy. The one exception is in the anatomy lab in Biddeford.

Anatomy Lab Attire

Please consult the Anatomy Lab Syllabus/Safety Protocols for the lab dress code. Students are required to wear scrubs. Anatomy lab coats are not required, but students are encouraged to wear additional layers underneath scrubs to provide warmth. Students are required to change clothes immediately following Anatomy Lab. Details regarding appropriate cadaver laboratory attire are below:

- Scrubs with full length pants – **NO** shorts or skirts permitted, even if made from scrub material.
  Scrubs are available in the campus bookstore (no specific color required)
- Close-toed shoes (no Crocs)
- Safety glasses for splash protection must be worn and are available in the lab
- Nitrile (non-latex) gloves must be worn while dissecting. *Nitrile gloves can be purchased on-line or in the bookstore. Make sure they are non-latex.*
- Long hair must be tied back, away from the face. Long necklaces should be removed.
- Contact lenses are **NOT** advised, as they are permeable to volatile compounds and may result in injury.

Special Occasions

The Dean may announce/allow attire reflective of a special holiday at his/her discretion during the year. This dress must not interfere with job function or the educational process and must not pose a safety risk or violation of infection control guidelines. Furthermore, he/she may also require a particular form of dress for special dental school events.

Dress Code Enforcement

The spirit of the dress code is intended to support the professional image of the dental students, faculty, staff, and volunteers as well as the image of the College of Dental Medicine. Additionally, the stated guidelines provide for patient, student, faculty, and staff safety. It is hoped that the dental school community will cooperate by complying with the code by self-regulation. If self-regulation fails, immediate supervisors will become involved in the enforcement process and the following actions may be taken:

- Warnings and other disciplinary action, up to and including termination of employment.
- Denials of access to clinics, classrooms, and/or laboratories.
- If a warning is given, compliance with the UNE CDM Dress Code is expected within 24 hours of the warning. If patient care is involved, the individual may be required to leave the specified area immediately.
- Continued violations by:
    - Students are managed by their Group Practice Leader and the Assistant Director of Student Success

Revised 1-29-2018

1.19 Student Messages

If an emergency situation arises, please instruct individuals to call the following telephone numbers and leave the appropriate message. The Dental Hygiene Program encourages you to provide those who may need to contact you with a copy of your school schedule. This will assist those involved in determining where you can be found in case of an emergency.

Dental Hygiene Program Staff: (207)-221-4471 (Please do NOT call the general clinic number as your message may not be retrieved immediately)

UNE Security Office: 207-602-2298 UNE Switchboard: 207-283-0171 (UC)
207-797-7261 (WCC)

Student Absences: See Illness Notification Policy 3.01 – In the event of illness please call the Dental Hygiene Program directly by calling the clinic staff line at 207-221-4471. Messages left at switchboard or sent by classmates are unacceptable. Inform the clinical course directors as well.

1.20 Grading Policies

Methods of grading and evaluation will be clearly documented in each course syllabus and reviewed with the students by the course director. The course director will determine what methodology will be used when assigning grades.

The following grading scale is in effect for dental hygiene courses:

A	94-100	
A-	90-93	
B+	87-89	
B	84-86	
B-	80-83	
C+	77-79	
C	74-76	
C-	70-73	Unsatisfactory
D+	67-69	Unsatisfactory
D	64-66	Unsatisfactory
F	0-63	Unsatisfactory

The Dental Hygiene Program requires that students receive a ***grade of C*** or better in all dental hygiene and science courses. If a C ***or higher*** is not achieved in co-requisite courses both components must be repeated. Students may repeat a dental hygiene course once. If the student does not achieve a grade of C ***or better*** the second time a course is taken he/she ***will*** be dismissed from the program. In many instances, courses serve as prerequisites for upper level courses; thus, slowing down the students' progression through the required dental hygiene and science courses. The Dental Hygiene Program cannot guarantee that courses that need to be repeated will be offered in a timely or convenient manner and scheduling conflicts may occur.

A grade ***below C*** in two or more dental hygiene or science courses in a single semester ***will*** result in program dismissal.

1.21 Program Probation and Remediation

Probation Policy

Any dental hygiene student whose ***grade falls below a 74*** at any time will be placed on program probation until the GPA has been brought up.

Remediation Policy

If a student fails an exam, (a score of 73 or lower) they will be sent written notice and be required to visit the SASC for help and must send confirmation of that visit and a plan for help to the course instructor before the next exam. If the student fails a second exam, they must again, after written notice, visit the Student Success Center and provide confirmation of that visit and new study plan to their course director. They must also meet one on one with the course instructor to review the test or seek help from the peer tutor and send that confirmation to the course instructor. Quizzes may be remediated at the discretion of the course instructor based on overall class outcome for grades. Failure of a 3rd exam will necessitate meeting with the course instructor and the Program Director.

Course Remediation Policy

The Dental Hygiene Program allows for remediation activity and reassessment prior to issuing a final course grade following unsuccessful achievement of course criteria. Permission for remediation must be granted by the program director and the course director with a plan articulated and agreed upon by the student, course director, and program director expressing dates and duration of the remediation. Criteria for eligibility include:

- Students attendance in the course must follow guidelines within the course syllabus
- Student must follow remediation policy
- Student must be passing the course at the final exam or
- Be within 2 points of passing the course after the final examination.

1.22 University Academic Probation

A student whose grade point average (GPA) for any semester falls below 1.70 or whose cumulative grade point average is below the minimum acceptable level is automatically placed on probation. A student placed on academic probation will be granted one fall or spring semester to raise his/her cumulative GPA to the minimum acceptable level and will be required to achieve a minimum GPA of 1.70 for the semester. Failure to meet both of these criteria will result in automatic dismissal from the University due to academic deficiency. (University of New England Undergraduate and Graduate Program Catalog)

1.23 Resolution of Differences

Students are encouraged to maintain open communication with faculty members. If concerns arise concerning course work, grades or conflicts, students must follow the appropriate channels to assist in conflict resolution. Conflicts are resolved using the appropriate channels in the order listed below:

1. Meet with faculty member involved in course
2. Talk with faculty advisor
3. Meet with the Program Director
4. Follow additional steps outlined in UNE Student Handbook

1.24 Academic Honesty

Academic Honesty – Charges of academic dishonesty will be handled through the Dental Hygiene Program Faculty and Program Director and referred to the Dean of the appropriate College, if necessary. Examples of academic dishonesty include:

1. Cheating, copying, or the offering or receiving of unauthorized assistance or information.
2. Fabrication or falsification of data, results, or sources for papers or reports.
3. Action which destroys or alters the work of another student.
4. Multiple submission of the same paper or report for assignments in more than one course without permission of each instructor.
5. Theft of personal property from students or clinic.
6. Plagiarism, the appropriation of records, research materials, ideas, or the language of other persons or writers and the submission of them as one's own.

Punitive action may be taken by the Program Director or as outlined in the UNE Student Handbook.

1.25 Academic and Disciplinary Appeals Policy

Students are advised to review the Academic and Disciplinary Appeals Policy stated in the UNE Student Handbook.

1.26 Incomplete Grading Policy

Incomplete grades are only granted under extenuating circumstances in consultation with the Program Director.

1.27 Substance Use and Abuse Policy

Students found to be or suspected of being under the influence of an intoxicating substance will be escorted from the building by campus security. Student's behavior will be reported to the Program Director for disciplinary action.

The use of tobacco by students is strongly discouraged. As health professionals, please guard against odors on the hair and clothing that are unpleasant and unhealthy; including the odor of tobacco smoke. If the odor of smoke is present the student will be dismissed from clinic and counted as an unexcused absence.

Students in need of substance abuse treatment or counseling are urged to take the necessary steps to do so. Guidance may be received from the Campus Health Center, the Dean of Student Affairs or the Dental Hygiene Program Director.

UNE Tobacco Policy:

Effective July 1, 2014, the University of New England is a tobacco and smoke-free campus. Smoking of tobacco or other substances and use of all tobacco products, including electronic cigarettes will not be permitted anywhere or anytime on the University campuses. This includes all parking lots, (including personal vehicles), buildings, residence halls and their grounds, clinics, laboratories, classrooms, private offices, balconies, roofs, plazas, vestibules, loading docks, sidewalks, and on any other campus property,

as well as within close proximity to or causing the obstruction of any building entrance, covered walkway or ventilation system. Please note FDA approved nicotine replacement therapy products will be permitted.

Signs are posted at each building's entrances and displayed in prominent, visible areas to inform all individuals entering or occupying UNE property that smoking and tobacco products are prohibited. This policy applies to all University of New England sites within and outside Maine.

The UNE Community will fully implement this policy related to smoking and tobacco use. All vendors and contractors retained by UNE will ensure that this policy is implemented when their employees are visiting or working on UNE property.

1.28 Health Examination and Immunization Status

Students are required to follow the University of New England and the Dental Hygiene Program policies in regard to physical examinations and immunizations. The Dental Hygiene students are required to show proof of having received the Hepatitis B vaccine and other required immunizations as well as the results of an annual TB test. See University Immunization Policy.

1.29 Students with Disabilities

Any student documented to need special services must contact the Student Access Center. The Dental Hygiene Program will follow any SAC recommendations that are brought forth.

1.30 Sexual Harassment Policy

University Policy on Harassment:

Consistent with state and federal law, the University of New England does not, under any circumstances, tolerate or condone harassment of its students on the basis of race, sex, handicapping conditions, religion, age, ancestry, national origin, or sexual preference. In keeping with efforts to promote and maintain an environment in which the dignity and worth of all people is respected, the University of New England considers harassment of students unacceptable and cause for serious disciplinary action, up to and including dismissal from the University. For more information, please refer to the University of New England's Student Handbook.

1.31 Violence in the Workplace Policy

In the event of violence in the workplace UNE Security must be called at ext. 366 using a UNE phone or 207-283-0176 from a cell phone. If violence threatens a person's physical well-being, be that of student, faculty, or patient, then UNE Security must be called, as well as the Portland Police at 911.

An incident report must be filled out and filed with the program director as soon as possible to report an incident of violence.

1.32 Campus Parking

Various parking lots are available to students around the University campuses. Vehicles must have a current parking decal and be parked in lots designated for student parking.

The Department of Safety and Security provides on-campus vehicle and pedestrian escorts to University members during the hours of darkness on a time available basis. On the Portland Campus, dial ext. 2298 and request an escort.

1.33 Children on Campus Policy (UNE Student Handbook)

The University of New England is a diverse environment of classrooms, offices, laboratories, recreational and other common areas. Visitors to campus are welcome and encouraged. However, appropriate precautions and limitations on visitation are necessary to protect health and safety and to maintain productivity and regulatory compliance. The University of New England values its students and employees and strives to support them in an environment where we balance work and family.

Safety is always a primary concern when considering the presence of children (and other visitors) on campus. A number of our facilities are not designed for unsupervised public access and therefore maintain the same appropriate limited access to children /visitors as at other academic institutions. Employees and students must understand their responsibility for supervision of their child. To this end, the University has instituted the following guidelines to ensure the safety and welfare of our employee or students' children (or visitors).

Student Guidelines:

1) A child should not be left unattended while the parent or guardian is attending class or conducting any other business or social function on campus;

2) Line of sight supervision by the parent or guardian is required at all times;

3) Children are not allowed in the high-risk areas:

    a) Laboratories, shops, studios, mechanical rooms, power plants, garages, docks, food preparation areas, and fitness centers.

    b) Any areas, indoors or out, containing power tools or machinery with exposed moving parts.

    c) UNE vehicles, boats, or other motorized equipment; excepting incidental travel in a University car, truck or van, consistent with the UNE Travel Policy.

    d) Any other high-risk areas (no playing in stairwells, elevators or doorways, no access to rooftops, construction zones, etc.).

4) Children are not allowed in classrooms while classrooms are in session unless the faculty member grants permission. Should a child become disruptive, the student and child may be asked to leave. Reference the Student Handbook.

1.34 Policy on Visitors and Observers in the Dental Hygiene Clinic

Due to the potentially hazardous environment of the clinical treatment area and acknowledging the responsibility of the faculty and staff to render quality care to patients through direct and attentive supervision of dental hygiene students, the following policies are in effect:

1. All visitors/observers must register with a dental hygiene program staff member upon arrival. The staff will indicate to the visitor the time restrictions depending on the intent of the visit.
2. Clinical course directors will be notified by the front desk personnel regarding expected or unanticipated visitors. The director of the clinic on any given day will assist and escort the visitor to assure compliance with clinic protocol and to conduct the visit in the least disruptive manner possible.
3. Visitors are to remain away from the treatment area when observing students. Observers are to respect the confidential nature of the relationship between the student operator and patient and are to refrain from interfering in the treatment with excessive verbal communication.

Visitors are defined as any individual not currently enrolled in or employed by the University of New England, Westbrook College Campus Dental Hygiene Program. Licensed dentists and dental hygienists serving as volunteer faculty are not to be considered under the status of visitors per se. However, items #1 and #2 do apply to them as well.

1.35 UNE Facilities

The Dental Hygiene Program encourages students to utilize the various facilities available on the Portland Campus including:

Alexander Hall – Dining Center
Alumni Hall
Art Gallery
Campus Center
Computer Services
Counseling Center
Dental Hygiene Clinic
Financial Aid
Finley Center
Health Center
Innovation Hall
Josephine S. Abplanalp Library
Oral Health Center
Parker Pavilion
Registrar's Office
Student Academic Success Center
Student Access Center

1.36 Complaints Policy

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

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

Taken from: American Dental Association Commission of Dental Accreditation, Evaluation Policies and Procedures, Reaffirmed: August 2015

1.37 Course Transferability Notice

The Commission on Dental on Dental Accreditation requires that the Dental Hygiene Program inform students and applicants of the transferability of course work. The UNE Undergraduate catalog states: Courses completed at another accredited college can be transferred to this degree program. Transferred courses must be reasonably close in scope and content to the required courses offered at UNE in order to count as exact equivalents. Otherwise, they may transfer as general electives. All courses completed must be no older than five years. Other restrictions apply. http://www.une.edu/registrar/2017-2018-academic-catalog/undergraduate-catalog/dental-hygiene

1.38 DENTAL HYGIENE CLINIC HIPAA POLICIES AND PROCEDURES

HEALTH INSURANCE PORTABILITY AND ACCOUNTABLITY ACT

The UNE Dental Hygiene Clinic complies with all HIPAA regulations.

Dental Hygiene Program Policies- Patient Records

1. Patient records will only be used for educational purposes if they have been effectively de-identified or appropriate written authorization has been received from the patient.
2. Patient records **will not** leave the Grace Coleman Building and will be reasonably secured when not in use.
3. All junior and senior dental hygiene students will be instructed in how to maintain the Dental Hygiene Program and Clinic HIPAA policies and procedures including de-identification, safe guarding patient information and research (if needed) through their identified dental hygiene courses.
4. All junior and senior dental hygiene students, staff and faculty will be required to read the Dental Hygiene Program HIPAA Manual.

Dental Hygiene Program Procedures for Training

1. Faculty and staff and student training will be conducted on an annual basis.
2. HIPAA training will be included in the curriculum of all dental hygiene junior students. Updating of any changes in HIPAA policies will be held for faculty and staff before the beginning of the academic year and anytime throughout the year if changes are made.
3. HIPAA training updates will be conducted for junior and senior dental hygiene students prior to their first clinical session in the fall.
4. ***Read the HIPAA manual.***

Front Desk Protocols

1. New patients will be given UNE's Notice of Privacy Practices at time of check-in. Returning patients will only receive the Notice of Privacy Practices if the document has been revised since last signature. Patients will then sign the Acknowledgement of Receipt electronically once seated with the student clinician.
2. If the acknowledgement cannot be obtained, a good faith effort should be made to obtain an authorization. If the authorization cannot be obtained, the reason will be documented in the patient's chart.
3. The student clinician will be notified through the computer when their patient has checked in. The student will then walk the patient down to the front desk at time of completion to review services done during their appointment.
4. When scheduling patients at the front desk, staff will be cautious about revealing any Protected Health Information.
5. A generic message will be left on patients' answering machines if necessary. Message will say, "This is the UNE Dental Hygiene Clinic calling to confirm your appointment tomorrow. If you cannot keep this appointment, please call us at 221-4900.
6. All discussions with or about patients will be limited to the dental hygiene program offices.
7. Everything is done electronically; however, any remaining paper charts are stored behind locked

doors for 7+ years, depending on DOB at time of last appointment.

8. A cover sheet will accompany all faxes sent from the DH Clinic.

Clinical Protocols

1. UNE DH Clinic complies with HIPAA through the use of privacy screens on all computers around the perimeter of the clinic.
2. The Appointment Book screen of the clinical computers will be minimized unless faculty/students are checking on their patient status.
3. The screen saver will come up on all clinical computers when not in use in order to ensure the privacy of Protected Health Information.
4. Cubicles protect patient's privacy and Protected Health Information (PHI).

1.39 Dental Hygiene Professional Conduct Contract

Dental Hygiene Professional Conduct Contract

1. Attendance policy:
   a. I understand that attendance is mandatory.
   b. I understand my absence from clinic/lab (on site or off) will affect my grade.
   c. I know I must be present 20 minutes (30 minutes for ICM1 / ICM2) prior to the start of my clinic session and that I must stay until the close of my clinic session.
   d. I know I must contact both the clinical course director (by e-mail) and the front desk administrator in the event that my absence is unavoidable. Consequences for noncompliance will be entered as a ***zero*** for the day and will ***significantly*** lower my grade.

2. Professional conduct
   a. I understand that I must dress professionally whenever I represent the UNE dental hygiene program on or off campus. Professional attire will be dictated by circumstances and as published in the Dental Hygiene Program Policies and Procedures Manual. Further requirements may be added by each course director.
   b. I understand the dental hygiene profession demands appropriate behavior at all times. I will be respectful, honest, polite and professional to all individuals as required by the American Dental Hygiene Code of Ethics.
   c. I understand that offensive language, gestures, behavior and tone will not be tolerated.
   d. I understand that infection control protocol and HIPAA will be enforced.
   e. Cell phone use is ***prohibited*** on the clinic floor and classroom unless otherwise authorized in each instance by clinic supervisor or course director.
   f. Use of laptops or other electronic devices is strictly limited to academic endeavors.
   g. Consequences for noncompliance will result in dismissal for the session, will be entered as a ***zero*** for the session/day and will ***significantly*** lower my grade.
   h. I understand and will follow the terms of the Social Media Policy. (see Sec. 1.11.1)
   i. I have read and understand the Program Policies and Procedures Manual and will abide by all policies.

I have read the Dental Hygiene Policies and Procedures Manual and I understand its contents.

_____
Signature

_____
Date

1.40 CPR Certification

All students, faculty and support staff involved with the direct provision of patient care must be continuously recognized / certified in basic life support procedures, including cardiopulmonary resuscitation. A course is offered annually for certification.

1.41 Formative Evaluation Policy

Formative evaluation is part of all University of New England dental hygiene program courses. Faculty will include formative evaluation early in the course and with frequency; these opportunities provide occasion for the student to self-evaluate their studying methods and adjust accordingly before a high stakes examination or competency. Formative evaluation offers chances to gauge success. Faculty will have the discretion to design formative evaluation methods either with quizzes or home assignments as examples. Please see each individual course syllabus for further information on each course.

1.42 Athletic Competition and Class Attendance

The Dental Hygiene Program is supportive of UNE dental hygiene students who are athletes. It is incumbent up athletes to inform their dental hygiene faculty of potential and real commitments around the sports schedule. Having knowledge will help the faculty plan for the students to make up examinations. Student athletes are responsible for obtaining all materials relevant to the course in the normal activity of class interaction. The following UNE Academic Policy will be observed by the Dental Hygiene Program.

"When an athlete misses class for a scheduled varsity intercollegiate competition, it is an excused absence. The student athlete should not suffer any academic penalty because of this absence. This policy does not apply to students on clinical rotations."

"When such absences occur, the student athlete is responsible for initiating collaboration with faculty and making arrangements to obtain all information and/or training contained in each missed class. The athlete must make arrangements to take exams scheduled for a day of absence early or late, at the instructor's preference. All assignments must be handed in on time."

"Faculty are not required to remediate student athletes as a result of these absences."

Reference: 2018-2019 Academic Catalog
Heather Davis, Assistant Athletic Director can be contacted if additional information regarding policy is needed or contact Dennis Leighton NCAA Compliance Officer and UNE Athletic Faculty representative.

1.43 Local Anesthesia Policy (Second Semester Seniors)

This policy is in place to ensure the safe delivery of local anesthesia to clinical patients and for the student to stay on track with the competency skills assessments. All senior students must comply with the following to implement the privilege to deliver local anesthesia in the last semester of their senior year.

The student will successfully complete:

- the fall course DEN 456 Pain Management.

- the laboratory section of the Pain Management course and/ or a remedial spring section of DEN 456 Pain Management.
- the CDCA Local Anesthesia Examination for Dental Hygienists scoring a 75% or better with a deadline of February 1st, of the spring semester.

Those completing the remedial course will consult with the program director and the clinical course director to map a plan for successful completion of local anesthesia competencies prior to the CDCA patient examinations. The CDCA requires documentation of completion of the CDCA LA Examination from UNE Dental Hygiene Program for the student to practice pain management during the patient portion of the examination.

SAFETY PROGRAM

Safety Program

2.1 Introduction

The Dental Hygiene Program at the University of New England strives to provide a safe and healthful environment for patients, faculty, staff and students. We do this by following specific guidelines in all activities where there is a risk or potential risk of infection.

This workplace safety program applies to students, staff, faculty, patients and observers in the clinic / laboratory setting. To ensure that all involved are knowledgeable of the specifics contained in the plan, training sessions will be conducted by experienced faculty for the students, staff and faculty. This will occur at the beginning of each academic year, or more often, if necessary.

The components of an effective workplace safety program are:

1. General Housekeeping
2. Infection/Exposure Control Plan/Bloodborne Pathogen Standard
3. Safety Standard
4. Hazard Communication Standard
5. Health and Safety committee to monitor compliance.
6. OSHA Training

Chemical Hygiene Plan

It is the policy of University of New England to take every reasonable precaution to provide a work environment that is free from recognized health and physical hazards for its employees in accordance with the General Duty clause of the OSHA Act (Public Law 91-596, Section 5(a) (l)). University of New England is also required by the OSHA Laboratory Standard to ensure that the necessary work practices, procedures and policies are implemented to protect laboratory employees from all potentially hazardous chemicals in use in their work area.

University of New England has established the University-wide Safety Committee with the responsibility to promote safe and proper chemical management at all University of New England Campuses and related facilities. The Charter of the University-wide Safety Committee is reprinted in Appendix A of this document. The Dental Hygiene Program has developed a Chemical Hygiene Plan.

Chemical Hygiene Addendum

This report is available on the desktop of the computer station at the entrance of the clinic floor. An addendum pertaining to our storage of compressed air is also on the desktop. The full Chemical Hygiene Plan is available for review on the UNE Environmental Health & Safety website at http://www.une.edu/campus/ehs.

Definition of a Hazardous Material

The US Environmental Protection Agency (USEPA) considers a substance hazardous if it can catch fire, if it can react or explode when mixed with other substances, if it is corrosive, or if it is toxic. When handled safely such substances are minimally hazardous. However, if improperly handled, such items can damage health and well-being and negatively affect the environment. Most sources indicate that there are seven basic classes/types of hazardous materials.

1. Flammable Materials – Included are any gases, vapors, liquids or solids which ignite easily and can burn rapidly after being exposed to an ignition source.

2. Spontaneously Ignitable Materials – A few liquids and solids can ignite in the absence of an ignition source. Sufficient heat to cause ignition can be generated within the material by oxidation or microbial action.
3. Explosives – Some chemicals as a result of impact/shock, heat or another mechanism (e.g., electric charge) can detonate.
4. Oxidizers – Some chemical can at room temperature or upon heating generate oxygen, which is hazardous because of its adverse tissue reactions and/or flammability.
5. Corrosive Materials – A number of solids, liquids or gaseous chemicals can damage skin rapidly upon contact. Such chemicals also react negatively with environmental surfaces, such as metals.
6. Toxic Materials – Such materials are commonly referred to as poisons. They can produce a variety of adverse health reactions, even death in relatively small amounts.
7. Radioactive Materials – Some materials spontaneously release energy as they decay into more stable atomic forms. Severe health consequences, even death, can occur when radioactive materials are improperly handled. Ionizing radiation safety is addressed in the UNE Environment Health and Safety Manual in chapter 14 and can be linked through this address: http://www.une.edu/sites/default/files/UNE%20Safety%20Manual_MAY%202017.pdf

2.2 Transmission of Bloodborne Pathogen Diseases

The carriers of certain diseases cannot always be readily identified through the medical history, or even lab tests. Blood, saliva, and gingival fluid from all dental patients should be considered infective. The following precautions must be routine to prevent the transmission of bloodborne pathogens in the clinical setting. The most common concern is to control the transmission of HBV, the hepatitis B and C viruses; HIV, the virus that causes AIDS.

2.3 Viral Hepatitis

Viral hepatitis is a primary infection of the liver caused by one of three distinct viruses. The four forms that are currently recognizable are type A, type B, non-A and non-B (NANB or type C), and delta (HDV).

Type A hepatitis is transmitted by fecal-oral route, with food or water contaminated by human waste being the major mode of transportation. No hepatitis-A carrier status has been documented, and the virus disappears from the person' blood upon recovery.

Non-A, non-B hepatitis (HCV) can be diagnosed by a blood test. It was first described in patients who receive routine blood transfusions and is now believed to be responsible for 80-90 percent of the post-transfusion hepatitis cases. It is becoming increasingly apparent that an infectious carrier state must exist in asymptomatic individuals.

Hepatitis B (HBV) is transmitted by blood and saliva along with other bodily secretions. This is the type of hepatitis that we are most concerned with. The hepatitis-B virus carries the hepatitis-B core antigen (HBcAg) and the hepatitis-B surface antigen (HBsAg). The presence of HBcAg indicates intact virus when associated with HBsAg. The HBsAg is a marker used to identify persons who are possibly affected with HBV, with or without clinical symptoms, and who may be transmitting the virus.

Antibodies to both HBsAg and HBcAg also can be detected in human blood. Anti-HBs (surface antibody) can be found in the blood following infection and may persist for years. It can also be detected in people who have not had clinical hepatitis. This core antibody (Anti-HBc) is usually found during the active phase of acute hepatitis.

Clinically, hepatitis-B cannot be distinguished from other forms of hepatitis. Five to ten percent of patients who contract hepatitis-B enter a chronic state and carry HBsAg in their blood for longer than sixteen weeks. People who become carriers of HBsAg may be infectious for as long as a lifetime.

Delta hepatitis virus (HDV) originally called the delta agent was discovered in 1977. HDV depends on HBV for clinical expression. In North America HDV appears to be confined to groups with frequent percutaneous exposures such as IV drug users and hemophiliacs. Hepatitis relating to delta infection occurs in two primary modes. The first mode is simultaneous infection with HBV and HDV. When this occurs, the acute clinical course of hepatitis is often limited with resolution of both HB and HD infections, although fulminant hepatitis may develop. The second mode involves acute delta super-infection in HbsAg carriers.

These patients are more likely to have a serious and possible acute fulminant form of hepatitis that often leads to chronic delta infection. Some of these patients will become carriers of HDV as well as HBV. HDV is defective in that it requires HBV as a helper virus for replication. Immunization to HBV confers protection against clinical exposure of a delta hepatitis infection.

2.4 HIV Infection

AIDS is the abbreviation for acquired immunodeficiency syndrome. With this disease, there is a defect in natural immunity. As a result, a person with AIDS becomes ill with diseases that would not be a threat to anyone whose immune system was functioning normally.

AIDS is caused by a virus that can infect certain cells of the immune system. It can also infect nerve cells in the brain and other parts of the central nervous system. This virus has been named the human immunodeficiency virus (HIV)

Blood tests can detect antibodies to HIV in 6 to 12 weeks after infection. After antibodies are detected, there may be no other indication of infection for two or more years. Symptoms of HIV infection may appear 2 to 10 years or later after the time of infection. Each year after infection, an average of 5% of adults who are infected have developed AIDS. No group of infected persons has been studied long enough to document how long risk persists or what percentage will eventually develop AIDS.

In 1988, health care workers who were stuck with a needle contaminated with the blood of patients infected with HIV had less than a 1% (0.5%) chance of becoming infected with HIV. By December 1994, 42 well-documented occupational HIV cases, with 91 possible occupational transmissions of HIV, were reported to the CDC. None of the documented occupational sero-conversions occurred in dental care workers. Although your risk of becoming infected with HIV through your work is very low, you have a much higher risk (up to 30%) of becoming infected with hepatitis B virus (HBV).

Protect yourself from coming into direct contact with blood. Apply the concept of standard precautions – that is, protect yourself from the blood of every patient.

2.5 Vaccinations

To minimize the possibility of transmitting any pathogen, the following steps shall be taken:

Vaccines

Faculty and students must be vaccinated against hepatitis. The vaccine consists of a series of three injections followed by a blood test to establish an antibody titer. The entire series and titer must be

completed during the student's first year at UNE. Documentation may be submitted to the health center. The vaccine must be completed prior to entering the clinical sequence DEN 309. Request for special exceptions need to be discussed with the course director.

2.6 Other Vaccines

Students and faculty must also be immunized and up-to-date on vaccines. On December 26, 1997, the recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Hospital Infection Control Practices Advisory Committee (HICPAC) for Immunization of Health Care workers reiterate that dental professionals are at risk for exposure to and possible transmission of vaccine-preventable diseases. Maintenance of immunization is an essential part of prevention for DHCWs.

A history of immunization will be obtained at the time of enrollment or initial employment. Based on documented nosocomial transmissions, dental health care workers are considered at significant risk for acquiring or transmitting HBV, influenza, measles, mumps, rubella, and varicella. (OSAP Research Foundation, 1997) Healthcare workers are also at risk for acquiring Hepatitis C. Hepatitis B, rubella, measles, mumps, influenza, polio, and varicella are recommended vaccines for oral health care workers.

2.7 Testing for TB

All students must be up-to-date with their annual TB test in accordance with section 1.27.

2.8 Personal Protective Equipment (PPE)

Dental health care workers must wear protective attire such as eye wear or a chin-length shield, disposable gloves, a disposable surgical quality mask, and protective clothing when performing procedures capable of causing splash, spatter, or other contact with body fluids, and / or mucous membranes. Protective attire must also be worn when touching items or surfaces that may be contaminated with these fluids, and during other activities that pose a risk of exposure to blood, saliva or tissue.

Gloves are single use items and must not be reused. Single use gloves may not be washed, disinfected or sterilized. They may be rinsed with water only to remove excess powder. Torn or compromised gloves must be replaced immediately. Non-latex or disposable medical quality gloves will be used for patient exams and procedures. Hands must be washed after glove removal and before re-gloving. Specific procedures for infection control will be provided in DEN 309.

Surgical masks that have at least 95% filtration efficiency for particles 3-5 micron in diameter must be worn whenever splash or spatter is anticipated. Masks should be changed for every patient or more often, particularly if heavy spatter is generated during treatment. Some literature suggests masks should be worn a maximum of 20 minutes in areas of high humidity, and a maximum of 60 minutes in dry climates. Masks should be handled by touching the periphery only, avoiding handling of the body of the mask.

Masks should not contact the mouth while being worn as the moisture generated will decrease the mask filtration efficiency, a mask should be selected that conforms well to the shape of the face. A face-shield does not substitute for a surgical mask.

Protective eyewear must have solid side-shields and be decontaminated by immersion in a cleaning agent between patients. A face-shield may substitute for protective eyewear. If protective eyewear or a face- shield is used to protect against damage from solid projectiles, the protective eyewear should meet American National Standards Institute (ANSI) Occupational and Educational Eye and Face Protection Standard (Z87.1-2010) and be clearly marked as such.

Protective clothing must have a high neck and protect the arms if splash and spatter are reasonably anticipated. Cotton or cotton/polyester or disposable clinic jackets or lab coats are usually satisfactory attire for routine dental procedures. The type and characteristics of protective clothing depend on the type of exposure anticipated. Gowns or jackets worn as protective attire should be changed at least daily, or more often if visibly soiled. Protective gowns or covers must be removed before leaving the work area. Protective attire may not be taken home and washed by employees. It may be laundered in the office if equipment is available and standard precautions are followed for handling and laundering contaminated attire. Contaminated linens transported away from the office for laundering should be in appropriate bags to prevent leaking, with a biohazard label or appropriately color-coded, unless the laundry facility employees practice universal precautions in the handling of all laundry. Disposable gowns may be used but must be discarded daily or more often if visibly soiled.

Utility gloves that are puncture-resistant, a mask, protective clothing and protective eyewear must be worn when handling and cleaning contaminated instruments, when performing operatory cleanup, and for surface cleaning and disinfecting. Utility gloves must be discarded if their barrier properties become compromised. Utility gloves, protective eye wear or face shields, and masks must be worn when mixing and / or using chemical sterilants or disinfectants. Used utility gloves must be considered contaminated and handled appropriately until properly disinfected or sterilized.

Lead apron with thyroid collar is used for the patient during the exposure to any radiation.

High gauntlet heat resistant gloves that must be used when operating the autoclaves.

Eyewash stations are marked and located throughout the clinic and lab. These give continuous eyewash.

Fire Extinguishers are to be used by trained personnel in case of fire.

Utility gloves are mandatory for handling contaminated materials and / or sharps.

2.9 Standard Precautions

Standard Precautions as defined by the Centers for Disease Control and Prevention (CDC) must be used in all patient care in dentistry. This term refers to a set of precautions designed to prevent transmission of human immunodeficiency virus (HIV), hepatitis B virus (HBV), and other bloodborne pathogens in health care settings. Under standard precautions, blood and saliva (in dentistry) of <u>all</u> patients are considered potentially infectious for HIV, HBV, and other bloodborne pathogens. Standard precautions means that the same infection control procedures for any given dental procedure must be used for all patients. Thus, the required infection control policies and procedures to be used for any given dental procedure are determined by the characteristics of the procedure. Therefore, standard precautions are procedure specific, not patient specific.

Not all infected patients can be identified by a thorough medical history, examination or even laboratory tests; therefore, it is essential to adhere to a routine set of precautions for <u>all</u> patients.

Always obtain a thorough medical history. Include specific questions about medications, current and recurrent illnesses, hepatitis, unintentional weight loss, lymphadenopathy, oral soft tissue lesions, or other infections. When the medical history reveals an active infection, or a communicable disease occurring within the past three months, medical consultation with the patient's physician is indicated.

Dental healthcare workers should wash hands before donning gloves, upon removal of gloves, and after inadvertent barehanded touching of contaminated surfaces or objects.

Use of antimicrobial soap for invasive procedures is required. Sinks, paper towels, soaps and antiseptic hand rubs (60-90% alcohol) are conveniently located throughout the clinic for use. A foot activated sink is available in the instrument preparation room. Vigorously rubbing lathered hands together for 15 seconds before thoroughly rinsing under a stream of water is adequate for routine handwashing; dry hands thoroughly, before donning gloves. Prior to the intra-oral examination it is recommended that the patient rinse with an antimicrobial mouth rinse for one minute to reduce the level of microorganisms present.

2.10 Sterilization, Disinfection

The policy of the University of New England, Westbrook College of Health Professions Dental Hygiene Program is to sterilize, in a steam autoclave, all instruments, equipment and supplies used in patient care, including handpieces. Disposable items are used extensively to eliminate the use of chemical disinfectant for objects. Surfaces are disinfected and covered where appropriate.

Before sterilization, instruments are cleaned to remove debris. Cleaning is accomplished by using an ultrasonic cleaner and / or washer / disinfector. Persons involved in cleaning and decontaminating instruments must wear glasses, masks and heavy-duty rubber gloves to prevent hand injuries. Metal and heat-stable dental instruments are routinely sterilized between use by steam under pressure. Persons removing instruments from the autoclave must wear high gauntlet, heat resistant mittens to prevent burns. The adequacy of sterilization cycles in each autoclave is verified by internal cassette integrators, heat sensing tape, and the weekly use of spore-testing with control devices. Results are posted in the instrument preparation room. Instruments are stored in a sterile area inside the wrapped cassette with controlled access to prevent contamination.

Dental units, computers, sealant lights, radiographic equipment and other equipment used during patient care must be thoroughly disinfected after each use and / or wrapped with a plastic barrier prior to seating the next patient.

At the completion of work activities all countertops and surfaces are cleaned and disinfected.

2.11 Sterilization Procedures

The following procedures are used by the UNE Dental Hygiene Clinic to provide a safe environment for the provision of dental hygiene services:

1. All instruments, handpieces, and prophy angles are sterilized according to standard procedures, unless they are disposable, in which case they are discarded promptly.

2. The autoclaves are cleaned according to manufacturer's specification and filled with fresh distilled water.

3. Biological monitoring of the autoclaves is conducted in this manner: Vials containing dual species spores are sterilized weekly. They are then incubated (in house) for one week. Incubated spores are monitored every 24 hours for presence of bacterial growth (determined by color change compared to a control spore).

4. Contaminated instruments are ultrasonically cleaned for 6 minutes prior to wrapping with sterilization wrap or cleaned with the instrument washer / disinfector. An integrator strip is inserted in each cassette and then are marked with heat sensitive tape or enclosed in an autoclave bag printed with a heat indicator strip.

5. The sterile instruments are kept in individual shelving compartments in the clinic. This storage space must be kept closed when not in use.

2.12 Waste Management

Students and faculty will keep the clinic in a clean sanitary condition. Anyone handling waste must wear glasses, lab attire and heavy-duty utility gloves.

Waste containers are the foot-operated, covered style to minimize the transfer of disease through handling of waste. They are labeled with a biohazard sign, with an explanation that the waste contained is not "biomedical" according to the Maine Department of Environment Definition, but, may contain saliva and small amounts of blood, so caution is advised.

These containers are to be tied twice before disposal, emptied frequently and the bags are to be thrown down the trash chute or placed in the trash pick-up area outside the compressor room.

2.13 Biomedical Waste

Biomedical Waste

Most of the waste generated by the Dental Hygiene Clinic is not "biomedical" according to State Department of Environmental Protection definition: Waste saturated[1] with human blood, blood products, or body fluids is considered biomedical waste. These may include items such as sponges, extracted teeth, surgical gloves and masks, drapes, aprons, dressings, disposable sheets and towels and plastic tubing. Biomedical waste must be placed in sealed, sturdy, impervious red bags to prevent leakage of the contained items. Such contained solid wastes can then be disposed of following appropriate UNE procedures.

Spills

In the event of an accidental spill of chemicals, trash, glass or bodily fluids the following procedure must be followed, using utility gloves, glasses, and mask:

1. Determine nature of spill and contact facilities as needed.

2. Obtain spill kit located in the Instrument preparation room.

3. Refer to the S.D.S. provided by the manufacturer for proper use of spill kit and handling of spill.

4. Treat broken glass as a contaminated sharp, and place in the labeled sharps container.

Hazardous Materials

The fixer solution and the lead foil used in radiography are considered hazardous material. This must be emptied into a container labeled with the contents, stored only until the container is ¾ full, then promptly removed by maintenance personnel to be disposed of in accordance with Dept. of Environmental Protection requirements. Other chemicals shall be disposed of as directed in the S.D.S. provided by the manufacturer.

[1] The intent is to include waste which at time of generation is soaked or dripping with human blood, blood products or body fluids.

2.14 Sharps

Sharp items (needles, dental hygiene instruments, and other sharp instruments) should be considered as potentially infective and must be handled with extraordinary care to prevent unintentional injuries.

Disposable syringes, needles and other sharp items must be placed into puncture resistant containers located as close as practical to the area in which they are to be used. To prevent needle stick injuries, disposable needles should not be recapped with two hands but instead the one-handed "scoop" technique should be employed. The disposable needle should not be purposefully bent or broken, removed from disposable syringes, or otherwise manipulated by hand after use.

Recapping of a needle increases the risk of unintentional needle stick injury. The one-hand "scoop" technique must be employed.

Because certain dental procedures on an individual patient may require multiple injections of anesthetic or other medications from a single syringe, the one-hand "scoop" technique is a prudent technique to employ. The "scoop" technique in which the needle cap has been placed on the instrument tray and following the injection, the administrator simply slides the needle tip into the cap (without touching the sides), scooping up the needle cap. This technique can be used for multiple injections without increased risk of needle stick injury. The now capped needle is discarded in a sharps container.

Sharps Container

All sharp items should be considered potentially infective and should be handled and disposed of with special precautions by wearing glasses, mask, gloves and utility gloves. They should be placed intact into puncture resistant containers before disposal.

2.15 Infection Control Considerations During Patient Treatment

- Standard precautions are to be followed with every patient.
- Gloves, masks, protective eyewear and clothing are to be worn throughout patient care procedures.
- When patient care is interrupted gloves should be removed, hands washed and dried, and new gloves donned before continuing patient care.

- Record handling – records used for teaching purposes in the clinical setting are to be considered contaminated. Gloves must be worn in all phases of record handling. The outside of the record folder, sleeve, or cover is to be protected from contamination for safety in handling by all record handlers. Further minimized contamination by using a barrier where hand rests on record.

- Use barrier technique wherever possible, (i.e., wrap sealant lights, ultrasonic scaling units, all switches and handles.)

- Handle sharps as outlined above.

- Treatment gloves should not be washed because the soap degrades the integrity of the barrier.

- Impression trays: after an impression has been taken rinse with water to remove saliva, blood, and debris. Place the impression in a baggy and spray with disinfectant allowing it to stand for at least 10 minutes.

- Never handle contaminated instrument tips

- In order to minimize exposure-prone procedures, the use of a mirror for retraction, rather than the operator's finger, during scaling and root planing is recommended.

- Instruments are to be placed on a tray or cassette**, NEVER** pass a sharp instrument to an assistant, student or instructor.

When treating patients requiring the exposure and developing of dental radiographs: follow the procedural guidelines for infection control located in the Dental Hygiene Program Radiology Manual.

2.16 Exposure Control Plan

Exposure-prone procedures include digital palpation of a needle tip in a body cavity or the simultaneous presence of the worker's fingers and a needle or other sharp instrument or object in a poorly visualized or highly confined anatomic site. Performance of exposure-prone procedures presents a recognized risk of percutaneous injury to the worker, and, if such an injury occurs, the worker's blood is likely to contact the patient's body cavity, subcutaneous tissues, and / or mucous membranes.
Being "exposed to blood" means having blood, blood-contaminated saliva, or a blood-contaminated object come into contact with broken skin or mucous membranes, or pierce the skin as through a needle stick or puncture. If a puncture with a needle or instrument occurs, the site of the wound and the glove, if it occurs on the hand, must be carefully examined to determine if a puncture has occurred. A surface scratch or torn glove alone is not an "exposure to blood."

If despite the use of universal precautions, percutaneous or mucosal exposure to any blood occurs, the persons exposed to blood must immediately wash the area thoroughly with soap and water. The incident will be documented in writing by the student and faculty involved using the Incident Report Form. The Clinical Supervisor will provide a form to note the type of exposure (percutaneous or mucosal), type and amount of body fluid, and the circumstance leading to the exposure.

The forms will be given to the Program Director to be included in a confidential file.
The Exposure Control flowchart is posted on the clinic floor.

2.17 Exposure to Blood

Flow Chart Protocol for UNE

1. **Determine if Percutaneous Exposure* has occurred.**
   A torn glove or a surface scratch is not an exposure.

2. **Wash Site with Soap and Water**

3. **Fill out Incident Report appropriate to location**
   With faculty assistance, report form is located and documented; if no exposure, document that fact.

4. **Pretest Counseling Student, Faculty, or Staff and Source (If known)**
   Under the supervision of the clinical supervisor or designee, complete consent and lab referral forms.

5. **Referral of Student, Faculty, or Staff and Source (If Known) for Testing**

   A. Student, faculty, staff or source may see their own private physician.

   B. Students may access testing through the campus Student Health Center.

   C. Faculty, staff or source may access testing at Brighton Campus, MMC. This is coordinated by the front desk personnel. Students may also access Brighton Campus in the event the Student Health Center is closed.

   D. If source known HIV infected, Post Exposure Prophylaxis Consultation within 24 hours[2] or go to Brighton Campus of MMC or MMC Emergency Room.

6. **Post Test Counseling With the Program Director or Designee**

7. **Retest 6 weeks, 3 and 6 Months**
   Consultation with physician

* Or other type of exposure to Blood

[2] **Post Exposure Prophylaxis CDC Recommendations May 15, 1998 vol. 47, No.RR-7. Exp.blo**

2.18 Occupational Exposure Referral

- When a student has an exposure in clinic, the course director needs to be notified immediately, or the designated substitute.

- Each course director or designee will have a packet of information to be used for this incident.

- The patient may go either to their private physician or Brighton Medical Center with the appropriate form. The college pays for the cost of the testing. The student may go either to their private physician, WCC Health Center (if open) or Brighton Medical Center with appropriate form.

- If the student has an exposure with a known HIV patient, he/she should immediately contact their private physician or go to either the Brighton or Maine Medical Center emergency room.

- The WCC Health Center should be notified each time it is necessary to send a student off campus for blood work.

- Extra forms will be stored in the Dental Hygiene Program Administrative Office. Please inform the assistant to the director if the supply of forms runs low.

2.19 Hospital Addresses

Maine Medical Center 22 Bramhall Street Portland, Maine Tel: 207/871-0111	Brighton First Care 335 Brighton Avenue Portland, Maine Tel: 207-662-8111 9:00 AM – 8:00 PM	WCC Health Center Tel: 207-221-4242 or (4242/4442 from UNE phone) 8:00 AM – 4:30 PM (Mon – Thurs) 8:00 AM – 4:00 PM (Friday)

2.20 Accident and Injury Policy

Following any accident or injury, the appropriate parties must complete a Dental Hygiene Incident Report. Forms may be obtained from the Dental Hygiene Program Administrative staff.

2.21 Bloodborne Pathogen Standard

Federal Blood Borne Pathogen Standards will be referenced during OSHA training.
http://www.osha.gov

2.22 Emergency and First Aid Equipment and Procedures

The emergency first aid kit is located in a mobile cart in a central area on the clinic floor. It is labeled as such, near the center of the clinic for easy access during all clinical or laboratory sessions. A first aid kit is present in the lab.

An oxygen tank and ambu-bag are centrally located on the clinic floor.

Barriers for use during CPR are located near the oxygen tank and in a central location.
A blanket is also located in the mobile cart.
There is a direct line phone on the clinic floor. Dial 911 in case of emergency. The phone is RED and is located near the main entrance and exit of the clinic. There is an additional cordless phone centrally located on the clinic floor.

Procedures for specific medical emergencies are outlined in detail in the section of this manual labeled Medical Emergencies.

All faculty and students must know and recognize that “Code Red” means a medical emergency is occurring and taking immediate action is required.

2.23 Hazard Communication and Safety Program

The University of New England Dental Hygiene Program has a system to ensure that potential hazards associated with the use, storage and disposal of chemicals is continually evaluated and that information is made available. The important components of the program are as follows:

1. **List of Chemicals** used in the department. This list is kept with all Safety Data Sheets (S.D.S.), as the table of contents in a binder.

2. **Safety Data Sheets (S.D.S.)** These sheets contain information on each chemical used in the department. They are kept in a red binder labeled "Safety Data Sheets" and is located at the entrance of the clinic floor for easy access at all times. The binder is reviewed and updated regularly with all the relevant information about the chemicals that we use or have stored in our facility. The S.D.S. are provided by the manufacturer and provide details on proper handling, storage, disposal and hazards associated with each chemical.

3. **Labeling.** Proper labels ensure a safe environment. Each container must be labeled with the identity of the chemical, the appropriate hazard warning and the name and address of the chemical manufacturer. Unlabeled or improperly labeled containers may not be used at any time in the dental hygiene facility.

4. **Training.** All students and employees of the University of New England Westbrook College Campus Dental Hygiene Program must be knowledgeable of the components of the Hazard Communications and Safety Program. This is accomplished through classes, clinical sessions and annual orientation of faculty by the Dental Hygiene Program Director.

2.24 Definition of a Hazardous Material

The US Environmental Protection Agency (USEPA) considers a substance hazardous if it can catch fire, if it can react or explode when mixed with other substances, if it is corrosive, or if it is toxic. When handled safely such substances are minimally hazardous. However, if improperly handled, such items can damage health and well-being and negatively affect the environment. Most sources indicate that there are seven basic classes/types of hazardous materials.

1. Flammable Materials – Included are any gases, vapors, liquids or solids which ignite easily and can burn rapidly after being exposed to an ignition source.

2. Spontaneously Ignitable Materials – A few liquids and solids can ignite in the absence of an ignition source. Sufficient heat to cause ignition can be generated within the material by oxidation or microbial action.

3. Explosives – Some chemicals as a result of impact/shock, heat or another mechanism (e.g., electric charge) can detonate.

4. Oxidizers – Some chemical can at room temperature or upon heating generate oxygen, which is hazardous because of its adverse tissue reactions and/or flammability.

5. Corrosive Materials – A number of solids, liquids or gaseous chemicals can damage skin rapidly upon contact. Such chemicals also react negatively with environmental surfaces, such as metals.

6. Toxic Materials – Such materials are commonly referred to as poisons. They can produce a variety of adverse health reactions, even death in relatively small amounts.

7. Radioactive Materials – Some materials spontaneously release energy as they decay into more stable atomic forms. Severe health consequences, even death, can occur when radioactive materials are improperly handled.

2.25 Health and Environmental Hazards Reactions to Combinations

Some chemicals are hazardous by themselves. Chemicals can become hazardous or even more dangerous when mixed in certain combinations. An example would the adding of a flammable liquid to a non- flammable toxic materials. The threat to human health and the environment would be greatly increased if such a mixture were to ignite. Sometimes when chemicals are mixed, new possibly hazardous products are the result. There are four possible scenarios for such actions.

1. Nothing – The mixing of chemicals often fails to reduce any new or more hazardous materials.

2. Toxic Material Formation – Incorporation of hazard or even initially benign chemicals can result in the formation of a toxic material or materials. Such mixtures are not always planned and can be the result of poor employee training and-or failure to read chemical labels/warning symbols and SDS.

3. Flammable or Explosive Material Formation – Mixing of chemicals, often the addition of a liquid to another liquid or a solid can create a flammable product. In some cases there is sufficient heat generated during the chemical reaction to cause an explosion.

4. Production of Heat – Chemicals especially oxidizers when mixed with flammable materials can produce sufficient heat to cause self-ignition.

2.26 Chronic Effect Codes OSHA – Health Hazards

A – Irritant
B – Corrosive
C – Sensitizer
D – Highly Toxic/Toxic
E – Carcinogens

Target Organ Effects:

F – Hepatotoxins
G – Nephrotoxins
H – Neurotoxins
I – Reproductive Toxins
J – Agents that act on the blood of the Hematpoeitic System
K – Agents that damage:
   1. Eyes
   2. Lungs
   3. Skin

4. Mucous Membranes
5. Hearing

L – <u>GI Tract</u>

2.27 Wilson's RISK Scale of Material Hazards

For compliance with the OSHA Labeling Standard (29 CFR 1910.1200), Genium includes the **RISK** scale. This numbering system of four hazardous categories represents a material's degree of hazard based on documented values and/or the best judgments of certified industrial hygienists. The higher numbers indicate an increased hazard.

1. REACTIVITY

Stable at room temperature; may be unstable at elevated temperatures.

INHALATION

TLV >500 ppm (Vapor

O

r

>10mg/m^3 (Solid)

SKIN CONTACT

Slight irritation; no tissue damage

KINDLING

FP > 200°F

2. REACTIVITY

Unstable; may under-go rapid chemical change. Will not detonate.

INHALATION

TLV 101-100 ppm (Vapor)

o

r

1.1-10 mg/m^3 (Solid)

SKIN CONTACT

Mild irritation; tissue damage

KINDLING

FP = 101-199°F

3. REACTIVITY

Capable of detonation explosive decomposition or reaction but required heat or other agent to initiate these.

INHALATION

TLV 11-100 ppm (Vapor)

o

r

0.11-1.0 mg/m^3 (Solid)

SKIN CONTACT

Severe irritation; tissue corrosion within short time period.

KINDLING
FP = 73-100°F

4. REACTIVITY
Readily capable of detonation or explosive decomposition or reaction at room temperature.

INHALATION
TLV < 10 ppm (Vapor)
O
r
< 0.1 mg/m^3 (Solid)

SKIN CONTACT
Corrosive to skin on contact.

KINDLING
FP < 73°F

2.28 Identification of the Health Hazards of Materials

Identification of Health Hazard Color Code: **BLUE**

Type of Possible Injury

4. Materials which on very short exposure could cause death or major residual injury even though prompt medical treatment was given.

3. Materials which on short exposure could cause serious temporary or residual injury even though prompt medical treatment was given.

2. Materials which on intense or continued exposure could cause temporary incapacitation or possible residual injury unless prompt medical treatment is given.

1. Materials which on exposure would cause irritation but only minor residual injury even if no treatment is given.

0. Materials which on exposure under fire conditions would offer no hazard beyond that of ordinary combustible material.

Identification of Flammability Color Code: **RED**

Susceptibility of Materials to Burning

4. Materials which will rapidly or completely vaporize at atmospheric pressure and normal ambient temperature, or which are readily dispersed in air and which will burn readily.

3. Liquids and solids that can be ignited under almost all ambient temperature conditions.

2. Materials that must be moderately heated or exposed to relatively high ambient temperatures before ignition can occur.

1. Materials that must be preheated before ignition can occur.

0. Materials that will not burn.

Identification of Reactivity (Stability) Color Code: **Yellow**

Susceptibility to Release of Energy

4. Materials which in themselves are readily capable of detonation or of explosive decomposition or reaction at normal temperatures and pressures.

3. Materials which in themselves are capable of detonation or explosive reaction but require a strong initiating source or which must be heated under confinement before initiation or which react explosively with water.

2. Materials which in themselves are normally unstable and readily undergo violent chemical change but do not detonate. Also, materials which may react violently with water or which may form potentially explosive mixtures with water.

1. Materials which in themselves are normally stable, but which can become unstable at elevated temperatures and pressures or which may react with water with some release of energy but not violently.

0. Materials which in themselves are normally stable, even under fire exposure conditions, and which are not reactive with water.

Color Code: WHITE may be used for various identification systems, including Hazard Index or Personal Protection Index.

For the prevention or in the event of a hazardous material incident, follow the recommended procedures indicated by labeling and special precautions indicated in the SDS.

2.29 Hazardous Materials Identification System

Hazard Index

4 Severe Hazard
3 Serious Hazard
2 Moderate Hazard
1 Slight Hazard
0 Minimal Hazard

Personal Protection Index

A. Safety glasses
B. Safety glasses, gloves
C. Safety glasses, synthetic apron
D. Face shield, gloves, synthetic apron
E. Safety glasses, gloves, dust respirator

F. Safety glasses, synthetic apron, dust respirator
G. Safety glasses, gloves, vapor respirator
H. Splash goggles, gloves, synthetic apron, vapor respirator
I. Safety glasses, gloves, dust and vapor respirator
J. Splash goggles, gloves, synthetic apron, dust and vapor respirator
K. Air line hood or mask, gloves, fall suit, boots
L. Ask your supervisor for guidance.

2.30 Emergency Evacuation

In the event of fire or other emergency requiring evacuation of the building, please leave the facility promptly. Escort your patient, if in clinic, through one of the available exits. Every room has at least two ways to exit and they are marked accordingly.
Once outside, you should remain on the lawn beside Ludcke Auditorium.
Remember: During any evacuation procedure, you must remain calm and proceed with care to avoid panic in yourself or others.

2.31 Responding to Fire Alarms

From the Safety / Security Coordinator:

Whenever a fire alarm sounds, you should always assume that an actual fire is occurring. Upon hearing the first alarm sound, take the following actions:

Independent Offices – Close windows; open curtains, shades or blinds; and close/lock your office door. Then proceed to the nearest exit and evacuate to the appropriate area. Pass on to Security any signs of fire noted.

Multi-Person Offices – Supervisor or senior person present should ensure that all windows are closed; open all curtains, shades, or blinds, and close/lock your office door. Then, along with all the people in your office, proceed to the nearest exit, and evacuate to the appropriate area. Pass on to Security any signs of fire noted, and the names of any persons that are unaccounted.

Instructors – During periods that you are in a classroom, ensure all windows are closed; open curtains, shades or blinds; and close/lock the door to your classroom. Then, along with the students in your class, proceed to the nearest exit and evacuate to the appropriate area. Pass on to Security any signs of fire noted, and the names of any person unaccounted for.

2.32 Muster Locations

Coleman - lawn by Ludcke Hall
Blewett - grass by Ludcke Hall
Hersey - grass area between Hersey Circle and College Street
Proctor - grass area between Hersey Circle and College Street
Goddard - grass area between Hersey Circle and College Street
Alexander - grass between Hersey Circle and College Street
Alumni - grass area between Hersey Circle and College Street
Library - grass area between Hersey Circle and College Street

2.33 Health and Safety Committee

Mission: The role of the Health and Safety Committee is to monitor compliance with the infection control program, to periodically review the protocol, to update faculty and students on changes, to recommend changes and improvements in the plan and to review the entire process annually with other faculty and the Program Director.

2.34 Accident and Injury Policy

Following any accident or injury, the appropriate parties must complete a Dental Hygiene Program Incident Report. Forms may be obtained from the Dental Hygiene Program Administrative staff.

2.35 Infection Prevention Checklist

The dental hygiene program uses the Centers for Disease Control Infection Prevention Checklist for Dental Settings. The checklist is conducted annually to ensure basic expectations for safe care. Any discrepancies are reported to the director and remedied immediately.
https://www.cdc.gov/oralhealth/infectioncontrol/pdf/safe-care-checklist.pdf

2.36 Quality Assurance Policy

UNE Dental Hygiene Program is committed to quality assurance and maintains a quality assurance program for risk management, the health and safety of patients, students, faculty and staff, and for the confidence that quality requirements will be fulfilled. The program maintains a manual posted on the UNE web site.

2.37 Radiographs and Radiographic Safety

Radiographs are acceptable and are of diagnostic quality. Appropriate number and type of radiographs and all radiographic findings are documented in patient's chart. Safety mechanisms employed are: X-ray machines are inspected by the state agency every 3 years and licensed annually, as directed by state law. Records are maintained per law. Lead aprons are used to protect patients. Triggers are behind safety walls and are of standard distance to protect the clinician. ADA guidelines are followed regarding exposure of the patient. Dosimeters are positioned outside of the operatory where the clinician would be stationed. Dosimeter reports are reviewed monthly. Students are penalized in daily performance, if retakes are taken without an instructor approval. Faculty are licensed and students are trained to competency. Students are further assessed in radiation safety. Dosimeter devises are available for students and faculty.

The UNE dental hygiene program follows the recommendations to reduce radiation exposure to the patient and the operator. The dental hygiene program does an annual quality assurance check on full mouth series and bite-wing series to ensure diagnostic quality of the examination.
http://www.ada.org/~/media/ADA/Member%20Center/FIles/Dental_Radiographic_Examinations_2012.pdf

The Radiology Safety Report:

This report is available on the desktop of the computer station at the entrance of the clinic floor. A hard copy can be requested at any time. This report, in part, describes the University of New England's

management of ionizing radiation and establishes procedures related to control and safe use of x-ray machines as they pertain to the Dental Hygiene Department on the Portland, Maine campus of the University of New England.

The full, un-amended Radiology Safety Report is available for review on the UNE Environmental Health & Safety website at http://www.une.edu/campus/ehs and should be reviewed annually by staff, faculty, and students who come in contact with and use ionizing radiation.

CLINIC PROTOCOL AND EVALUATION PROCESS

Clinic Protocol and Evaluation Process

3.1 General Guidelines for Dental Hygiene Students

Your personal conduct and appearance as a dental hygiene student is of primary importance because of its effect on patients, health personnel and the community in general. High standards of conduct and appearance are expected of you as a professional person; patients and the public expect competence, integrity, and moderation from professional people. Therefore, because you have chosen to enter a health profession, it is necessary to take all possible measures to ensure the cooperation and respect of patients and the public by maintaining high standards of conduct and appearance.

1. Clinic Attire (see 3.32) / Student Attire (see 1.17)

2. Faculty should be addressed as either Professor or Doctor as appropriate. Patients and students shall be addressed respectfully as well.

3. Students are responsible for notices posted on the bulletin board. It would be to your advantage to consult the bulletin board daily.

4. Chewing gum is not permitted during clinical or laboratory sessions. Please do not bring any food or drink into the Clinic. Please use the designated areas on the lower level for eating. The lobby may not be used for a lunch area.

5. A locker is assigned to you and is the only place where books and other personal belongings may be stored. Clinic, lobby, and demonstration rooms must be kept neat.

6. You are required to notify dental hygiene personnel on any day that it is necessary for you to be absent or tardy for any class, clinic, or lab. If you must call prior to the opening of clinic, please leave a message on the clinic staff line at **207-221-4471** (note: please do not leave messages on the general clinic line for patients as your message may not be retrieved immediately). In the event that time from clinic is needed, it is your responsibility to plan with the clinical course directors. Advance notice is crucial for patient scheduling purposes.

7. If you are to be an oral health educator, you should set an example for others to follow. All necessary dental treatment should be attended to.

8. Mouthwash should be used as necessary.

9. The use of make-up and cologne should be kept to a minimum. Heavy make-up or cologne is not appropriate in the clinical setting. Attention must be given to eliminate odors, especially smoke, on clothing and hair.

10. For sanitary reasons, hair is to be combed in the restroom downstairs and **NOT** in clinic; mirrors are provided. All personal grooming including oral hygiene care is to be done in the locker-room.

11. All students will sign a dental hygiene program contract.

12. Students not in a particular clinic may not be on the clinic floor without permission from the floor supervisor. It can be disruptive to scheduled students and faculty.

13. Instruments can be sterilized prior to scheduled clinic times, with permission of the clinical course director, usually right before lunch time.

3.2 Attendance Policy

Class and clinic attendance is an expectation. It is the student's responsibility to inform the clinical course directors and the front desk of any absence. Individual course syllabi will state the penalty for missed classes, laboratories and clinics.

Clinic/Affiliation (Enrichment) Attendance Policy – Great care was exercised in scheduling intra-extra mural clinical assignments so as best to provide each student with a rich practical experience. Absences for any reasons are strongly discouraged. As a general rule, absences (including those due to minor illnesses) will be reflected in the final grade as stated in individual course syllabi. In the event that the enrichment assignment is cancelled the students will need to attend clinic.

Transportation Policy – Please note that students are personally responsible for arranging transportation to and from all affiliation sites.

Illness Notification Policy – In the event of illness, please call the Dental Hygiene Program directly by calling the clinic staff line at 207-221-4471. Messages left at switchboard or sent by classmates are unacceptable. Inform the clinical course directors as well.

Patient Appointment Scheduling and Cancellations – Although the receptionist will make every effort to fill all clinical appointments with patients, the ultimate responsibility for this rests with the individual student. It is in each student's best interest to recruit in advance a host of patients who would be able to fill openings at a moment's notice. Compile these patients in the form of a call list. Clinical time lost due to appointment cancellations will be reflected in the student's final clinic grade.

The student is responsible to recruit their mock board and board patient.

Patient Call List – ***The student is strongly advised*** to have a **Patient Call List** for use in last minute cancellations and no-shows. ***Multiple no-shows can affect the student's clinic grade***.

3.3 Clinical Evaluation and Assessment of Student Learning

The UNE Dental Hygiene Program uses a secure web-based scoring system. The clinical patient care competencies system is designed to assess dental hygiene patient care skills. The term "competencies" is defined as skills that a student dental hygienist is expected to perform at a reasonable level of care. Competent is defined as fitting, suitable or sufficient for the purpose, adequate or properly performed. The grading rubric further defines competent, capable, developing, and ineffective. Competency items (see 3.29) are grouped into major task areas which include: process of care and 14 sub-competencies listed as categories on the TalEval grade sheets.

The fourteen Subcategories are: Risk Assessment, Medical/dental History, Intra/Extra Oral Assessment, Occlussal Assessment, Periodontal Assessment, Radiographic Process & Assessment, Hard Tissue Exam, Deposit Assessment, Treatment planning, Prevention and Supportive Treatment, Instrumentation – Ultrasonics, Handscaling and Debridement, Calculus Removal, Evaluation and Quality Assurance, Ethics and Professionalism.

The Objective Method

The assessment of student performance is by the Objective Method. The "Objective Method" is an objective grading system that utilizes a mathematical formula based on three different factors:
1. Mean of total class performance in every skill set
2. Deduction of "Critical Errors" in every skill set for individual student performance.
3. Points gained from patient treatment types (calculus and periodontal skill levels)

The instructor conducts no math calculations at the time of the evaluation. The weights of the symbols above are unknown at the time of the evaluation if you are utilizing The Objective Grading Method. Weights are not assigned until all data is gathered over half of the term/semester (approximately 6-7 weeks). At the end of that timeframe, the total number of errors are calculated using mean of individual and total class performances. Typically the first half of the term (i.e. Clinic IA) becomes the midterm grade, and the last half of the term (Clinic IB) becomes the second grade. The two grades are averaged together to form the Clinic I grade. The tally is performed by the TalEval software. The program uses the data collected to deduct points lost from errors against points gained for performance on patients who present with various levels of periodontal conditions ranging from healthy to advanced periodontitis with light to heavy amounts of calculus deposits.

TalEval is programmed for mathematical computations on the average number of patients seen in 5-7 weeks. Longer grading periods inflate the grades as they do not allow for the advantage of progression of student skill development which requires a decrease in patient point values to appropriately adjust the grade as the student advances through the clinical education levels.

TalEval never adds critical Error deductions to the total class data to affect the weights of the grades. They are only deducted at the Summative and Formative Grade Evaluations when each student's grade is calculated. Critical errors are the most crucial part of evaluating individual student clinical performance and students are not compared to one another in the critical error component of TalEval. TalEval counts the number of times all the students make any type of error and that affects the mean, but the additional points lost for critical errors only affects the grade of the student who makes the error(s).

Critical errors are pre-weighted for quality assurance in patient care and for assessment of individual student performance.

3.3.1 Radiographic Policies & Procedures for Clinical Sessions

Student Responsibilities:

1. The Patient's most recent radiographs should be mounted or on the computer screen for use during the appointment. **Credit will be lost if this is not done.**

2. After completing the visual components of the patient assessment and discussing the need for radiographs with the patient, the student must confer with the assigned instructor ***prior to*** taking any films. The student must then inform the Radiographic Assistant that x-rays will be taken.

3. The student (DEN 322 Lab) or RA (clinic) must follow the appropriate infection control protocol before and after the x-ray exposure.

4. Review digital exposures or films with your assigned instructor during clinic to determine if there are any POOR films that require a retake.

ALL RETAKES MUST BE SUPERVISED BY YOUR ASSIGNED INSTRUCTOR.

A maximum of TWO retakes on Bitewings and THREE retakes will be allowed on a Full Mouth Series, except under extenuating circumstances. Retakes should be taken on the same day the series is exposed provided there is an adequate amount of time remaining.

5 ***Prior to*** your instructor's evaluation, all films must be evaluated for technique and interpreted by the student.

6. Students should keep track of the number of FMX's and BW's taken throughout each semester in their logs. You should include the date of exposure, name of the patient, the number and type of films exposed, and whether the series fulfilled a clinical requirement. This will greatly assist you in tracking your radiology requirements for clinic.

7. If possible, traditional and digital radiographs should be evaluated by the student on the clinic floor after patient dismissal. Patient radiographs are to be viewed and evaluated in the Dental Hygiene Clinic; patient information does not leave the dental hygiene building.

8. After your instructor has evaluated and graded your FMX, it is essential that the radiographic interpretation be transferred into the patient's record.

9. Failure to transfer the radiographic interpretation into the patient record could adversely impact future patient care.

***** Failure to transfer the radiographic interpretation to the patient record will result in an automatic zero for the FMX and no credit will be given to count towards clinic requirements*****

Instructor Responsibilities

1. After completing the patient assessment, only necessary films should be approved by the assigned instructor using appropriate clinical criteria for exposing radiographs.

2. Each student rendering radiographic services should be closely monitored by the assigned instructor. Students at different competency levels will require variable monitoring.

3. The assigned instructor will evaluate during the clinical session or laboratory session BW and PA radiographs for diagnostic acceptability and determine the need for any retakes. Evaluation of the technique is based upon the Criteria of Radiographic Acceptability found in this Radiology Lab Manual (page). BW surveys that meet this standard should be indicated on the student's clinical evaluation sheet as an acceptable set of BW's and credit will be given.

4. **All exposures to be retaken must be supervised by the assigned instructor.** The instructor must initial the radiographic evaluation form in those instances where he/she directly assisted with the film exposure or in those instances where it is determined that a retake would not improve the original image.

5. Final critique and interpretation of FMX including any previously approved retakes will be evaluated by the student's instructor for that session.

RADIOLOGY STUDENTS AND RADIOGRAPHIC ASSISTANT (RA) DUTIES

At the end of every radiology lab session, radiology students are required to perform the duties listed directly below. When a student is performing the job of Radiographic Assistant (RA) during clinic sessions, the RA will need to perform all the duties listed below

X-RAY OPERATORIES

1. Fold up the extension arms and carefully move the x-ray machine toward the wall, placing the Position Indicating Device (PID) or tube head **parallel** to floor. Please do not let go of the machine when moving it to any position. A freely moving machine will be damaged when it suddenly stops; the walls or mounted control panel at point of impact will suffer as well.

2. All paper and debris must be cleaned up and placed in trash receptacles.

3. Lead aprons must never be folded, but hung on the hooks provided in the operatories.

4. All x-ray machines must be turned off at the end of clinical or lab sessions.

5. All digital sensors must be unplugged and hung up on the wall.

6. Computers should be logged off and shutdown at the end of the clinic or lab.

7. Operatories need to be left cleaned and disinfected at the end of the day.

3.4 Grading Rubric and the UNE Dental Hygiene Web-based Grading System

The criteria for the performance of clinical patient care competencies are judged on a four-step rubric. A number ✔, ✕, or N 3, 2, 1, or 0 is assigned to the patient care competencies performed. A score of 2.25 is equivalent to a 75%.

3- **Competent** - The student has the ability of independent performance reasonable speed, accuracy, knowledge and judgment, reasonable ability to modify performance according to natural cues, and the student is beginning to internalize standards in the mastery of the dental hygiene process of care.

✔ - 2- **Capable** - The student has control over many facts and skills, can understand the purpose of the skills and can somewhat modify their performance. The quality of their performance may be inconsistent with minor errors.

✕-1 **Developing -** The student demonstrates beginner behavior and performs slowly with many errors, is dependent on faculty, wants only one method of skill performance, and tends to be motivated by extrinsic forces.

0 **Ineffective -** Or the student has one critical or major error, causes harm, is ineffective, obtrusive or unprofessional.

N - Not applicable - indicates competency / skill not performed or observed.

The system for determining each clinical course grade is clearly listed in individual clinical course syllabi.

Formulas increase in weight as the expectation of competency increases through the clinical course sequence.

The UNE web-based grading system is an objective grading system that includes a comprehensive itemized list of procedures from ADA/CODA Standard 2-19, listed in 3.07. Instructors go through the list when they evaluate student clinical performance and the list assures that faculty observes the care process.

Mastery of the dental hygiene process of care is evidenced by a fewer number of values (✔ 1 and ✕0) and more frequent assignment of 3 and 2.

Students are expected to be more proficient as they move through their clinical sequence. Therefore, the difficulty of the patient pool also increases over the course sequence.

The UNE dental hygiene grading system computes the grade by a standard formula. The system for determining each clinical course grade is clearly listed in individual clinical course syllabi. The following formula will calculate a rubric grade into a percent grade: 25 + (rubric x 25) = percentage. Percentile grades are then calculated with a formula for each course sequence.

The UNE dental hygiene grading system and Dentrix track patient treatment by each student, which includes age, gender, deposit and periodontal classification, ASA levels, Special Needs/ Care patients, medically compromised and recare (recall and reappointments).

3.4.1 Interprofessional Competencies

Interprofessional Clinical/Field Competency Evaluations among the WCHP programs are measured based on the **IPEC Expert Panel Report**, specifically **RR3**: Engage diverse healthcare professionals who complement one's own professional expertise, as well as associated resources, to develop strategies to meet specific patient care needs.

The UNE Dental Hygiene Program evaluates this competency on the **Web-Based Grading System**;

Communication Interaction/Professionalism Referrals for Treatment
Referrals from Treatment

Evaluation grade is based on the Grading Rubric:

3 = No errors with 1 attempt	100
2 = 1 minor errors with 1 attempt	66
1 = 2 minor errors or 2 attempts	33
0 = 3 or more minor errors, 3 or more attempts,	0

Must attempt another session and continue and/or
1 major safety error attempts until competent to a 75%

3.5 Clinical Performance

The clinical course directors monitor student performance and use a variety of methods to evaluate competent performance such as: Procedure for Assessing Competence (PACs), internally validated clinical examinations and externally validated clinical examinations, mock licensure examinations, and graded clinical performance days.

3.6 Clinical Requirements

The fulfillment of clinical requirements is mandatory to ensure that the student dental hygienist is informed and active in fulfilling a variety of patient services in compliance with the philosophy of total patient care. Requirements ensure that each student will see a variety of patients that may include but may not be limited to infants, children, adolescents, adults, geriatric and special needs/ care populations of varying degrees of difficulty before graduation, as well as medically compromised patients.

Each semester students should strive to practice clinical requirements in order to remain competent and to demonstrate continued competence. Failure to do so may result in a point deduction from the requirement score.

The total minimum number of clinical requirements that must be met with a grade that reflects clinical competency with a minimum grade of 75 or 2.25 by semester prior to graduation is:

Spring Junior Year
2 full mouth series of radiographs
4 bitewing series of radiographs/Adult
1 bitewing series either mixed or primary dentition
2 sealants
1 panoramic radiograph
1 pedodontic patients (age 0-12)
1 adolescent patient (age 13-18)

2 adult patients (age 19 – 61)
1 geriatric patients (age 62 and over)
2 Class I deposit patients
2 Class II deposit patients
1 Class II periodontal involvement
1 Sequences of PAC's
1 Velscope
1 Nutritional Counseling

Fall Senior Year
3 amalgam polishing surfaces with 2 proximal surfaces
3 full mouth series of radiographs
1 panoramic radiograph
4 bitewing series of radiographs Adult
1 bitewing series either mixed or primary dentition
1 bitewing series of radiographs Vertical
2 sealants (2 surfaces)
1 panographic radiographs
2 adult patients (age 19 – 61)
2 geriatric patients (age 62 and over)
2 special needs (at least ASA II)
2 Class I deposit patients
4 Class II deposit patients
3 Class II periodontal involvement
1 Class III deposit patients
1 Class III periodontal involvement patients
1 periodontal re-evaluation
1 Sequence of PAC's

Spring Senior Year
2 amalgam polishing surfaces with 2 proximal surfaces
3 full mouth series of radiographs
4 bitewing series of radiographs Adult
1 bitewing series of radiographs Vertical
2 sealants (2 surfaces)
1 adult patients (age 19 – 61)
2 geriatric patients (age 62 and over)
3 special needs (at least ASA II)
1 Class I deposit patients
5 Class II deposit patients
1 Class II periodontal involvement
2 Class III deposit patients
2 Class III periodontal involvement patients
1 Class IV deposit patient
1 Class IV periodontal involvement
2 periodontal re-evaluation

Total Requirements for Graduation
Amalgam Polishing Surfaces (5), (2) must be proximal
FMX (8)

Bitewings (12) Adult
Vertical Bitewing (2)
Bitewing (1) Primary Dentition
Bitewing (1) Mixed Dentition
Sealants (10 surfaces)
Nutritional Counseling (1)
Pan (3)
Pedodontic and children (1) (age 0-12)
Adolescents Patient (1) (age 13-18)
Adults (5) (age 19-61)
Geriatric (5) (Age 62 and over)
Special Needs/Medically Compromised (5), At least ASA II and at least 1 Med. Compromised
Deposit Classifications:
Class I Deposit (5)
Class II Deposit (11)
Class III Deposit (3)
Class IV Deposit (1)
PERIODONTAL CLASSIFICATIONS:
Class II Perio (5)
Class III Perio (3)
Class IV Perio (1)
Periodontal Re-evaluations (3)
Velscope (1)

3 Pac's DEN 311, 410, 411 SERIES
Date completed

3.7 Patient Care Competencies

The dental hygienist is a licensed preventive oral health professional who uses knowledge of health and disease to prevent, identify, and manage oral disease. The dental hygiene process of care applies principles from the biomedical, clinical, and social sciences to support optimal health in individuals and communities. Care is provided to all regardless of social or cultural background.

PATIENT CARE

1. Assessment -
a. perform a comprehensive examination using clinical, radiographic, periodontal, dental charting, and other data collection procedures to assess the patient's needs
b. Recognize predisposing and etiologic risk factors that require intervention to prevent disease
c. Obtain, review and update a complete medical and dental history
d. Recognize health conditions and medications that impact overall patient care
e. Identify patients at risk for a medical emergency and manage the patient in a manner that prevents an emergency

2. Diagnosis
a. Use assessment findings, etiologic factors and clinical data in determining a dental hygiene diagnosis
b. Identify patient needs and significant findings that impact the delivery of dental hygiene services
c. Obtain the proper consultations as indicated

3. Planning
a. Establish a planned sequence of care based on the dental hygiene diagnosis; identified oral conditions; potential problems; etiologic and risk factors; and available treatment modalities
b. Prioritize the care plan based on the health status and actual and potential problems of the individual to facilitate optimal health
c. Establish a collaborative relationship with the patient in the planned care to include the etiology, prognosis, and treatment alternatives
d. Make referrals to other health care professionals
e. Obtain the patient's informed consent

4. Implementation
a. Utilize accepted infection control procedures
b. Obtain diagnostic quality radiographs
c. Apply basic and advanced techniques of dental hygiene instrumentation to remove deposits without trauma to hard and soft tissues
d. select and administer appropriate chemotherapeutic agents and provide pre and post treatment instructions
e. provide adjunct dental hygiene services that are legally permitted
f. Provide oral health education to assist patients in assuming responsibility for their own oral health

5. Evaluation
a. Evaluate the effectiveness of the patient's self-care and the dental hygiene treatment in attaining or maintaining oral health
b. Determine the clinical outcomes of dental hygiene interventions
c. Develop a maintenance program that meets the patient's needs
d. Provide referrals for subsequent treatment based on the evaluation findings

3.8 Community Involvement and Health Promotion and Disease Prevention

In community-centered settings, the dental hygienist conducts educational and clinical programs using a population-centered approach. In this role, the hygienist requires an understanding of the determinants of health and the characteristics of the particular populations, as well as the individuals who comprise the population. The hygienist provides information and data to influence the facilitation of access to care and services.

<u>COMMUNITY INVOLVEMENT</u>

1. Provide community oral health services in a variety of settings.
2. Provide screening, referral and education services that facilitate public access to the health care system.
3. Respond to patient or community requests for information about contemporary dental problems.
4. Promote the dental hygiene profession by actively participating in the membership, leadership and / or service in professional organizations.
5. Assess and evaluate community based oral disease prevention strategies that aim to improve the oral health of the public.

<u>HEALTH PROMOTION AND DISEASE PREVENTION</u>

1. Evaluate and utilize methods to ensure the health and safety of the patient and the dental hygienist in the delivery of dental hygiene.

2. Evaluate factors that can be used to promote patient adherence to disease prevention and/or health maintenance strategies.
3. Provide educational methods using appropriate communication skills and educational strategies to promote optimal health.
4. Promote preventive health behaviors by personally striving to maintain oral and general health.
5. Identify individual and population risk factors and develop strategies that promote health related quality of life.

3.9 Broken Instrument Policy and Procedure

The following will be the Dental Hygiene Department's procedure regarding a broken instrument.

IF AN INSTRUMENT IS BROKEN IN A PATIENT'S MOUTH:

1. Calmly remove instrument fragment when possible and inform the instructor.

2. Sterilize and save all parts of the instrument; take a radiograph of the area to confirm complete removal of the object.

3. If the instrument fragment cannot be easily removed, notify the instructor and isolate the area with cotton rolls and calmly inform the patient not to swallow. Maintain isolation at all times and avoid use of the aspirator. Reattempt removal of the instrument fragment using Perioretiever found in the emergency kit. Maintain isolation during the procedure. Take a radiograph to confirm complete removal.

4. If an instrument is broken subgingivally and cannot be removed, take a double film radiograph of the area involved. (One copy will be kept in the patient's permanent record and the other copy is for the secretary's file.) Consultation with an oral surgeon may be advised.

5. Complete an incident report and file with the assistant to the Director.

6. Student, instructor, and/or supervising dentist will sign the incident report.

7. File all parts of the instrument, the radiograph and incident report to the secretary.

3.10 Child Abuse Policy

The State Law of Maine makes it mandatory for all health professionals to report any situation in which there is "reasonable cause to suspect" child abuse/neglect. The dental hygienist is named specifically as a mandated reporter. The professional does not have an option in the matter of reporting such cases for investigation. Reporting in good faith frees the professional from any liability if the report proves to be unfounded. Willful failure to report opens the professional to criminal or civil liabilities. The right to privileged communication and confidentiality is waived between the physician and patient by state law in suspected child abuse and neglect cases. You must report all suspected cases.

Whenever the assessment leads to "reasonable cause to suspect" that a child has been abused or neglected, or is at risk of abuse or neglect, whoever in the institution is identified as the reporting individual (student, instructor, or dentist) will make an immediate telephone report to the State Department of Human

Services, Child Protective Services, and will prepare a follow-up written report if requested to do so by DHS, CPS. All aspects of observations must be documented in the client's chart under services rendered.

A report is not an accusation and does not require clinical confirmation of suspicion. Rather, the report should be looked upon as a request for further investigation and intervention. Professionals, who have a broad range of experience in differentiating and dealing with this kind of problem, investigate the report. By means of classroom lecture/discussion, Dental Hygiene students will be provided with information, which will enable them to recognize signs of child abuse and report such occurrences, which they are obligated to do.

Adult and Child Abuse – Neglect Toll Free Number for the State of Maine is 1-800-452-1999.

3.11 Latex Allergies Policy

The Dental Hygiene Clinic is a latex-free environment for most products. The increased incidence of latex allergy in the workplace and in the general population has led to the development of this policy.

The most common type of reaction to latex is a non-allergic hand dermatitis caused by skin irritation. Latex can also trigger a Type IV allergic contact dermatitis or a more serious Type I allergic reaction that may cause anaphylaxis.

Alternatives are available in clinic for students, faculty and patients who are hyper-sensitive or allergic to latex. If, however, it is deemed that a procedure or product may cause a person eminent danger, the Dental Hygiene Program reserves the right to dismiss the person from the Dental Hygiene clinic.

Latex free products are available for use in clinic, as well as powder free latex products to reduce the risk of upper respiratory sensitivity.

Reference: Brick, P., Berthold, M. (1996). Latex allergies-the hidden occupational hazard. Access, 10 (10), 17-22.

3.12 Policy for Patient Records

Patient records may be requested of staff at the front desk to facilitate quality patient preparation and patient care. Records are confidential and must be treated as such. Records must never leave the building and must be returned promptly to the front desk after use.

3.13 Referral Form Policy and Procedure

The referral form is used to communicate dental hygiene findings and services rendered to the primary care dentist of patients that are treated at the University of New England Dental Hygiene Clinic. Patient referral is a professional responsibility of the dental hygiene student to ensure that the patient will receive comprehensive care. Patients who do not leave with a referral form with specific dental concerns will initial and date a general referral stamp found on the inside of their chart. This stamp states that the University of New England Dental Hygiene Clinic is not their dental home and that the clinic recommends a yearly exam with a general dentist.

The student will consult with their instructor on the need of a direct or general referral. An example of the form and the initial / dated general referral stamp are in the appendix.

3.14 Sealant Policy

The following must be done in determination of the need for placing sealants as a service to our patients.

1. Teeth to be sealed need prior designation in the patient record, accompanied by a faculty signature and date.

2. The parent or guardian is to be advised ahead of time of the total cost of such services, and give their approval for the same.

Any sealant lost within one year of the date of application in the University of New England Westbrook College Campus Dental Hygiene Clinic will be replaced at no charge. After one year in place, lost sealants will be replaced at the present fee.

Should a patient call for an appointment for sealants only, the patient will be appointed as a new patient and charged accordingly. The sealants will be placed as stated during the initial appointment at the standard fee. This procedure allows total patient care and treatment: medical history, and oral exam; and oral hygiene instructions, complete plaque removal, and fluoride treatment will be provided as appropriate.

As sealant material is designed to be applied to the etched tooth surface as a preventive agent by the dental hygienist no alteration of the hard tissue prior to sealant placement will be performed in the University of New England Westbrook College Campus Dental Hygiene Clinic.

3.15 Fees for Dental Hygiene Services

The clinic fee schedule is updated periodically. The most current schedule appears in the appendix section of this manual.

Approximate cost for exam & prophylaxis:

Adult (Ages 13-61)	$36.00
Child (Ages 0-12)	$16.00
Senior (Ages 62 & over)	$25.00
Edentulous (exam/denture clean)	$20.00

(above fees do not include fluoride or x-rays)

Periodontal Maintenance	
Adult (Ages 13-61)	$36.00
Senior (Ages 62 & Over)	$25.00
Panorex:	$35.00
FMX	$35.00
2BW's	$5.00
4BW's	$8.00
PA's	$4.00 ea.
Fluoride	$5.00
Sealants per tooth	$8.00 ea.
Quadrant Scale (per quad)	$36 Adult
	$25 Senior Cit.

3.16 Indices and Classification Systems

Indices and classification systems are assessment methods used to collect data concerning patient assessment, treatment, and follow-up of dental hygiene services, and may serve as evaluation measures of patient's outcomes. Classification is assigned each patient on the Daily Evaluation Form.

3.17 Periodontal Screening Record (PSR)

The PSR is used to determine periodontal need of the patients at the initial screening appointment. Patients are then appointed to the appropriate clinical sequence.

3.18 Plaque Index – Patient Hygiene Performance (PHP)

The purpose of the PHP is to quantify in numerical form the amount of oral debris. This index will provide baseline data for subsequent visits on homecare. It is performed at each visit.

3.19 UNE Dental Hygiene Classification of Periodontal Involvement

Class H Periodontal Health (No Attachment Loss)

Assess pseudopockets, 0-3 mm probable.

No clinically detectable inflammation.

Class I – Gingivitis (No attachment loss)

Assess pseudopockets, 0-3 mm probable.

Inflammation of the gingiva characterized clinically by surface appearance and presence of bleeding and/or exudate. Variable probing depths due to inflammation. No Alveolar bone loss present.

Class II – Initial Periodontitis (1mm – 2mm of Clinical Attachment Loss) – Stage I Periodontitis

Assess 1-5 mm pockets probable, consider recession.

Pocket depths vary dependent upon edema or recession. Progression of the gingival inflammation into the deeper periodontal structures and alveolar bone crest, with slight bone loss, ≤10% radiographic bone loss.

Class III - Moderate Periodontitis (3mm – 4mm of Clinical Attachment Loss) – Stage II Periodontitis

Assess 1-6 mm pockets probable, consider recession.

A more advanced stage of the above condition, with increased destruction of the periodontal structures, with noticeable loss of bone support possibly accompanied by an increase in tooth mobility. ≤33% bone loss may be detected radiographically. <u>There may be furcation involvement in multirooted teeth.</u>

Class IV – Severe and Advanced Periodontitis (5mm or more of Clinical Attachment Loss)
Stage III Periodontitis – less than or equal to 4 teeth lost
Stage IV Periodontitis – less than or equal to 5 teeth lost

Assess 1-greater than 6 mm pockets probable, consider recession

Further progression of periodontitis with major loss of alveolar bone support usually accompanied by increased tooth mobility. Furcation involvement in multirooted teeth is likely with > 33% radiographic bone loss detected. Potential for lost teeth.

Adapted from the "Description of Procedural Terminology," published by the American Academy of Periodontology.
Journal of Periodontology Volume 71 – Number 5 – May 2000 (Supplement)
Tonetti, M., Greenwall, H., Kornman, K.. Staging and Grading of Periodontitis: Framework and Proposal of a New Classification and Case Definition. J Periodontal. 2018; 89 (Suppl1):S159-S172.

3.20 Patient Classification for Deposit

Patients are classified according to the amount and location of explorable detectable calculus occurring on the teeth. In general the term "trace" is used to describe deposit that is barely detectable; “slight” describes deposit that is less than 1mm in width; “moderate” described deposit 1mm-2mm in width; and “heavy” described deposit that is greater than 2mm in width. Examiner discretion is advised when “width of deposit” is not the appropriate criteria to determine the classification; depth, location, number of teeth involved, or tenacity of deposit may also be used.

Class C:
Primary mixed dentition; generally a child who is under the age of 12 years, unless calculus is present.

Class I:
A. Trace or slight supragingival calculus and/or
B. Trace or slight extrinsic stain and/or
C. Trace subgingival calculus

Class II:
A. Moderate supragingival calculus and/or
B. Moderate extrinsic stain and/or
C. Slight subgingival calculus

Class III:
A. Heavy supragingival calculus and/or
B. Heavy extrinsic stain and/or
C. Moderate subgingival calculus

Class IV:
A. Heavy supragingival calculus and
B. Heavy extrinsic stain and Heavy subgingival calculus
C. Heavy subgingival calculus only

3.21 Black’s Classification of Caries and Caries Risk Assessment

Class I Caries beginning in the structural defects of the teeth; pits and fissures. These are located in the occlusal surfaces of the premolars and molars, in the occlusal two-thirds of the buccal groove of the molars, in the lingual surface of the upper anteriors in the cingulum area, and the lingual groove of upper and lower molars.

Class II Caries in proximal surfaces of premolars and molars.

Class III Caries in proximal surfaces of incisors and canines which do not involve the removal and restoration of the incisal angle.

Class IV Caries in the proximal surfaces of the incisors and canines which require the removal and restoration of the incisal angle.

Class V Caries in the cervical third of the crown.

Class VI Caries above the crest of contour on anterior teeth or on the cusp tip on posterior teeth.

Evidence of caries, developmental, physical, mental disabilities may indicate the need for caries risk assessment. See appendices for Caries Risk Assessment Form.

3.22 Miller Classification of Gingival Recession

Class I Class I Miller defect. The gingival recession does not involve the interproximal papillae or the mucogingival junction.

Class II The recession in a Class II Miller defect extends past the mucogingival junction but does not involve the interproximal tissues.

Class III The chances for root coverage are decreased when the recession involves the interproximal papillae (Class III Miller defect).

Class IV Full coverage of exposed root surfaces should not be expected after a soft tissue graft when there is marked loss of the interproximal papillae.

3.23 Student Clinical Duties

The principle clinical duty of the student is as a chair side student dental hygienist providing patient care. Other duties, on a very limited basis consist, of screening new patients, Clinical Assistant 1, and Clinical Assistant 2, and Radiographic Assistant. See Appendix for an operational list of other duties in the format of an evaluation form.

3.24 Guidelines for Patient Treatment Sequence

Clinic Check-In/Check-Out Procedures

1. Pre-appointment procedures.
2. Greet patients.
3. Seat patients.
4. "Release Form" completion signature check.
5. Health History/Vital Signs
6. Dental History
7. Soft tissue, periodontal, and hard tissue evaluation.
8. Risk Assessments
9. Prepare to discuss treatment/appointment plan with faculty. CHECK-IN:
   a. Comprehensive check of procedures.
   b. Confirm or revise comprehensive treatment plan.
10. PHP (utilize for patient education).

11. Initiate treatment.
12. Check treatment completion.
13. CHECK-OUT:
    a. Request 30 minutes prior to end of clinic or as agreed upon with instructor/mentor.
    b. Final examination will be performed upon completion of treatment as outlined by treatment plan.
    c. Modified check-out is required for patients to be reappointed.
14. Post-appointment procedures.
    Instructors may interrupt and check procedures completed to a certain point in order to avoid student waiting.

3.25 Informed Consent

Informed consent acknowledges that the patient plays an active role in the decision making process of patient treatment. The patient must understand all relevant information about the procedures and freely consent to them.

3.26 Local Anesthesia Consent

The local anesthesia consent form must be explained and signed before local anesthesia can be delivered. Local anesthesia can be delivered by 2nd semester senior dental hygiene students to meet competency requirements.

3.27 Expectations for the Mentor/Instructor

During daily student learning the clinical chair-side mentor/instructor is encouraged to:

- Give positive feedback and accurately describe student's strengths, weaknesses and progress.
- Encourage and accept students' questions.
- Answer questions tactfully.
- Accept student as one developing new skills and applying knowledge.
- Provide a climate for students' independent action.
- Be aware of each student, distributing time daily and appropriately.
- Encourage discussion of patient care.
- Observe student and be present for support.
- Be available to the student at the clinical unit.
- Assist students in answering their own questions.
- Clarify the purpose of his/her presence.
- Demonstrate professionalism and competency.

3.28 Faculty Training

Faculty training in student patient care competencies criteria and for grading will occur through each course director and the Faculty Evaluation and Assessment Manual. Also, annual faculty training occurs in the fall. UNE dental hygiene evaluation and grading systems also provides instructor calibration in every category of the dental hygiene process of care.

Instructors go through the COMPREHENSIVE "Itemized list" when they evaluate student clinical performance and the list assures that instructors do not forget to observe every aspect of the process of care. This in itself provides Quality Assurance in Patient Care.

3.29 Performance Criteria for Assessing Patient Care Competencies

Students are required to perform the following services as part of the dental hygiene process of care. The student must satisfactorily meet competency (rubric) standards to graduate.

The following criteria are evaluated and graded using the TalEval web-based Performance Form and the Grading Rubric 3.4 and Patient Competencies 3.7.

ASSESSMENT AND DENTAL HYGIENE DIAGNOSTIC DECISION MAKING

Category I. Risk Assessment Medical/ Dental Histories

Item 1 Further Questions Findings

Circles yes answers in red and further questions patients about those items on questionnaire **+**
Failure to circle yes answers in red or further question patients about a "yes" answer ✓
Both of the above and/or errors on more than one "yes answer **X**

Item 2 Uses Reference

Refers to drug handbook, medical dictionary, medline, etc. to research disease processes, drugs patient is taking +
Failure to research an unknown disease process or medication ✓
Failure to research disease process and medication for its treatment X

Item 3 Vital Signs

Uses proper techniques for taking accurate vital signs +
Uses inappropriate technique for taking a vital sign ✓
Uses inappropriate techniques for taking more than one vital sign X
Forgets to take vital signs and proceeds with appointment X

Item 4 Notifies Instructor of Risk Factors

Student notifies instructor if vital signs or medical history findings require a consult with patient's physician prior to treatment +
Failure to notify instructor of patient condition or disease that is a risk for treatment X

Item 5 Documents Appropriately in the Medical Alert Box

Accurate documentation in the medical alert box +
Documenting a non-alert finding in "Alert Box" ✓
More than one non-alert finding in "Alert Box" X
Failure to document a risk factor in the "Alert Box" X

Item 6 Documents Medications and Contraindications to Treatment

All information on medications patient is taking is documented +
Incomplete by one omission or one inaccuracy ✓
More than one omission or inaccuracy X

Item 7 Documents lifestyle risk factors such as Tobacco use, Alcohol and/or Drug Use

Documents all lifestyle risk factors +
Incomplete by omission of risk factor(s) X ☐

Item 8 Health Summary

Documents health summary section of medical history with a statement that summarizes the patients overall health condition + or One ✓☐item

Item 9 Updates at Successive and Recall Appointments

Asks appropriate questions and checks vital signs +
Does not do either of the above X

Category II. Extra/Intra Oral Assessment

Item 10 Technique: visual, palpation, auscultation, order, thoroughness

Performs assessment using correct techniques +
One error in technique ✓
Two or more errors in techniques X

Item11 Identifies abnormality: measures, describes, documents

Measures, describes and documents all findings +
Failure to measure or describe one non-pathological finding in record ✓
Failure to measure, describe or document one risk (possible pathology) finding or one or more nonpathological finding X

Item 12 Assessment Update at Successive and Recare Appointments

Documents all changes in Extra/Intra Oral Assessment at each appointment +
Incomplete by one omission or one inaccuracy of non risk factor finding ✓☐
More than one omission or inaccuracy or one pathological risk factor X

Category III. Occlusal Assessment

Item 13 Angle's Classification or Jaw Relationship

Angles or skeletal classification of I, II, III Left or right side inaccurate ✓
Both left and right sides different and inaccurate X

Item 14 Overjet/Underbite

Measurements documented + or One ✓☐item

Item 15 Overbite/Openbite

Measurements documented + or One ✓☐item

Item 16 Crossbite

Records teeth numbers of specific areas affected + ✓or☐X item

Item 17 Deviate versions

Recorded as facial, lingual, midline, torso + ✓or☐X item Deviate swallow noted

Item 18 Parafunctional Habits

Questions and documents: nail biting, bruxism, chewing pens, hair pins +
Fails to document one habit ✓
Fails to document more than one habit X

Item 19 Study Models

Uses proper technique for taking impressions and completing study models +
Incorporates study models in occlusal assessment+
Fails to do one of the above ✓
Fails to do two of the above X

Category IV. Periodontal Assessment

Recognizes changes as follows: If correct = +, 1 error = ✓, more than one minor error = X one acute pathology missed X

Item 20 Gingival Description

Color:
Differentiates pink from light to bright red, or pigmented oral soft tissues
Size:

Describes and differentiates enlargement, shrinkage and/or gingival changes whether localized to margins or papillae

Shape margin/papillae:

Describes changes in shape to margins (flat, irregular to rounded) or papillae (knife-like to bulbous, blunted or cratered)

Consistency:

Describes as spongy, edematous, firm or indurated, ulcerated, etc.

Texture:

Describes tissue as smooth and shiny (punched out rete pegs), or fibrotic

Item 21 Recession measurements

Measures all areas of recession and determines the "clinical attachment level" (CAL)

Item 22 Pocket measurement accuracy

Accurate measurements of pocket depths, documents depths of 4mm or greater in red

Item 23 C.A.L. Measures attached gingiva and notes clinical attachment levels.

Documents all areas of <1 mm of attached gingiva

Item 24 Bleeding points

Records all areas of bleeding on probing with red pencil notations on periodontal chart

Item 25 Mobility

Accurately records mobile teeth according to classifications I, II, III +

Item 26 Furcation Involvements

Records all furcation involvements according to classifications ΔΔΔ☐

Item 27 Etiological Factors

Documents etiological factors such as bacterial plaque and local irritants, systemic disorders, tobacco use, or malocclusion.

Item 28 Accuracy of summary of statement of periodontal status +

Inaccurate summary or failure to update at each appointment + or One ✓☐item

Category V. Radiographic Process & Assessment

Item 29 Prescription Prior to Taking Radiographs +

Failure to obtain prescription prior to taking radiographs X

Item 30 Technique/process/retake approval +

Error in one of the above ✓

Error in more than one of the above X

Item 31 Interpretation/correlation with EO/IO, perio and hard tissue exam

Error in one of the above ✓

Error in more than one of the above X

Item 32 Name/date on radiographs and computerized records +

Failure to label radiographs X

Item 33 Cumulative radiation record completed + or One ✓☐item

Item 34 Confers with Dr. on diagnosis +

Failure to notify Dr. for diagnosis X Hard Tissue Exam

Category VI. Hard Tissue Exam

Item 35 Missing teeth I.D.

Correctly identifies and charts which teeth are missing (extracted or unerupted)

+ ✓or☐X item

Item 36 Restoration I.D.

Correctly identifies and charts restoration materials, surfaces restored, crowns, abutments, pontics of bridges, or sealants + ✓or☐X item

Item 37 Caries I.D.

Correctly identifies and charts areas suspicious as carious lesions + ✓or☐X item

Item 38 Abnormality Identification

Any findings not noted other than caries, missing teeth, or restorations, such as: fractures, erosions, abrasions, attrition, hypocalcifications, mottled enamel, rotations, imperfections, supernumerary teeth, and any anomalies + ✓or☐X item

Item 39 Assessment Update at successive and recall appointments

Failure to update X

Category VII. Deposit Assessment

Grade according to Clinic Level: If percentage expected for each level the grade is +

If <10% inaccurate ☐ If > 10% inaccurate X

Clinic Grading Period	Student must detect:	
I	90% of Supragingival Cal	80% of Subgingival Cal
II-A	95%	80%
II-B	100%	85%
III-A	100%	90%
III-B	100%	95%

Item 40 Supragingival underassessed/overassessed + ✓or☐X item

Item 41 Subgingival underassessed/overassessed + ✓or☐X item

Item 42 Soft deposit assessment + ✓or☐X item

Item 43 Assessment of stain + ✓or☐X item

Item 44 Updates at successive and recare appointments + ✓or☐X item

PLANNING AND SELECTION OF INTERVENTIONS

Category VIII. Treatment Planning

Item 45 Formulates and presents dental hygiene diagnosis +☐

Inaccurate assessment ✓

Inapproprate presentation ✓

Failure to formulate or failure to present X

Item 46 Prioritizes on patient needs, makes changes as needed

Makes inappropriate change ✓

No change made when findings indicate the need X

Item 47 Has realistic goals for the process of care + or One ✓☐item

Item 48 Correct number and sequence of appointments

Prepares a realistic treatment plan regarding the correct number of appointments and the proper sequence of treatment procedures +

Unrealistic plan of too few appointments, or too many appointments planned ✓

Inappropriate number of appointments and poor sequence of procedures X

No treatment plan in place X

Item 49 Plans for pain control and stress reduction +

Allows patient to dictate need for local anesthesia or stress reduction protocol ✓
Proceeds with treatment even though patient is in need of pain control as evidenced by patient behavior and reaction to treatment X

Item 50 Plans timeframe for recare appointments +

Inappropriate timeframe scheduled for recare appointments ✓
No recare appointments planned or scheduled X

Item 51 Explains the need for referral to specialty practices +

Inappropriate referral made ✓
No referral made when one is necessary X

Item 52 Clearly explains alternatives, outcomes, expenses + ✓or☐X item

Item 53 Patient consent confirmed with signatures

Responsible for 3 signatures: Patient, Student, Faculty + ✓or☐X item

IMPLEMENTATION AND ACTIVATING THE PLAN

Category IX. Preventive and Supportive Treatment

Item 54 Educates patient on conditions, needs, and commitment + or One ✓☐item

Missing one of the above ✓
Missing two or more of the above ✓
No presentation given to the patient on this information X

Item 55 Overall health status considered in instruction

Failure to consider health problem placing patient at risk X

Item 56 Selects the correct toothbrushing method + or One ✓☐item

Item 57 Interdental Aids

Selects interdental aids appropriate for patient needs, especially when pocket depths are greater than 3mm.(Perio Aide, toothpicking), or diastemas(Proxy brush), or crowding of teeth that makes plaque removal more difficult. (Informs patient that floss alone will not remove plaque in pocket depths greater than 3mm) + ✓or☐x item

Item 58 Presentation

When educating patients, visual aids are used to explain progression of the disease
Uses terminology that is appropriate for patient age and educational level. Defines terms and/or presents in lay terms as needed. + ✓or☐x item

Item 59 Plaque index

Completes an accurate plaque index on every new patient, and every returning patient and explains the plaque score to the patient +
Completed plaque index is inaccurate ✓
Fails to complete a plaque indices X

Item 60 Patient as plaque free as possible after instruction + or X only item

Item 61 Tobacco cessation utilizing current methodology +

Failure to present information to patient X

Item 62 Dietary counseling and lifestyle concerns as indicated + or One ✓☐item

Item 63 Selective coronal polishing: explains, uses correct techniques + ✓or☐X item

Item 64 Topical fluoride treatment: explains, and uses correct techniques + ✓or☐X item

Item 65 Fl self care instruction if needed + or One ✓☐item

Item 66 Care of restorations, oral appliances, dentures + ✓or☐X item

Item 67 Pit & fissure sealants as prescribed, using correct materials, techniques, placement +

Item 68 Antibacterial placement agents (Arestin, etc.) + ✓or☐X item
Item 69 Chemotherapeutic agents (chlorhexidine, etc.) + or One ✓☐item
Item 70 Desensitizing products, techniques (varnishes, MI Paste, etc.) + ✓or☐X item
Item 71 Updates at successive and recare appointments + or One ✓☐item

Category X. Pain Control

Item 72 Pain Control Indications/contraindications – clinician's judgement + or One ✓☐item
Item 73 Explains the need, procedure, post op. precautions + ✓or☐X item
Item 74 Selection of type of local anesthetic + or One ✓☐item
Item 75 Topical anesthetic application + ✓or☐X item
Item 76 Local anesthesia set up/administration technique + ✓or☐X item
Item 77 Sedation: preparation/monitoring + ✓or☐X item
Item 78 Antianxiety measures (presedation) clinician's judgement +✓or☐X item
Item 79 Documents record noting analgesia, anesthesia: type, amount, effectiveness, reactions + or One ✓ item

Category XI. Instrumentation - Ultrasonics

Item 80 Appropriate indications for ultrasonics: deposits, lavage, health status, risks +
Item 81 Explanation of procedure to patient + or One ✓☐item
Describes procedure and explains need for suction and avoidance of swallowing water and debris +

Failure to explain ✓
Item 82 Equipment preparation, tip selection and patient/operator protection and safety
Correctly sets up ultrasonic equipment (water control etc.) and drapes patient and gives paper towels, and safety glasses.+
Forgets one item ✓
Forgets more than one item X
Item 83 Pt/op positioning-neutral wrist. Clock/handle position
Item 84 Technique – placement and movement of tip/fulcrum
Places side of tip on deposit and moves continuously to avoid heating up tooth surface and does so with fulcrum maintained. + ✓or X item
Item 85 Retraction of soft tissue, avoids spray on patient's face + ✓or☐X item
Item 86 Fluid Control suction, patient not swallowing water, debris + ✓or☐X item

Hand Scaling & Debridement

Item 87 Patient – Operator Positioning All aspects of positioning are correct +
One or the other is incorrect ✓
Both patient and operator positioning are incorrect X
Item 88 Indirect Vision
Uses indirect vision with dental mirror +
Isolated incidence of not using indirect vision where needed to assure proper positioning and good visibility☐✓
Repeated incidence of not using indirect vision where needed X

Item 89 Instrument Selection – correct end/edge - sharpness

Selects appropriate instrument and correct end/edge for specific areas and tooth surfaces+

Isolated incidence of not selecting appropriate instrument and end/edge ☐ Instruments not sharp ✓

Repeated incidences of not selecting appropriate instrument and end/edge X

Item 90 Grasp

Grasp is correct at all times+ (fingers all together, no split, fulcrum finger advanced, thumb and index forming soft "C")

Grasp is incorrect in one area of the mouth, or with one particular instrument✓

Grasp is incorrect in more than one area of the mouth with instrument X

Item 91 Fulcrum

Fulcrum is rigid (support beam), fixed (not traveling during instrumentation), in proper position and correctly used throughout instrumentation +

Isolated area of inability to employ fulcrum, or using weak fulcrum (bent, traveling during instrumentation), or not in the correct place for area working ✓

If repeatedly failing to employ fulcrum in correct manner X

Item 92 Parallelism

Terminal shank is parallel to the long axis of the tooth during instrumentation +

Isolated area of not placing instrument parallel to long-axis of the tooth ✓

Repeatedly failing to keep instrument parallel to long-axis of the tooth X

Item 93 Ease of Insertion (places instrument on "Get Ready Zone" to line up for insertion)

Inserts instrument subgingivally at proper line angle, with no pressure, and as close to 0 degrees as possible to avoid tissue trauma +

One isolated insertion error ✓

More than one insertion error X

Item 94 Exploratory Stroke

Uses a light exploratory stroke with scaling instrument to detect calculus, and positions toe 1/3 of working end of instrument under the deposit before activating +

Isolated incidence of not using exploratory stroke ✓

Repeated incidence of not using exploratory stroke X

Item 95 Adaptation

Toe 1/3 is consistently adapted during instrumentation +

Isolated area of not adapting instrument to tooth ✓

Repeatedly failing to adapt instrument to tooth X

Item 96 Activation

Employs fulcrum and lateral pressure while opening + ✓or☐X item

Item 97 Angulation

Instrument is inserted at 0 degrees, activation is initiated at 0 degrees and face of instrument is opened to 60-80 degrees during activation +

Isolated area of not initiating at 0, or opening to 60-80(closing on face) ✓

Repeatedly incorrect in angulation X

Item 98 Pressure During Activation

Uses light to moderate pressure, no scraping or heavy pressure during activation +

One incident of scraping instead of short controlled bite or longer lighter shave ✓

Repeated incidents of scraping instead of short controlled bites or longer light shaving X

Item 99 Stroke Control

The scaling stroke is less than 2mm. long and ends with instrument on the tooth +

Lifting the instrument off the tooth at stroke's end ✓

Repeatedly lifting the instrument off the tooth at stroke's end X

Item 100 Vertical and Oblique Working Strokes

Uses vertical and oblique working strokes to remove calculus deposits. Only uses horizontal or circumferencial strokes for fine scaling, and multi-directional strokes for root planing +

Failure to use productive vertical or oblique working strokes for calculus removal in one area ✓

Failure to use productive vertical or oblique working strokes for calculus removal in more than one area X

Item 101 Hands Steady - Not shaking when performing instrumentation

Does not shake during instrumentation, regardless of nervousness during performance, as hands are in control when performing instrumentation +

Isolated incidence of shaking during instrumentation ✓

Repeatedly shaking during instrumentation X

Item 102 Gauze, Rinse Suction

Takes every precaution to prevent patient from swallowing blood or loose calculus by using gauze and suction to absorb blood and collect loose deposits. Rinses and uses suction to avoid patient swallowing blood, or deposits. Finishes deep scaling procedures by using irrigation with Peridex or Listerine +

Failure to do any one of the above: gauze, suction, rinse, irrigate☐✓

Failure to do more than one of the above X☐☐

Item 103 Finishes by flossing and using subgingival irrigation +

Failure to do one of the above ✓

Failure to do both of the above X

Category XII. Calculus Removal

Grade according to Clinic Level: If percentage for each level the grade is + not met ✓

If more than 10% of level expected remains X

I	90% of Supragingival calculus	80% of Subgingival calculus
II-A	95%	80%
II-B	100%	85%
III-A	100%	90%
III-B	100%	95%

Item 104 Supragingival removal + ✓or☐X item

Within 10% of requirement ☐

Greater than 10% of requirement X

Item 105 Subgingival removal + ✓or☐X item

Within 10% of requirement ✓

Greater than 10% of requirement X

Item 106 No lacerations + ✓or☐X item

One laceration ✓

More than 1 laceration X

Item 107 No burnished calculus + ✓or X item

One surface of burnished calculus ✓

More than one surface of burnished calculus X

Item 108 At check out, states exactly where calculus remains + or One ✓☐item

EVALUATION COLLECTING FEEDBACK ON EFFECTIVENESS AND DOCUMENTATION-COMPREHENSIVE RECORDING KEEPING

Category XIII. Evaluation and Quality Assurance

Item 109 Organization, appropriate sequence in appointment procedures

Item 110 Equipment preparation, organization and sequence

Uses proper equipment and follows proper sequence during the appointment +
Is not prepared with proper armamentarium for procedure ✓
Failing to check-in or out, misses or performs one procedure out of order ✓
More than one procedure or item missing or out of order X

Item 111 Evaluation, documentation, computerized record control

Prepared for evaluation: proper documents filled out and entered into computerized records +
One missing item ✓
More than one missing item X

Item 112 Student should NOT be wearing gloves at check-in so they can document instructor notes and wearing gloves at check-out to assist instructor with instrument transfer and suctioning.

Student following protocol on gloves, documenting and assisting when necessary +
Wearing gloves at check-in ✓
Not wearing gloves at check-out ✓
Not documenting instructor findings ✓
Not assisting when necessary ✓ More than one of the above X

Item 113 Reason for visit discussed, documented +

Failure to discuss or document reason for visit ✓
Failure to discuss and document reason for visit X

Item 114 Treatment record page documented +

One error in treatment record documentation ✓
More than one error in treatment record documentation X

Item 115 Patient's name/date on every page

Name and date on every page +
Name and date missing on one page ✓
Name and date missing on more than one page X

Item 116 Signs forms, seeks instructor and patient for signatures

Patient Bill of Rights and consent forms presented to patient and signed by patient +
Failure to present and/or get signatures on the above ✓
Failure to get signatures and answer questions pertaining to Bill of Rights X

Item 117 Completes student QA chart review of previous record of treatment and documentation

Chart review is complete, accurate and up to date +
One item missing or inaccurate or not updated ✓
Two or more of the above not completed X

Item 118 Treatment Plan followed

Patient treatment followed to completion as planned +
Patient care is fragmented and not according to timelines ✓
Patient's treatment is not completed X

Item 119 Student evaluation of care (treatment results documented) +

Student has an inaccurate assessment of results or rationale for results of prior patient treatment ✓
Student makes inappropriate plan to resolve problematic response to prior treatment ✓

Student fails to evaluate and update at all X

All entries on treatment record page are detailed, correct and signed by student +

One error in documentation of treatment record ☐

More than one error in documentation of treatment record X Continued comprehensive care referrals recommended +

Student fails to do either of the above X

Item 120 Continued comprehensive care referrals recommended +

Student fails to do either of the above

Item 121 Recare appointment times scheduled

Student schedules recare appointment at appropriate interval and follows through with recare appointment + Student fails to do either of the above X

XIV. Ethics and Professionalism

Item 122 Attendance and Punctuality

Student is in attendance and on time +

Student is either late or leaves early ✓

Student came in late and left early X

Item 123 Time Management

Student is using time wisely in the best interest of the patient +

Student is not using time wisely and is wasting the patient's time X

Item 124 Infection control and patient safety assured

Student follows all protocols for infection control and patient safety +

Student does not follow protocols X

Item 125 Appearance, Demeanor, Attitude, Composure

Student is professional in all ways +

Student is unprofessional with one isolated and minor appearance ✓

Student has more than one appearance problem X

Student is unprofessional in anyway in demeanor, attitude or composure X

Item 126 Consent forms signed prior to any procedures, treatment

All forms signed +

Any consent forms not signed X

Item 127 Discretion and privacy of patient protected

Student is very discrete and protects patient privacy +

Student is indiscrete or not protective of patient privacy X

Item 128 Patient Rapport and Compassion

Student establishes patient rapport and shows compassion +

Student establishes minimal patient rapport ✓

Student fails to establish any patient rapport X

Student does not show compassion X

Item 129 Teamplayer, Self-directed, Helps

Student helps where needed without having to be told +

Student wants to be helpful, but does not realize what he/she needs to do ✓☐

Student is not self-directed or not a teamplayer X

Item 130 Accepts fair, negative feedback

Student welcomes fair, negative feedback +

Student does not accept the feedback X

Item 131 Recognizes the Need to Learn

Student recognizes that they need to learn and improve +
Student does not recognize or is unwilling to change X

Item 132 Acknowledges and Corrects Errors

Student acknowledges errors and makes corrections +
Student refuses to acknowledge errors X

Item 133 Practices effective communication skills

Communicates with patient at their level of understanding +
Uses technical terms when lay terms are necessary ✓
Uses lay terms when patient has a background to understand technical terms ✓
Fails to clarify conditions, procedures to patient X

Item 134 Proper grammar spoken and written

Uses correct grammar when speaking and writing, and correct spelling when writing +
One error in grammar or spelling ✓
More than one error in grammar and/or spelling X

Item 135 Practices within limits of knowledge and skills

Stays within limits of knowledge and skills +
Practices beyond the limits of knowledge and skills X

Item 136 Follows Rules, Laws & Regulations

Follows all rules +
Does not follow one or more rules X

Item 137 Meets commitments

Is accountable and reliable in meeting all commitments +
Failure to meet one or more commitments X

Item 138 Reports Misconduct

Reports misconduct to instructors, administration or law officials as indicated +
Fails to report misconduct X

Item 139 Completes assignments on time

Completes all assignments on time +
Fails to complete one or more assignments on time X

Item 140 Makes learning a priority

Values learning as a priority +
During this session student is grade oriented or anxious to get through the appointment instead of being learning oriented X

3.30 Clinician Medication Policy

People take medications for many conditions and such matters are confidential. As professionals, we must recognize when our abilities are impaired. Safety is an important aspect of professional practice.

We must respect safe interaction with patients, our colleagues, and ourselves.

Any student or faculty member who takes medication that impairs their ability, must recognize this and refrain from any work in the clinical setting. This would include RA, CA, screening, and all chairside duties. Students and faculty who are impaired will be dismissed from all clinical duties.

Students are encouraged to consult with the clinical course directors about absences for any reason. See sections 3.1 and 3.2 for policies regarding attendance.

3.31 UNE Dental Hygiene Program Standards of Care (See 1.5)

3.32 Program Clinic and Lab Attire

I. Clinical Attire

A. Clinic/Laboratory setting – working on patients
   1. Scrubs
   2. Protective gown/cover – provided by the Department
   3. White shoes/sneakers
   4. White socks
      a. Legs should be completely covered
   5. Tattoos must be covered

B. Hair must be fastened off the face with no obvious loose ends
   1. If you put your head down and hair falls onto your face, you need to pin it back
   2. Bobby pins, hair clips and non-porous head bands that are impervious to fluid and can be disinfected may be worn to keep hair back and away from the patient
   3. Disposable surgical hats may be worn if desired

C. All jewelry must be removed
   1. Wedding rings
   2. Watches
   3. Tongue rings
   4. Necklaces
   5. Facial jewelry

D. Protective gowns/covers must be removed before leaving the work area

E. Clinic attire should be laundered in hot water, detergent and bleach daily

II. Lab Attire

A. If working in a lab setting (no patients), students may wear slacks (no jeans), closed-toed shoes, and an appropriate protective gown/cover

B. No jewelry

III. Classroom / Professional Presentations

A. Professional business attire is expected in some cases. See individual course syllabi.

3.33 Risk Assessments

Many patients are not aware that they have risk factors for systemic and/or oral disease. Risk assessment provides a way to evaluate patients and to identify factors to prevent disease or to provide early intervention for conditions to minimize the factor's impact.

It is an expectation that risk assessment be conducted on each patient, assessments for oral health include, tobacco use, enamel caries and root caries, and periodontal risk assessment.

Risk Assessments are accomplished by the use of risk assessment forms. Examples of forms can be found in the appendix.

Assessing the Patient for Tobacco Use

Numerous oral conditions are attributed to tobacco use and vary with the type of tobacco used. Because of that, tobacco use can seriously compromise patient care or the patient's ability to heal from dental treatment. Use information from the Patient History to assess the willingness of a patient who answered affirmatively to tobacco use on the health history to end his or her tobacco use.

Remember the 5-A's: Ask, Advise, Assess, Assist, Arrange.

The Brief Intervention

A few simple questions about tobacco use and quitting behavior can serve as an effective assessment to determine when to initiate a brief intervention.

Tools for brief interventions and assessment:

Brief Conversations: An effective assessment can be conducted using a few simple questions:

- Have you used tobacco in the past 6 months?
- Do you currently use tobacco?
- How often do you use tobacco?
- Have you ever tried to quit or thought about quitting?
- What strategies or medications did you use?

In-depth Counseling

For more in-depth or intensive counseling, a number of assessment tools have been developed which can be of great assistance in gathering important information.

Fagerstrom Tolerance Questionnaire: See the Tobacco Use Assessment Form

This brief questionnaire provides a means of quantifying the degree of dependence on tobacco which is being exhibited by the patient or client. A key question in this assessment is: "How soon after waking do you smoke your first cigarette?" Research has shown that this question is at least as important as asking an individual about how much they smoke.

SBIRT: Screening, Brief Intervention and Referral to Treatment

Screening, brief intervention, and referral to treatment (SBIRT) is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services. The risk screening and brief intervention is used for persons with substance use disorders and those whose use is at higher levels of risk. Primary care centers, schools, clinics and other community settings provide excellent opportunities for early intervention with at-risk substance users and for intervention for persons with substance use disorders. The dental hygiene program is committed to provide preventive patient care with this screening and brief intervention.

Caries Risk Assessment

Caries management by risk assessment is an accepted method to identify risk factors for caries, including root caries and recommendations for treatment. This risk assessment and proposed interventions are based on the concept of altering the balance of pathologic factors and protective factors. Caries risk assessment forms: (Age 0-6) and form(Age >6) by the American Dental Association are in the Appendix.

Hyposalivation Screening Tool Xerostomia is a risk factor for caries, cervical caries and other oral conditions, such as fungal infections. The American Dental Hygienist's Association provides a tool to assess hyposalivation, including risk and treatment options for the risk categories.

Periodontal Disease Risk Assessment

The student will conduct a periodontal risk assessment to help predict a patient's risk for developing periodontal disease and to assist the patient in acquiring motivation, knowledge, attitudes and practices that will lead to successful management of periodontal disease (s) or the prevention of periodontal disease(s). The University Of New England Periodontal Disease Risk Assessment Form adapted from the American Academy of Periodontology is in the Appendix.

3.34 Periodontal Treatment Protocol

All faculty and students will be aware of the Dental Hygiene Program's Periodontal Treatment Protocol (PTP) and use it accordingly. The policy includes the use of criteria for assessment, dental hygiene diagnosis, planning, implementation, and evaluation of case indicators and the suggestion of clinical judgment by the clinician for recommending periodontal maintenance, as well as recommendations for individualized education and home care instruction. This policy is based on the American Academy of Periodontology's Parameters of Care. A copy of the PTP is in Appendix IV.

MEDICAL CONSIDERATIONS FOR PATIENT CARE

TABLE OF CONTENTS

Medical Considerations for Patient Care

4.1 Medical History Complications Procedure for the Medically Compromised Patient

Significant complications noted on a patient's medical history should be reviewed with your instructor before proceeding to any definitive care.

*Significant medical history should be noted in **RED** on the upper right front corner of each patient's chart and noted under medical alerts in Dentrix.

The protocol for all conditions of significant medical history is the same:

1. **CONSULT** with your instructor before proceeding to any oral exam or procedure.
2. **DETERMINE** the need for any special precautions before proceeding.
3. **DOCUMENT** any decisions and recommendations received from an instructor or consulting physician.

1. Consultation: Before consulting with your instructor, prepare by reviewing the appropriate text material or this manual.

2. Determination: The patient should be categorized as "High Risk" or "Low Risk" depending on the medical facts. Management or precautionary treatment should always be based on the latest protocols established by the appropriate professional review board. Review the ASA Physical Status Classification System note at the end of 4.00 to help determine the risk of dental hygiene treatment and the appropriate action.

3. Documentation: All decisions should be written in the narrative/services rendered section of the patient chart. Documentation includes a written record of any phone consultations with a physician. The date, time, and content of the conversation must be recorded, and witnessed by the instructor. Completeness is essential for all documentation. It is most prudent to have the physician follow up this conversation with a document relating all diagnostic and preventive information considered appropriate. This document will become a part of the patient's clinic record.

The medically compromised patient may be defined as the patient with a disorder or treatment that would necessitate alterations in the provision of dental hygiene treatment.

ASA* Physical Status Classification System
(*ASA American Society of Anesthesiologists)

The ASA Risk Management System has been adapted to fit the clinical needs of the Dental Hygiene Clinic. The following classifications and examples are meant to guide dental hygiene care delivery. The ASA classification provides a means for the identification of the medically compromised patient. The following is intended to be a relative value system based on clinical judgment and assessment of relevant clinical data. Whenever the clinician is unsure of any clinical data provided by the patient or determined by physical exam, the patient is classified ASA IV, Red Light for elective treatment. Consultation should be initiated. After consultation with the patient's physician or other dental colleague, the patient's ASA status may be upgraded to one of the treatable classifications or may remain in the untreatable category.[1, 2]

ASA I Normal healthy individuals
Green Light for treatment

ASA II Mild systemic disease or extremely anxious ASA I
Yellow Light for treatment; proceed with CAUTION; minimal risk for elective hygiene treatment

Examples of ASA II patients:

- Adult onset diabetes
- Epilepsy
- Uncontrolled asthma
- well-controlled hyper or hypo-thyroid disorders - no symptoms
- ASA I patients with upper respiratory infection
- healthy pregnant women
- ASA I patients with drug allergies
- ASA I patients with extreme dental anxiety
- ASA I patients over 60 years old
  Adults with BP 140-159 systolic and 90-94 diastolic

ASA III Severe systemic disease that limits activity but is not incapacitating. Symptoms only seen when patient is stressed.
Yellow Light for treatment; proceed with CAUTION; moderate risk may require treatment plan modification.

Examples of ASA III patients:
- Unstable angina pectoris
- status post-myocardial infarction more than 6 months
- status post-CVA more than 6 months
- well-controlled IDDM
- CHF with orthopnea and ankle edema
- COPD: emphysema or chronic bronchitis
- exercise induced asthma – can also be caused by anxiety
- less well controlled epilepsy
- hyper or hypothyroid disorders with symptoms
- adults with BP 160-199 systolic and/or 95-114 diastolic

ASA IV No elective dental care
Red Light for treatment

Examples of ASA IV patients
- unstable angina pectoris
- myocardial infarction within 6 months
- CVA within 6 months
- adult BP above 200 systolic and/or 115 diastolic
- severe COPD or CHF (reqs O2 bottle or confined to wheelchair)
- uncontrolled epilepsy (Hx of hospitalization)

- uncontrolled IDDM (Hx of hospitalization)

ASA V Not expected to survive more than 24 hours
Red Light for treatment
Examples of ASA V patients
- end-stage renal disease
- end-stage hepatic disease
- end-stage cancer
- end-stage infectious disease
- end-stage cardiovascular disease
- end-stage respiratory disease

1 Malamed SF. Medical Emergencies in the Dental Office. 5th ed. St.Louis, Missouri: Mosby, Inc; 2000. 2 Grimes, EB. Medical Emergencies Essentials for the Dental Professional, N.J.: Pearson Prentice Hall, 2009.

4.2 Diseases with Significant Oral Care Precautions

I. Cardiovascular Diseases

A. Hypertension (≥140/90mm Hg)
RISK: A sustained elevation of diastolic blood pressure caused by increased peripheral arteriolar resistance may lead to cardiac, renal, retinal or cerebrovascular complications.
MANAGEMENT: Strive to reduce patient stress and anxiety. Provide patient with card indicating: date, pressure reading, and arm used for measurement. See Appendix II for management table. Check for xerostomia if patient is on antihypertensive medications. Do not use local anesthesia formulations with epinephrine vasoconstrictors.

B. Heart Attack
RISK: If a history or heart attack within the last six months exists, there is an elevated risk of repeat attacks.
MANAGEMENT: No dental hygiene care if less than six months. No restrictions if longer than six months.

C. Angina Pectoris
RISK: Patients with unstable angina pectoris are very susceptible to arrhythmias, myocardial infarctions, and sudden death.
MANAGEMENT: Unstable angina is a High Risk situation – no dental care. Stable angina (under the current care of a physician) is a Low Risk situation – dental care given only if patient has nitroglycerin medication with them.

D. Heart Murmur of Pathologic Origin, Congenital Heart Defect or Lesion, and Artificial Heart Valve
RISK: Patients with any of the above conditions, as determined by their physician, are susceptible to bacterial endocarditis.

MANAGEMENT: If susceptible, and gingival bleeding is anticipated, oral antibiotic prophylaxis is required. (See Appendix I)

E. Arrhythmias

RISK: Arrhythmia may precipitate fibrillation and sudden death. High Risk patients are unstable with symptoms, pulse greater than 100, irregular pulse, or bradycardia with a pacemaker. Moderate Risk patients are taking chronic medication but are asymptomatic or have a pacemaker. Low Risk patients have no symptoms and no medications but episodic, identifiable etiology.
MANAGEMENT: High Risk patients – no dental treatment – refer to physician. Moderate Risk – consult with physician before any dental treatment. Strive to reduce stress and anxiety of dental appointment, and avoid excessive use of vasoconstrictor. Patients with pacemakers do not require oral antibiotic prophylaxis. Low Risk patients – unrestricted dental treatment but clinician should always be aware that arrhythmic problems may occur.

F. Stroke - Cerebrovascular Accident

RISK: Stroke is a sudden life-threatening condition. High Risk patients are less than 6 months post-attack. Low Risk patients have survived beyond 6 months with or without permanent physical handicaps.
MANAGEMENT: High Risk – no dental treatment. Low Risk patients can receive dental care with the following precautions: 1) strive to reduce appointment stress and anxiety, 2) be aware of prolonged period needed to achieve homeostasis if on anticoagulant medication, and 3) avoid excessive vasoconstrictor in local anesthesia.

II. BLOODBORNE PATHOGENS

This is a diverse category but the common denominator is that these pathogens all are transmitted within blood droplets. The greatest risks to clinicians are needle stick injury and infected blood entering a wound or the oral cavity.

A. Acquired Immune Deficiency Syndrome (AIDS)

RISK: Infection with the HIV-1 and HIV-2 virus is universally fatal. Prevention of virus infection to others via contaminated blood should be of prime concern.
MANAGEMENT: HIV-infected asymptomatic patients are managed like any other patient in the clinic. Use Universal Precautions. AIDS patients with thrombocytopenia present clotting problems during scaling procedures; consult with the physician about possible platelet augmentation. Patients with advanced immunosuppression and neutropenia will require oral antibiotic prophylaxis; consult with the physician if in doubt. All HIV-infected patients are more susceptible to opportunistic infections and will require closer periodontal management. It is recommended that daily chlorhexidine mouth rinse be advised to keep all oral infections minimized. Patients with severe AIDS symptoms should be treated to reduce pain and oral infection in these patients. Aggressive periodontal procedures are contraindicated since thrombocytopenia will create clotting problems.

B. Hepatitis

RISK: Type B hepatitis (HBV), type C hepatitis (HCV), and type D hepatitis (HDV) have varying degrees if infectivity, but all are blood borne pathogens. Chronic liver destruction and death is a consequence of infection.

MANAGEMENT: A careful health history and Universal Precautions are always practiced. Patients with active hepatitis will not receive hygiene care. Patients with a known history of hepatitis should be encouraged to have laboratory tests to determine whether the patient is a carrier of the type B surface antigen HbsAg. The patient will need counseling by their physician on the patient's infectivity and how to prevent infection of others. Patients with the signs and symptoms of hepatitis should be referred to a physician, no hygiene care is rendered.

III. HEMATOLOGIC DISORDERS

A. Bleeding Disorders

RISK: Congenital or acquired bleeding disorders and drug induced bleeding problems pose a hemostasis problem during hygiene scaling procedures. Patients identified by health history with the following conditions require special precautions.

- Hemophilia
- Von Willibrand's disease
- Anticoagulation therapy such as; Warfarin, Pradaxa, Xarelto (e.g. stroke and phlebitis)
- Aspirin therapy
- Liver cirrhosis
- Severe hepatitis
- Malnutrition
- NSAID therapy (non-steroidal anti-inflammatory drugs)
- Cancer chemotherapy

MANAGEMENT: No hygiene procedures that may cause gingival bleeding should be performed if the patient health history, oral exam, or medication list indicates a bleeding disorder exists. The patient should be referred to his physician for diagnosis. A patient under the supervision of a physician for a bleeding disorder, should not be given hygiene care until the supervising physician is consulted. (See Appendix III for blood chemistry values and discussion of INR).

B. Immunoincompetence

RISK: Several congenital or acquired conditions cause the immune system to be incompetent to control infection or repair tissue damage. Life-threatening infection can be caused by invasive hygiene procedures and subsequent bacteria. The following is a partial list of such conditions:

- HIV infection/AIDS
- Immunosuppressive drug therapy (cancer and organ transplantation)
- Corticosteroid therapy
- Diabetes mellitus (UNCONTROLLED)
- Alcoholism
- Splenectomized patients
- Leukemia (white-blood cell disorders)

MANAGEMENT: Before any invasive hygiene procedures, and consultation with the current physician is required. It is imperative to determine the status of the patient's hematological condition, and the need for antibiotic coverage to prevent life-threatening septicemias. (See Appendix III for pertinent blood cell laboratory values)

C. Kidney Transplant

Kidney patients are advised to tell their kidney doctor when a dental procedure is required. The doctor may recommend antibiotics be taken prior to the procedure to help guard against infection. The dentist should be made aware that their patient has kidney disease or is on dialysis. Ideally, dental procedures, such as tooth extraction, should occur on a non-dialysis day for those on hemodialysis. Heparin, administered during hemodialysis, may cause some people to have extra bleeding.

During workup for a kidney transplant a person will undergo a thorough oral exam. Infections from gum disease or advanced tooth decay can prevent someone from being eligible or delay the transplant until dental work is completed.

For UNE dental hygiene patients receiving dialysis, we require consultation from their Nephrologist on the need of antibiotic premedication. Peritoneal dialysis presents no additional problems in dental management. However, this is not the case with patients who are receiving hemodialysis.

(Little, J and Falace, D. (2013), Dental Management of the Medically Compromised Patient. 197-198)

IV. RESPIRATORY TRACT

A. Anaphylactic Bronchoconstriction

RISK: Systemic reaction to an allergen precipitates life-threatening constriction of bronchiole smooth muscles. Patients with a history of allergies to antibiotics, pain-relievers, local anesthetics and latex are of special concern to hygienists.
MANAGEMENT: Injection of epinephrine (Epi-Pen) is recommended to quickly reverse the symptoms created by muscle contraction.

B. Emphysema

RISK: Life-threatening hypoxia may occur if physiologic oxygen demands exceed ability of damaged alveoli to oxygenate blood.
MANAGEMENT: Do not place patient in supine position, strive to reduce appointment stress and anxiety, and ensure current physician-recommended medications such as bronchodilators are available.

C. Asthma

RISK: Life-threatening bronchospasm caused by hypersensitive airway may occur.
MANAGEMENT: Ensure that patient is compliant with physician recommendations for drug therapy. Patient should have prescribed emergency drug readily available (e.g. theophylline). Do not use local anesthetics with epinephrine if patient is also using other sympathomimetic agents.

V. ENDOCRINE DISORDERS

A. Diabetes Mellitus

RISK: Uncontrolled diabetics are at HIGH RISK for life-threatening infections following invasive hygiene therapy. Diabetics whose condition is under control using physician prescribed drugs or

diet modification are at LOW RISK for infections. Under control means that no recent episodes of insulin shock has occurred, no recent changes in drug therapy have been required, no recent history of frequent infections and no concurrent medical conditions such as hypertension or coronary artery disease exist. The patient's control can be ascertained by the HBA1C Test which reflects the average blood glucose level over the last three months. See Appendix for chart on interpretation of the HBA1C Test.

MANAGEMENT: High Risk patients with an A1C greater than 8 should not receive dental hygiene treatment without consultation between the dental professional and appropriate physician. Low Risk patients may receive hygiene care. For insulin-dependent diabetics, recommend normal insulin dosages, a normal breakfast, and morning hygiene appointments (high glucose and low insulin activity). Strive to reduce appointment stress and anxiety that will limit the release of endogenous epinephrine. Epinephrine is antagonistic to insulin. Local anesthetics with epinephrine should be used sparingly.

IF IN DOUBT, CONSULT THE PHYSICIAN BEFORE TREATMENT.

B. Thyroid Disease

RISK: Uncontrolled hyperthyroidism is a HIGH RISK condition that is life-threatening when a "thyroid storm" occurs. This attack may cause extreme tachycardia and fever. Patients with controlled hypothyroidism taking thyroid supplements are at LOW RISK.

MANAGEMENT: High Risk patients should not receive hygiene care since their ability to tolerate stress is limited. Low Risk patients may receive hygiene care.

VI. MUSCULOSKELETAL CONDITIONS

A. Joint Prosthesis

RISK: Patients at HIGH RISK have a history of joint replacement, with or without active periodontal infection, unstable prosthesis, severe diabetes type I, immunoincompetency, or other blood dyscrasias. LOW RISK patients exhibit no complications with the prostesis or other systemic conditions.

MANAGEMENT: No hygiene care should be given to High or Low Risk patients without first consulting with the orthopedic physician. The physician's recommendation for antibiotic coverage should be followed. AAOS recommends <u>all</u> patients with prosthetic joint replacement Immunocompromised/immunosuppressed patients, Inflammatory arthropathies (e.g.: rheumatoid arthritis, systemic lupus erythematosus), Drug-induced immunosuppression, Radiation-induced immunosuppression, Patients with co-morbidities (e.g.: diabetes, obesity, HIV, smoking) previous prosthetic joint infections, Malnourishment, Hemophilia, HIV infection; be considered for antibiotic prophylaxis.

B. Bisphosphonate related Osteonecrosis of the Jaw (ONJ)

RISK: Patients taking IV Bisphosphonate, commonly, for the management of metastatic breast cancer and multiple myeloma and patients taking oral bisphosphonates for the management of osteoporosis are at LOW RISK for ONJ, between 1 and 10 percent for IV bisphosphonate and 1 in 10,000 or less than 1 in 100,000 patient-treatment years for oral bisphosphonate use.

MANAGEMENT: Because IV use of bisphosphonates generally accompanies comorbidities, such as cancer, and puts the patient at higher risk, a consultation with the oncologist is recommended before invasive dental or dental hygiene care. Oral use of bisphosphonates for osteoporosis puts

patients at LOW RISK for ONJ, patients must be informed of the low risk of ONJ. Low risk patients are eligible for all normal hygiene care.*

*Footnote:

Suzuki JB, Klemes AB, Osteoporosis and osteonecrosis of the jaw. Access, special supplementary issue. American Dental Hygienists' Association, March 2008.

1. American Dental Association – oral bisphosphonate for less than 3 years, no clinical risk factors. ADA recommends a three month drug holiday before and after oral surgery. There is no data to support this recommendation and ADA suggests clinical judgment based on individual benefit/risk management.
2. American Association of Oral and Maxillofacial Surgeons – routine dental treatment should not be modified solely on the basis of oral bisphosphonate therapy.
3. American Society for Bone and Mineral Research – patients should have the same dental care (prophylaxis, restorations, and root canal therapy) recommended for the general population.

VII. HIGHLY CONTAGIOUS INFECTIONS

A. Tuberculosis

RISK: Infected patients can disseminate highly infectious microbes to clinician and other patient; mode of transmission is exhalation aerosol. Health history notes showing positive TB test, fever, weight loss, night sweats, cough, blood in sputum, tender lymph nodes, current medications includes anti-tuberculosis drugs (streptomycin, ethambutol, isoniazid) all indicate HIGH RISK patient.

MANAGEMENT: Contagious individuals will not receive hygiene care. All High Risk patients must be designated non-contagious by a consultation with current physician

B. Impetigo

RISK: Discharge from skin lesions is highly infectious source of pathogens.

MANAGEMENT: No hygiene care given until lesions are completely resolved.

C. Herpes Simplex

RISK: Active herpetic lesions transmit HSV-1 and HSV-2 viruses which are highly contagious. MANAGEMENT: Patients who report recurrent "fever blisters" on their health history should be classified as HIGH RISK individuals. Universal Precautions should be strictly followed for all patients and is the primary method to "break the chain of infection". If an active lesion is discovered during routine oral exam, the patients should be informed and educated about their infectivity. They are a risk to themselves for further lesions and to their family and intimates for new disease. Hygiene care is not recommended since the virus can be spread to other sites on the patient. High Risk patients should be instructed to reschedule any imminent appointment if an active or prodromal lesion is evident.

D. Potentially Infectious patients, students and staff

Patients, students and staff that are potentially infectious and display illness should be dismissed from the clinic. Patients at intake should be asked about their travel and occupational history, including respiratory signs and symptoms and fever.

The major source of all of the above material on medical considerations was:
Little, J.W. & Falace, D.A. (1997). *Dental Management of the Medically Compromised Patient* St. Louis: Mosby.

The American Academy Orthopaedic Surgeons, "**Antibiotic Prophylaxis for Bacteremia in Patients with Joint Replacements".** http://www.aaos.org/about/papers/advistmt/1033.asp.

4.3 Medical Emergency Risk Management

Prevention is the best management tool for all medical emergency possibilities. Being alert and observant are your most important clinical traits. Knowledge of the various at risk diseases and conditions that are common in the patient population, will allow the clinician to mentally prepare and physically cope with the most common dental clinic medical emergencies.

A well-taken medical history will inform the clinician of the patient's current and past history of disease. A thorough review of the patient's medications is vital, as well as, drug interaction guidelines. Read the narrative section of the patient chart to discover any abnormal occurrences during previous hygiene appointments. Observe the patient's present physical (vital signs, skin color, etc.) and mental (anxiety level, ability to understand conversation) appearance, and proceed with the intended treatment plan if all signs appear normal.

4.4 Medical Emergency Plan of Action Protocol

Plan of Action – Emergencies in the Dental Hygiene Building

1. Recognize the emergency. Immediately say "Code Red" to the nearest instructor.

2. The student clinician should take appropriate immediate action with the patient.

3. The student clinician should ask a neighboring student to get an airway, oxygen tank, blanket, and emergency kit. The student clinician should never leave the patient unattended.

4. When the instructor takes over control, the student clinician should inform the instructor of any pertinent medical history, e.g. heart condition, diabetes.

5. The instructor may ask the student to call for medical emergency services, the patient's physician, or the patient's dentist.

   A. There is a phone by the main exit of the clinic, in each faculty office, and at the Reception Desk in the lobby. Promptly use the nearest phone to contact medical emergency services.

   B. Emergency phone numbers are listed by the telephone.
      MEDICAL EMERGENCY dial "**911**" to reach MEDCU, Fire and Police.
      POISON CONTROL telephone number is **1-800-442-6305**.

   C. Quickly state:
      Emergency – Example: unconscious person
      Location – Dental Hygiene Building

University of New England/ Westbrook College
Campus 716 Stevens Avenue
Portland
Type of Emergency (if known) – Example: cardiac arrest

6. The instructor will ask the student to proceed to the Reception Desk area in the lobby to direct arriving MEDCU, Fire, or Police personnel.

7. All other students should stay with their patients and keep calm.

8. Keep all unnecessary personnel away from the patient.

4.5 Emergency Procedures

1. Vasodepressor Syncope

   A. Symptoms
      1. Presyncope
         a. pale
         b. cold sweat
         c. dizzy
         d. nausea
         e. warm feeling
      2. Syncope
         a. death-like appearance
         b. shallow gasping breathing
         c. dilated pupils
         d. convulsive movements (possible)

   B. First Aid
      1. Remain calm
      2. Place patient in Trendelenburg positions (supine position with feet slightly elevated)
      3. Maintain open airway through the head-tilt neck-lift method
      4. Use ammonia capsule
      5. Furnish oxygen
      6. Monitor vital signs
      7. Make patient comfortable (loosen / tighten clothes)
      8. Record all information in patient chart

2. Airway Obstruction

   A. Causes
      1. extracted teeth
      2. amalgam
      3. rubber dam clamp
      4. crowns
      5. impressions materials
      6. broken burs

B. First Aid

1. Partial obstruction – adequate air exchange:
   Position Patient upright and encourage the patient to cough
2. Partial obstruction – inadequate air exchange:
   Treat the condition as if the patient was suffering from a complete obstruction
3. Complete airway obstruction –
   conscious: Abdominal thrusts
4. Complete airway obstruction – unconscious:
   a. Open airway
   b. Attempt to ventilate
   c. If unable, reposition airway
   d. Attempt to ventilate
   e. Abdominal thrusts
   f. Two finger sweeps

3. Cardiac Arrest
   A. Symptoms
      1. no pulse
      2. gasping, followed by no breathing
      3. cyanosis
   B. First Aid
      1. Immediately initiate CPR
      2. Summon medical assistance

4. Respiratory
   A. Symptoms
      1. labored or weak respiration or cessation of breathing
      2. cyanosis
   B. First Aid
      1. Lay patient down flat
      2. Monitor vitals
      3. Administer oxygen

5. Cerebrovascular Accident (CVA)
   A. Symptoms
      1. headache
      2. unconscious
      3. paralysis
      4. confusion
      5. impaired speech
      6. unequal pupils
      7. respiratory difficulty
   B. First Aid
      1. Stop all dental treatment
      2. Position the patient with the head slightly elevated
      3. Monitor vital signs
      4. Administer oxygen
      5. Summon medical assistance
      6. Keep patient calm and quiet

7. Provide CPR if needed
8. Do no administer drugs that alter neurological activity

*If victim is greatly overweight or in the late stages of pregnancy, give chest thrusts.

6. Angina Pectoris

A. Symptoms
1. subternal chest pain
2. patient remains motionless
3. normal appearance or paleness

B. First Aid
1. Remain calm
2. Stop dental treatment
3. Position patient in their most comfortable position
4. Administer nitroglycerin

7. Myocardial Infarction

A. Symptoms
1. pain usually occurs at rest
2. compresing, squeezing pain beginning substernal and spreading
3. severity of pain varies
4. pain is not relieve by nitroglycerin
5. cold, clammy skin
6. vomiting
7. nausea
8. sweating
9. weakness or extreme fatigue
10. feeling of impending doom

B. First Aid
1. Stop dental treatment
2. Administer nitroglycerin
3. Summon medical assistance if nitroglycerin does not relieve pain
4. Keep patient quiet and calm
5. Position patient in a seated position
6. Provide oxygen
7. Be prepared to perform CPR

8. Anaphylaxis

A. Symptoms
1. Skin
   a. generalized prupritus
   b. urticaria
   c. angioedema

2. Gastrointestinal
    a. nausea
    b. vomiting
    c. diarrhea
3. Respiratory
    laryngeal edema
4. Circulatory
    a. hypotension
    b. shock
    c. cardiac arrythmias
    d. complete circulatory collapse
5. PLUS
    a. sweating
    b. anxious feeling
    c. nervousness

B. First Aid
1. Summon medical assistance
2. Place the patient in supine position
3. Administer oxygen
4. Administer epinephrine
5. Administer antihistamine as needed
6. Perform cricothyrotomy if needed
7. Initiate CPR if needed

9. Diabetes Mellitus Hypoglycemia (insulin shock)

A. Symptoms
1. cold sweats
2. nervousness
3. trembling
4. weakness
5. personality change

B. First Aid
1. Conscious patient:
    Administer sugar source
2. Unconscious patient:
    a. Give injection of glucagon
    b. Administer sugar source

9A. Diabetes Mellitus Hyperglycemia / Ketosis (diabetic coma)

A. Symptoms
1. increased thirst
2. increased urination
3. loss of appetite

4. nausea
5. vomiting
6. fatigue
7. abdominal pains
8. generalize aches

B. First Aid
1. Conscious patient:
   Administer their own insulin
2. Unconscious patient:
   Transport to medical facility

10. Contact Dermatitis

A. Symptoms
1. itching
2. erythema
3. edema
4. vesicle formation

B. First Aid
1. Remove contactants
2. Antihistamine
3. Corticosterioda

11. Urticaria (hives)

A. Symptoms
Raised areas of erythema and edema

B. First Aid
Remove substance

12. Angioedema

A. Symptoms
1. localized swelling of submucosa
2. localized swelling of subcutaneous tissue
3. usually single lesions – no pain

B. First Aid
1. Remove the cause
2. Administer antihistamine

13. Epilepsy

A. Symptoms
   1. Grand Mal
      a. prodromal phase: personality change and aura
      b. convulsive phase: tonic movements and clonic movements, sphincter muscle control loss, bladder control loss
      c. postical phase: regaining of consciousness, confusion, deep sleep
   2. Peit Mal "Absence Seizure"
      a. blank stare
      b. twitch
      c. rapid blink
      d. short duration
   3. Partial Seizure
      a. jerking movements of one body part
      b. trance-like state
      c. fidgets

B. First Aid
   1. Remove dental materials from patient's mouth
   2. Remove objects that may injure the patient
   3. Remove glasses and loosen clothing
   4. Do not restrain the patient
   5. Place the patient on one side once seizure is over
   6. Reassure the patient
   7. Do not give the patient anything to eat or drink
   8. Let the patient recover

14. Asthma

A. Symptoms
   1. coughing
   2. sweating
   3. tightness in chest
   4. difficulty in breathing
   5. wheezing
   6. blood pressure normal or elevated
   7. increase in heart rate
   8. nervousness

B. First Aid
   1. Stop treatment – remove everything fro mouth
   2. Position patient in an upright position
   3. Administer bronchodilator
   4. Administer oxygen
   5. Administer epinephrine
   6. Summon medical help

15. Hyperventilation

A. Symptoms
1. Nervousness
2. increase in rate of respirations
3. feeling of suffocation
4. tightness in chest
5. dizziness
6. tingling in extremities

B. First Aid
1. Stop treatment
2. Position the patient in an upright position
3. Calm the patient
4. Have patient breathe into paper bag
5. Drug therapy if needed (deazepam)

16. Burns

A. Symptoms
1. First degree
   Skin reddened
2. Second degree
   Blisters

3. Third degree
   a. serious burn
   b. severe damage
4. Chemical burn of oral mucous membrane

B. First Aid
1. First Degree
   a. Immerse or cover with cool or cold water or ice
   b. Do not apply ointment, grease or baking soda
2. Second Degree
   a. Call ambulance
   b. Do not remove clothing
   c. Keep patient warm
   d. Cover loosely with nonadherant dressing
3. Chemical burn of oral mucous membrane
   a. Flush with cool water
   b. Advise bland diet during healing

17. Foreign Body in Eye

A. Symptoms
1. tears

2. stinging

B. First Aid
   1. Two Eye Wash Stations
      a. Sink near emergency exit door
      b. Lab downstairs
   2. Irrigate promptly with copious amounts of water
   3. Turn head so water flows away from inner aspect of the eye. Continue for 15-20 minutes.

APPENDICES

APPENDICES

APPENDIX I

RECOMMENDATIONS FOR PREVENTION OF BACTERIAL ENDOCARDITIS

The American Heart Association guidelines for prevention of BE are substantially different from previously published guidelines. This information replaces previous information that was based on guidelines published in 1997.

The American Heart Association's Endocarditis Committee together with national and international experts on BE extensively reviewed published studies in order to determine whether dental, gastrointestinal (GI), or genitourinary (GU) tract procedures are possible causes of BE. These experts determined that there is no conclusive evidence that links dental, GI, or GU tract procedures with the development of BE.

The current practice of giving patients antibiotics prior to a dental procedure is no longer recommended **EXCEPT** for patients with the highest risk of adverse outcomes resulting from BE. The Committee cannot exclude the possibility that an exceedingly small number of cases, if any, of BE may be prevented by antibiotic prophylaxis prior to a dental procedure. If such benefit from prophylaxis exists, it should be reserved **ONLY** for those patients listed below. The Committee recognizes the importance of good oral and dental health and regular visits to the dentist for patients at risk of BE.

Antibiotic prophylaxis with dental procedures is recommended only for patients with cardiac conditions associated with the highest risk of adverse outcomes from endocarditis, including:

- ***Prosthetic cardiac valve***
- ***Previous endocarditis***
- ***Congenital heart disease only in the following categories:***

  –Unrepaired cyanotic congenital heart disease, including those with palliative shunts and conduits

  –Completely repaired congenital heart disease with prosthetic material or device, whether placed by surgery or catheter intervention, during the first six months after the procedure*

  –Repaired congenital heart disease with residual defects at the site or adjacent to the site of a prosthetic patch or prosthetic device (which inhibit endothelialization)

- ***Cardiac transplantation recipients with cardiac valvular disease***

****Prophylaxis is recommended because endothelialization of prosthetic material occurs within six months after the procedure.***

All dental procedures that involve manipulation of gingival tissue or the periapical region of teeth, or perforation of the oral mucosa*

***Antibiotic prophylaxis is NOT recommended for the following dental procedures or events:** routine anesthetic injections through noninfected tissue; taking dental radiographs; placement of removable prosthodontic or orthodontic appliances; adjustment of orthodontic appliances; placement of orthodontic brackets; and shedding of deciduous teeth and bleeding from trauma to the lips or oral mucosa.

Antibiotic Prophylactic Regimens Recommended for Dental Procedures

Situation	Agent	Regimen – Single dose 30–60 minutes before procedure	
		Adults	Children
Oral	Amoxicillin	2 gm	50 mg/kg
Unable to take oral medication	Ampicillin **OR**	2 g IM or IV*	50 mg/kg IM or IV
	Cefazolin or ceftriaxone	1 g IM or IV	50 mg/kg IM or IV
Allergic to penicillins or ampicillin – Oral regimen	Cephalexin**†	2 g	50 mg/kg
	OR		
	Clindamycin	600 mg	20 mg/kg
	OR		
	Azithromycin or clarithromycin	500 mg	15 mg/kg
Allergic to penicillins or ampicillin and unable to take oral medication	Cefazolin or ceftriaxone† **OR**	1 g IM or IV	50 mg/kg IM or IV
	Clindamycin	600 mg IM or IV	20 mg/kg IM or IV

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

for procedures of the respiratory tract or infected skin, tissues just under the skin, or musculoskeletal tissue is recommended **ONLY** for patients with the underlying cardiac conditions shown above.

Adapted from *Prevention of Infective Endocarditis: Guidelines From the American Heart Association*, by the Committee on Rheumatic Fever, Endocarditis, and Kawasaki Disease. *Circulation*, e-published April 19, 2007. Accessible at www.americanheart.org/presenter.jhtml?identifier=3004539.

** Pre medication will only be dispensed to a patient if deemed appropriate by the orthopedic surgeon on a limited basis. Patients are responsible to use premedication provided by their physician.

Orthopedic Implants

Management of patients with prosthetic joints undergoing dental procedures

Clinical Recommendation:
In general, for patients with prosthetic joint implants, prophylactic antibiotics are not recommended prior to dental procedures to prevent prosthetic joint infection.

For patients with a history of complications associated with their joint replacement surgery who are undergoing dental procedures that include gingival manipulation or mucosal incision, prophylactic antibiotics should only be considered after consultation with the patient and orthopedic surgeon.* To assess a patient's medical status, a complete health history is always recommended when making final decisions regarding the need for antibiotic prophylaxis.

Clinical Reasoning for the Recommendation:
• There is evidence that dental procedures are not associated with prosthetic joint implant infections.
• There is evidence that antibiotics provided before oral care do not prevent prosthetic joint implant infections.
• There are potential harms of antibiotics including risk for anaphylaxis, antibiotic resistance, and opportunistic infections like *Clostridium difficile*.
• The benefits of antibiotic prophylaxis may not exceed the harms for most patients.
• The individual patient's circumstances and preferences should be considered when deciding whether to prescribe prophylactic antibiotics prior to dental procedures.

* In cases where antibiotics are deemed necessary, it is most appropriate that the orthopedic surgeon recommend the appropriate antibiotic regimen and when reasonable write the prescription.

Sollecito T, Abt E, Lockhart P, et al. The use of prophylactic antibiotics prior to dental procedures in patients with prosthetic joints: Evidence-based clinical practice guideline for dental practitioners — a report of the American Dental Association Council on Scientific Affairs. JADA. 2015;146(1):11-16.

ADA Center for Evidence-Based Dentistry

Appendix II

Management of the Hypertensive Patient: Determining Risk and Providing Dental Treatment

TABLE 1: Adults: New Blood Pressure Ranges / Categories

Blood Pressure Category	Systolic mm Hg		Diastolic mm Hg	Management
Normal	Less than 120		Less than 80	Keep up with heart-healthy habits
Elevated	120 to 129		Less than 80	Likely to develop high blood pressure unless steps are taken to control it
High Blood Pressure (Hypertension) Stage 1	130 to 139		80 to 89	Health care provider may modify pharmacological treatment based on the risk of atherosclerotic cardiovascular disease; positive lifestyle changes are needed
High Blood Pressure (Hypertension) Stage 2	140 or higher		90 and higher	Health care providers are likely to prescribe a combination of blood pressure medications; positive lifestyle changes are needed
Hypertensive Crisis (Consult a physician immediately)	Higher than 180		Higher than 120	Requires medical attention; call 911 if there are signs of organ damage

TABLE 2: Adolescents: Blood Pressure Ranges / Categories

Blood Pressure Category	Age	Systolic mm Hg	Diastolic mm Hg	Blood Pressure at Percentile for age, sex, and height
Normal	>= 13 years old	< 120	< 80	< 90th
Elevated	>= 13 years old	120 to 129	< 80	>= 90th and < 95th
Hypertension	>= 13 years old	>= 130/80	>= 80	>= 95th
Hypertension Stage 1	>= 13 years old	130 to 139	80 to 89	>= 95th to < 95th percentile + 12 mm Hg
Hypertension Stage 2	>= 13 years old	>= 140	>= 90	>= 95th percentile + 12 mm Hg

[1] Adapted from American Dental Association, JADA https://doi.org/10.1016/j.adaj.2018.01.047

[15] Adapted from Davide, S. and Lam A. , Incorporating the New Blood pressure Guidelines Into Practice, *Decisions in Dentistry* July 2018; 4:7. DecisionsInDentsitry.com

Dental Management of the Hypertensive Patient: Reduction of Stress and Anxiety
• Establish honest, supportive relationship with the Patient • Discuss patient's questions, concerns, fears • Schedule morning appointments • Avoid long appointments • Use premedication as needed – (benzodiazepines) • Use nitrous oxide as needed (avoid hypoxia) • Provide gradual changes of position to prevent postural hypotension • Avoid stimulating gag reflex • Dismiss patient if stress appears excessive

Chart Source: Little, J.W., Falace, D.A., Miller, C.S., Rhodus, N.L. (2007). Dental Management of the Medically Compromised Patient, 7th Edition. St. Louis: Mosby.

Appendix III

Blood Chemistry

TESTS USED FOR BLOOD EVALUATION

TEST	NORMAL RANGE*	CAUSES OF DEVIATION
Hemoglobin	Males: 14-18g/100ml Females: 12-16g/100ml	Increased in Polycythemia, Dehydration Decreased in Anemias, Hemorrage, Leukemias
Hematocrit (volume of packed red cells)	Males: 40-54% Females: 37-47%	Increased in Polycythemia, Dehydration Decreased in Anemias, Hemorrage, Leukemias
Bleeding Time	Duke: 1-3 ½ minutes Ivy: less than 5 min. Modified Ivy: 2 ½ - 10 minutes (Mielke templates)	Prolonged in Disorders of platelet function, Thrombocytopenia, von Willebrand's disease, Luekemias, Aspirin and certain other drug use
Clotting Time	Glass tube: 4-8 min.	Prolonged in Vitamin K deficiency, Severe hemophilia, Anticoagulant therapy, Liver diseases
Prothrombin Time (P.T.)	11-15 seconds	Prolonged in : Polycythemia vera, Prothrombin deficiency, Anticoagulant therapy, Vitamin K deficiency, Liver diseases, Aspirin use
Partial Thrombo-plastin Time (P.T.T.)	68-82 seconds	Prolonged in: Hemophilia A and B, von Willebrand's disease, Anticoagulant therapy

*The normal range varies with the specificity of the technique used. There is also a range variation, depending on the health facility and the laboratory.

Source: Wilkins, E.M., Clinical Practice of the Dental Hygienist, 10th Edition, 2009. Lippincott, William and Wilkins, Philadelphia.

INTERNATIONAL NORMALIZED RATIO (INR)

Management of the Patient Taking Coumadin for Whom Invasive Procedures are Planned.

Patients who are on oral anticoagulant therapy such as one of the coumarin drugs will not have normal clotting times. Prothrombin Time (PT) is a measure of the status of the coagulation mechanism. This laboratory test reflects the ability of blood lost from vessels in the area of injury to coagulate.

Prothrombin Time has shown to be imprecise and variable. There may be little comparability of PT values taken in different laboratories. The consequences can be life-threatening for some patients undergoing complicated surgery.

The International Normalized Ratio was developed to introduce a way of comparing PT's from one laboratory to another. Each lab establishes a control plasma PT based on set standards. Ask for each labs normal PT range along with the INR. (See tests used for blood evaluation, Appendix III of this manual.)

Management Guidelines[3]

Preoperative

Consultation with physician

- Confirm diagnosis
- Status of medical condition
- Confirm PT or INR
- Discuss type of procedure planned (periodontal scaling)
- Discuss need for dosage reduction

Level of anticoagulation and the need for altering the dose to avoid excessive bleeding

- INR (2.0-3.0) Dosage does not need to be altered
- INR (3.0-3.5) Dosage may need to be altered – must consult physician
- INR (3.5 or >) Delay invasive procedure until dosage decreased

The decision to alter dosage of anticoagulant

- Physician will reduce patient's dosage
- Affect of reduced dosage will take 3 to 5 days
- Dental appointment needs to be scheduled within 2 days once desired reduction in PT or INR has been confirmed

Postoperative

- Tell patient to call if bleeding occurs during the first 24 to 48 hours
- Use local means to control bleeding if present (pressure packs, Gelfoam/thrombin, Oxycel, Surgicel, Microfibrillar collagen)

[1] Little, J.W., Falace, D.A., Miller, C.S., Rhodus, N.L. (2002). Dental Management of the Medically Compromised Patient, 6th Edition. St. Louis: Mosby.

INTERNATIONAL NORMALIZED RATIO (INR)

Patients who are on oral anticoagulant therapy such as one of the coumarin drugs will not have normal clotting times. Prothrombin Time (PT) is a measure of the status of the coagulation mechanism. This laboratory test reflects the ability of blood lost from vessels in the area of injury to coagulate.

The American Medical Association and the American Dental Association suggest that a patient have a PT no greater than 1.5-1 times normal before a surgical procedure such as periodontal scaling is attempted. If the physician reduces the anticoagulant drug dosage prior to planned surgery, it will take 2-3 days for the clotting mechanism to return to safe levels.

Prothrombin Time has shown to be imprecise and variable. There may be little comparability of PT values taken in different laboratories. The consequences can be life-threatening for some patients undergoing complicated surgery.

The International Normalized Ratio was developed to introduce a way of comparing PT's from one laboratory to another. Each lab establishes a control plasma PT based on set standards.

INR = Prothrombin Time Ratio = Patient's PT / control plasma PT

A recent study recommends adjustment of anticoagulation to a target INR = 3.0 before patients with the higher risk cardiac valve prosthesis undergo dental procedures involving risk of bleeding. Patients with less risk can be adjusted to INR = 2.0-3.0 for better clotting

Litte, J.W., Falace, D.A. et al (1997). *Dental Management of the Medically Compromised Patient* St. Louis: Mosby, p487.

A sample report from Maine Medical Center affiliated lab, Northern Diagnostic Laboratoes, is shown below.

TEST NAME	RESULT	UNIT	REFERENCE RANGE	LOW		HI	
Prothrombin Time #P	17.6	Second	10.0-			*	

International Normalized Ratio (INR) reference ranges:

To standardize the reporting of Prothrombin Times for patients on long-term anticoagulant therapy, the World Health Organization recommends the use of the INR. Ranges recommended by the American Collge of Chest Physicians and the National Heart, Lung and

IN	Intensity	NorDx	Clinical
2.0-	Moderate	15.6-	Prophylaxis of venous thrombosis (high risk surgery) Treatment of venous thrombosis Treatment of pulmonary embolish Prevention of systemic embolism Tissue heart valve Mechanical prosthetic heart valve Acute myocardial infarction Valvular heart
2.5-	High	16.8-	

Dental Treatment	Suboptimal INR range		Target INR Range Other Conditions /Mech Heart Valve			Out of Range
	< 1.5	1.5 to < 2.0	2.0 to < 2.5	2.5 to < 3.0	3.0 to < 3.5	> 3.5
Exam, X-ray, study models						
Simple Restorations, supragingival prophy						
Complex restorations, root planning, endodontics					Caution: probably safe	
Simple extraction, curettage, gingivoplasty				Caution: local measures	Caution: local measures	
Multiple extractions, single bony impaction			Caution: local measures	Caution: local measures	Caution: local measures	
Gingivectomy, apicoectomy, minor perio flap surgery, single implant placement	Caution: probably safe	Caution: probably safe	Caution: probably safe			
Full mouth/ full arch extractions	Caution: probably safe	Caution: local measures				
Extensive flap surgery, multiple bony impactions, multiple implant placement	Caution: probably safe					
Open-fracture reduction, orthognathic surgery	hospital procedure	hospital procedure	hospital procedure	hospital procedure	hospital procedure	hospital procedure

Safe Use caution Not advised at current INR

Table modified from Herman WW et al. Current perspectives on dental patients receiving coumarin anticoagulant therapy. Journal of the American Dental Association. 1997;128:327-335.

Consultation with the physician is recommended for patients who are taking anticoagulant medications, such as Warfarin and Pradaxa®. However, many dental procedures can be done on full doses of anticoagulants. Detailed recommendations exist as to which dental procedures can be done on full dose anticoagulants (teeth cleaning, root canal, one or two teeth extractions), and for which the level of anticoagulant needs to be reduced. See Chart Above. Individualized treatment decisions need to be given. If tissue is highly inflamed, and heavy bleeding is expected, tissue conditioning or "pre-healing" may be recommended before subgingival scaling. Assessing risk to the patient's forming a blood clot must be given. A medical consultation is recommended if consideration of stopping Pradaxa® if it is an option.

Posted April 14, 2011 Pradaxa – Interruption for Colonoscopy, Dental Work, Surgery, etc.
http://clotconnect.wordpress.com/2011/04/14/pradaxa-interruption-for-colonoscopy-dental-procedures-surgery-etc/

Regional anesthetic injections and subgingival scaling are a presumed moderate bleeding risk. Peri-procedural recommendations are to continue therapeutic anticoagulation and antiplatelet therapy. There is evidence to support that not altering medications prior to dental hygiene interventions.
http://www.ada.org/en/member-center/oral-health-topics/anticoagulant-antiplatelet-medications-and-dental-

Normal white blood cell counts are provided on the following table:

NORMAL WHITE BLOOD CELL COUNT

(WBC) = 4000 to 10,000/mm3
Differential

Granulocytes		
Neutrophils		
"Segs" (or Polys or PMN)	40-60%	(2500-6000)
"Bands" (immature PMN)	0-5%	(0-50)
Eosinophils	1-3%	(50-300)
Basophils	0-1%	(0-100)
Monocytes	208%	(1000)
Lymphocytes	20-40%	(1000-4000)

THE ABSOLUTE NEUTROPHIL COUNT =
(WBC) X (%"Segs" + % "Bands")

References

Coleman and Nelson. Principles of Oral Diagnosis, 1993.
Biomedical Communications. Oral Management of the Cancer Patient, Fifth edition, 1996.

Appendix IV

UNE Accident/Incident Report
Dental Hygiene Program

To be completed by staff or faculty member

Date and time of accident or incident:_____
Name:_____
Address:_____
Phone:_____
Location of incident (be specific):_____

Type of activity/circumstance: _____

Equipment involved (if any): _____
Explain the type of injury (bruise, laceration, etc.) and how it occurred:_____

Cause of accident/incident
_____Failure to comply with Program policy
_____Misuse of equipment
_____Lack of knowledge or skill
_____Personal factors
_____Other (Explain):_____
Type of first aid administered (and by whom):_____

Was the injured party referred to medical assistance? Yes ____No
If no, was the injured person transported? ___Yes ___No
Transportation to medical assistance: ____ not applicable
____ Self _____ Friend _____ Ambulance _____ Other

Was there a witness when incident occurred?

Names, addresses and telephone numbers of one or more witnesses:
1._____
2._____

Injured person's name:_____
Signature

Responder's name:_____
Signature

Waiver Release

It is the policy of the University to respond to medical emergencies and to render any and all basic assistance. This includes providing first aid and calling for an ambulance (EMT) if a serious situation exists. Should an injured/ ill person refuse this assistance the signed denial signifies that the individual waives all rights to recourse against the University, its employees, and volunteers, and accepts the full responsibility for their actions.

I understand the waiver release and voluntarily sign below:
Name:_____
Signature:_____

Blood and Body Fluid Exposure Protocol

Step 1: Immediate Treatment

Percutaneous (needlesticks/sharp objects) Injury-where there is the slightest suggestion that the integrity of the skin has been broken by a potentially contaminated item.

1. Wash wound thoroughly with sudsy soap and water; if water is not available, use alcohol.

2. Remove any foreign materials embedded in wound.

Non-intact skin Exposure (wound)

1. Wash skin thoroughly as in #1.

2. Cleanse with disinfectant solution and/or soap and water

There is no evidence that squeezing the wound or applying topical antiseptics further reduces the risk of viral transmission.

Mucous Membrane Exposure

1. Irrigate copiously with tap water, sterile saline or sterile water.

Intact Skin Exposure

Exposure of intact skin to potentially contaminated material is not considered an exposure and not in need of medical evaluation. Thoroughly clean and wash exposed intact skin.

The above guidelines apply to these body fluids:

Blood, semen vaginal secretions, body tissues, cerebrospinal, synovial, pleural, peritoneal, pericardial, and amniotic fluids.

- Saliva (only in dental settings, where saliva is likely to be contaminated with blood.) Otherwise, exposure to saliva not a risk of viral transmission.

- When it is difficult to identify the specific body fluid or when body fluids are visibly contaminated with blood, treat as risk of viral transmission.

The guidelines do not apply to the following:

Feces, nasal secretions, sputum, sweat, tears, urine, vomitus.

Step 2: Exposure Protocol

1. Report incident to faculty and source. Complete Incident Report. If no exposure, report that as well.
2. Refer Student to the Student Health Center ASAP for pretest counseling, consultation and appropriate lab testing. (Hepatitis B surface AB, Hepatitis C surface AB, HIV AB.)
3. Student Health Center Hours:

   During the School Year- Mon.-Thurs., 8-4:30 Fri. 8-4 pm. Closed on weekends.
4. If source is known HIV positive, refer student to Brighton First Care or Maine Medical Center for evaluation, post exposure prophylaxis (within 24 hours), and lab testing.
5. Refer source (patient), Faculty or Staff to Brighton Quick Care or their Primary Care Physician for evaluation and testing. Laboratory requisition forms will be kept in both the Dental Hygiene and Nursing Program Administrative Offices. Please inform the Student Health Center when supply of requisitions are running low.

Step 3: Post test Counseling and Treatment

1. 3 day follow up to discuss lab results and to counsel regarding treatment plan.
2. Retest for Hep. C-AB, HIV at 6 weeks post exposure
3. Retest for HIV at 12 week post expsosure
4. Retest for Hep. C-AB, HIV, ALT at 6 months post exposure
5. Repeat HIV at 12 months only at health care provider's discretion of exposure to high-risk source.

1. CDC. Updated U.S. Public Guidelines for the management of occupational exposures to HBV, HCV, and HIV and recommendations for postexposure prophylaxis. MMWR 2001; 50,(No. RR-11.).

2.Concentra. Most of the Information is provided verbatim free from Centers for Diseasce Control Review of the full text of referenced statutes and regulations may be necessary. KR 6/09.

3.University of Waterloo-Universal Precaution Guidelines. www.healthservices.uwaterloo.ca/occupational health/universal.

4. Marshall University School of Medicine-JCESOM-Blood/Body Fluid Exposure Protocolhttp://musom.marshall.edu/emergency/bloodexposure.asp

5. Emergency Medicine-www.emedmag.con/html/pre/cov/covers/042050006.asp

6. CDC, Emergency Needlestick Information, www.cec.gov/niosh/topics/bbp/emergnedl.html

EXPOSURE TO BLOOD
Percutaneous Accident*
Flow Chart Protocol for HCW**

1. **Determine if Percutaneous Exposure has Occurred**
   A torn glove or a surface scratch is not an exposure

2. **Wash Site with Soap and Water**

3. **Alert Faculty and Source**

4. **Complete Incident Report**
   A. With faculty assistance, complete Incident Report found in Front Desk area.
   B. If no exposure, document that fact as well.

5. **Pretest Counseling for HCW and Source (If Known)**
   A. Obtain forms and lab referral forms from Front Desk
   B. Under supervision of faculty, complete appropriate forms
      - Consent Form / Pre-Test Counseling

6. **Referral of HCW and Source (If Known) for Testing**
   A. HCW and/or Source may see own private physician or access testing at Brighton Campus, MMC. This is coordinated by front desk personnel.
   B. Student may see own private physician or access Student Health Center. If the Health Center is closed, testing may be done at Brighton Campus, MMC. This is coordinated by front desk personnel.
   C. If Source is HIV infected, refer HCW for Post Exposure Prophylaxis Consultation within 24 hours[1]

7. **Post Test Counseling**
   A. With Program Director or designee

8. **Retest as Determined to Be Appropriate**
   A. Consultation with physician
   B. 6 weeks, 3 months, 6 months, 12 months

* Or other type of exposure to blood or OPIM
** HCW Health Care Worker – Student, Faculty and Staff

[1] CDC. Updated U.S. Public Health Service guidelines for the management of occupational exposures to HBV, HCV, and HIV and recommendations for postexposure prophylaxis. MMWR 2001;50(No.RR-11).

University of New England - Dental Hygiene Program

D.O.B _____

Code: _____

Exposure Consent Form

According to Maine Law (Title 5 MRSA Sections 19201-19208), you cannot be tested for HIV (Human Immunodeficiency Virus) antibodies unless you have signed a consent form and "know that the test is being performed", "the nature of the test", "the persons to whom the results of the test may be disclosed", "the purpose for which the test results may be used", and "any reasonably foreseeable risks and benefits resulting from the test". The only people who are exempt from signing a consent form are those people who are being tested at an anonymous test site and certain others specified by law.

This test and a test for Hepatitis B and C are being performed because an accidental exposure has occurred during the provision of dental hygiene care. The test is being performed to establish a baseline record of HIV, HBV and HCV status. These results will be reported to the exposed person(s) for appropriate follow-up testing and care.

A positive HIV test indicates that you are infected with HIV, the virus that causes AIDS, and that you can pass the virus to other people. A positive HBV and/or HCV test indicates that you are carrying the Hepatitis virus, and can pass the virus to others.

Neither the fact that you had these tests nor the result of your tests will become part of your medical record, unless you specifically request it in writing. The result of your test will be released to the Director of the Dental Hygiene Program or designee. However, all confidentiality provisions of Maine Law apply to this test result and it will not be further disclosed without your written permission.

Risks of being tested include the possible discrimination that may result from others knowledge of your test; emotional distress, and possible bruising at the site of the needle puncture. Benefits of being tested include informing the exposed person and/or yourself of the HIV/HBV/HCV infection risk so that early medical care may be accessed and risk-reducing behaviors may be practiced.

The above information has been orally summarized to me and I understand it. Further information will be discussed during the pre-test counseling session.

☐ I hereby give my consent to the University of New England to receive the results of a test for the presence of HIV/HBV/HVC antibody or antigen. This consent is given without express or implied coercion.

_____ _____ _____
Name (print) Signature Date

☐ I hereby refuse to give my consent to be tested for the presence of HIV/HBV/HCV antibody or antigen.

_____ _____ _____
Name (print) Signature Date

_____ _____ _____
Faculty Name Signature Date

DH/Forms/HIV-ConsentForm.doc

UNE Dental Hygiene Program - Pre-Test Counseling Procedure - HIV

The test is being performed to determine the presence or absence of HIV –1 antibodies and is not being done for purposes of blood donation.

The following interpretive information has been explained to me:

A **Negative** result means that the antibody to HIV-1 was not detected in the specimen submitted to the laboratory. This usually means that the individual has not been exposed to HIV-1. Since the course of antibody production is variable and may not yet have begun, a negative test result does not exclude the possibility of exposure to or infection with HIV-1. Negative test results may also occur in individuals with AIDS related symptoms. A negative antibody test can not be used to exclude the diagnosis.

A **Positive** result means that the antibody to HIV-1 is present in the specimen submitted. This usually means that the individual has been infected with HIV-1. The implications of a positive test result in an asymptomatic individual are not known. It is not possible to identify those asymtomatic persons with the antibody to HIV-1 who will eventually develop AIDS. The presence of the antibody to HIV-1 is not diagnostic of AIDS or AIDS Related Complex. Since HIV-1 can exist in the presence of specific antibodies, all individuals with positive antibody test results must be considered potentially infectious. Individuals with HIV-1 antibodies should be permanently deferred from donating blood for transfusion.

A **Positive** result with a **Negative** confirmatory test means that the specimen has been tested for the antibody to HIV-1 and was found to be positive by a sensitive EIA screening procedure. A specific confirmatory test was unable to confirm this result. Therefore, the specificity of the screening test is in question, and it is not possible to determine whether the individual has the antibodies to HIV-1 at this time. It is highly recommended that retesting be done at 6 weeks, 3 and 6 months.

I understand the following testing sequence:

1. All specimens will be screened by a federally licensed EIA procedure for the detection of antibodies to HIV-1.
2. Specimens found to be negative will be reported as negative for antibody to HIV-1.
3. Specimens found to be positive will be repeated in the EIA procedure.
4. Specimens which repeat positive by EIA will be tested by a confirmatory procedure (Western Blot).
5. Results of the EIA and confirmatory procedures will be reported.

PRECAUTIONS:

1. Post Exposure Prophylaxis
2. Behavioral Measures (6-12 weeks)
    a. sexual abstinence
    b. use of condoms
    c. avoid pregnancy
    d. consult physician regarding breast-feeding
    e. avoid blood, plasma, organ, tissue, and semen donation
3. Seek a medical evaluation if you exhibit the following: acute illness, fever, rash, myalgia, fatigue, malaise, and/or lymphadenopathy.

_____ This information has been reviewed with me.
(initial)

_____ I have refused the opportunity to have this information reviewed with me.
(initial)

Name: _____ Code: _____

Faculty Signature: _____ Date: _____

PretestCounselingForm
Updated Fall 2004

University of New England - Dental Hygiene Program

Post – Test Counseling Procedure – HIV (page 1)

In accordance with Maine Law (SMRSA Sections 19201-19208) post test counseling must occur following an HIV test consented to because of an accidental exposure to blood in a medical/dental setting.

The information and counseling is being given to you by the Dental Hygiene Program Director/designee and is held in strict confidence, separate from any medical or student record that you may have at the University of New England.

I have received and understand post test counseling during which the following topics were discussed:

1.Test results and their reliability and significance.

A Negative result means that the antibody to HIV-1 was not detected in the specimen submitted to the laboratory. This usually means that the individual has not been exposed to HIV-1. Since the course of antibody production is variable and may not yet have begun, a negative test result does not exclude the possibility of exposure to or infection with HIV-1. Negative test results may also occur in individuals with AIDS related symptoms. A negative antibody test can not be used to exclude the diagnosis.

A Positive result means that the antibody to HIV-1 is present in the specimen submitted. This usually means that the individual has been infected with HIV-1. The implications of a positive test result in an asymptomatic individual are not known. It is not possible to identify those asymtomatic persons with the antibody to HIV-1 who will eventually develop AIDS. The presence of the antibody to HIV-1 is not diagnostic of AIDS or AIDS Related Complex. Since HIV-1 can exist in the presence of specific antibodies, all individuals with positive antibody test results must be considered potentially infectious. Individuals with HIV-1 antibodies should be permanently deferred from donating blood for transfusion.

A Positive result with a Negative confirmatory test means that the specimen has been tested for the antibody to HIV-1 and was found to be positive by a sensitive EIA screening procedure. A specific confirmatory test was unable to confirm this result. Therefore, the specificity of the screening test is in question, and it is not possible to determine whether the individual has the antibodies to HIV-1 at this time. It is highly recommended that retesting be done at 6 weeks, 3 and 6 months.

Post – Test Counseling Procedure – HIV (page 2)

I understand the following testing sequence:

A. All specimens are screened by a federally licensed EIA procedure for the detection of antibodies to HIV-1.
B. Specimens found to be negative are reported as negative for antibody to HIV-1.
C. Specimens found to be positive are repeated in the EIA procedure.
D. Specimens which repeat positive by EIA are tested by a confirmatory procedure (Western Blot).
E. Results of the EIA and confirmatory procedures are reported.

2 Information of risk reduction and prevention.

A. Behavioral Measures (6-12 weeks)

1. sexual abstinence
2. use of condoms
3. avoid pregnancy
4. consult physician regarding breast-feeding
5. avoid blood, plasma, organ, tissue, and semen donation
6. Seek a medical evaluation if you exhibit the following: acute illness, fever, rash, myalgia, fatigue, malaise, and/or lymphadenopathy.

3 Referrals for medical care and other support services.

A copy of the counseling discussion is provided for your information. It is your responsibility to restrict or allow access to the information held therein at your discretion.

The University of New England will not release this information without your express written consent.

Date: _____ Name: _____

Date: _____ Post-Test Counselor: _____

Declined face to face counseling

_____ This information has been reviewed with me.
(initial)

_____ I have refused the opportunity to have this information reviewed with me.
(initial)

Name: _____ Code: _____

Faculty Signature: _____ Date: _____

UNIVERSITY OF NEW ENGLAND
WESTBROOK COLLEGE CAMPUS
Dental Hygiene Program

Statement of Services

A dental hygiene appointment consists of the following services which are available to patients. They are provided by student hygienists under the supervision of a clinical dentist and faculty as needed. Our philosophy is one of the "total patient care" whereby patients are offered all services deemed appropriate by the student and / or faculty for optimal oral health. They include:

- A complete Medical / Dental History
- Assessment of factors in the health history that may require medical attention
- Inspection of the extra and intraoral aspects of the oral cavity
- Evaluation of periodontal status
- Hard tissue examination
- Radiographs – full mouth series, bitewing and extra-oral
- Treatment and appointment plan
- Patient education / motivation
- Removal of hard and soft deposits from the teeth
- Removal of stain / polishing
- Nutritional counseling
- Sealants
- Fluoride application and recommendations
- Polish of restorations
- Impression / study model fabrication
- Pupal vitality testing

The services you require will be provided to you in a professional manner using sterilized or disposable instruments and protective barriers for your health and safety.

PATIENT APPOINTMENT

The University of New England Dental Hygiene Program provides quality dental hygiene care to many individuals. The clinic provides dental hygiene treatment for you in cooperation with your primary care dentist. All patients are encouraged to see their own primary care dentist at least once a year.

Although the University of New England Dental Hygiene Clinic strives to accommodate all patients, those with the greatest oral health needs are given priority in our scheduling. Most patients are generally seen for dental hygiene therapy only once a year.

As a teaching institution, the University of New England Dental Hygiene Program is pleased to have the opportunity to serve the needs of its patients and students alike.

We hope you will recommend the clinic to others, especially those who have deferred dental visits and are now seeking a clinic. We also appreciate your understanding of the learning requirements of students and your willingness to commit the necessary time to your appointment.

Thank you!

University of New England – College of Health Professions
Westbrook College Campus – Dental Hygiene Program

Informed Consent & Clinic Registration Form

The University of New England Dental Hygiene Clinic is part of an institution committed to student learning and the advancement of knowledge through research. Our primary goal is quality education of dental hygiene students and excellence in patient services.

You should understand the following:

1. Students are required to obtain a thorough medical and dental history of each person prior to initiating any treatment. The goal of this procedure is to safely provide the highest quality of care. Some medical conditions may require a consultation between the student dental hygienist, a clinical faculty member, and the patient's physician. This consultation is necessary to ensure that the appropriate dental care may be planned. Although this may require delaying treatment until such treatment plans are established, it should be understood that no patient will be denied care unless such care is considered inappropriate by the patient's physician. All information revealed in the medical and dental history will be kept strictly confidential.

2. Treatment in our clinic proceeds more slowly than in a private office since the services are rendered by students, and are carefully checked by faculty members (licensed dental hygienist or dentist). Although it is the goal to complete all procedures for each patient, completion of all procedures cannot be guaranteed in any specified period of time.

3. Patients will be referred to a private dentist or dental clinic to receive any needed dental care beyond the limits of this institution.

4. **Failure to keep appointments without 24 hours notice or two cancellations, or two no-shows, may lead to your dismissal as a clinic patient**.

5. Diagnostic aids such as x-ray, photographs, plaster models, etc., are the property of the UNE Dental Hygiene Clinic. However, upon your written and/or verbal request, or that of your dentist, a duplicate set of x-rays may be sent with your signed authorization. Records are the property of the University and are not released, but all recommendations and observations are shared with you and your primary care dentist or a dental specialist by Patient Referral Form.

6. An important part of every dental hygiene exam is to verify that all dental restorations are secure. A cracked restoration, a loosely bonded plastic restoration, or a loose fixed bridgework can lead to tooth decay. All dental hygienists are trained to test each restoration with an instrument and report any defective restorations to the patient. Patients must realize that no dental hygienist using a hygiene instrument is strong enough to dislodge a satisfactory restoration. If any defective restorations are discovered the patient will be referred immediately to their dentist for the necessary work.

7. **Anonymous** data gathered from records may be used for educational and research purposes. If any research project conducted by this University intends to use patient data that could be tracked to a particular patient an additional informed consent document must be signed by each patient involved. In addition, before any research project of any design can be initiated the entire project must receive written approval by the University of New England, Institutional Review Board. This approval shall be available for inspection by any participating patient.

8. **You** are responsible for payment of all services rendered. Prices are subject to change without notice.

9. All cell phone use is prohibited in the clinic, this includes photography and social media usage. This policy is to protect the privacy of all patients.

Patient's Rights and Responsibilities

Dental hygiene care in this institution is patient-centered and therefore focuses on the well-being of our patients. This statement is included to communicate and advocate the expressed wants and needs of our patients and to help the provider-patient relationship to realize excellence in care.

Patients can expect:

1. To be treated with respect, consideration, confidentiality and to uphold privacy.

2. A thorough assessment of their current needs, by student hygienists.

3. To be informed of appointment and fee schedules in advance.

4. To receive an explanation of recommended treatment, treatment alternatives, the option to refuse treatment, the risk of no treatment, and expected outcomes of various treatments, to make an informed consent before any treatment is begun.

5. To receive treatment that meets the standard of care in the profession of dental hygiene.

6. To receive appropriate and timely referrals for other needed services.

7. Continuity and completeness of care.

Patients are expected to:

1. To cooperate as partners in their care by asking for information and clarification, and to participate in goal setting and planning of treatment.

2. Comply with recommended or agreed upon therapies or actions of care.

3. Accommodate student learning needs by returning for further appointments, if required.

4. Attempt to keep scheduled appointments, so that student learning and patient care may proceed.

5. Recognize that care received by dental hygiene students under the supervision of qualified faculty is dental hygiene care. Any restorative or emergency dental care will require the expertise of a licensed dentist in your community.

Having read the above, I verify that I understand the information contained there-in, and I grant the authority to the UNE –College of Health Professions, Dental Hygiene Clinic to perform treatment procedures deemed necessary for me.

_____/_____ _____

Patient's Full Name (Print) / Patient's Signature or Responsible Adult Date

I also agree to make payment for services in accordance with my treatment.

_____

If Responsible Adult, what is your name & relationship to dependent?

_____

Address

University of New England
Dental Hygiene Clinic
Local Anesthesia Consent

Dental local anesthesia is considered an extremely safe procedure. However, in rare cases certain complications can occur. These complications may include: needle breakage, pain on injection, permanent numbness or paresthesia, pain or difficulty opening the mouth, bruising or swelling of injection site, infection, lip chewing leading to trauma, facial nerve paralysis, post anesthetic ulcers in the mouth, overdose reaction, allergy, and unusual reactions (idiosyncratic).

I fully understand the risks involved in receiving local anesthesia at the University of New England Dental Hygiene Clinic. They have been described to me in a satisfactory manner and I have had the opportunity to ask questions and receive informational answers. I understand the nature and purpose of the procedure and the risks involved in receiving and in refusing local anesthesia. I have been given no guarantee by the dental hygiene treatment team as to the results that may be obtained from the injection.

I understand that in the event complications arise resulting from the local anesthesia, financial compensation will not be provided by the University of New England. Furthermore, it is my responsibility to seek medical attention as needed beyond the University of New England Dental Hygiene Clinic. I agree to report immediately any evidence of pain, swelling or inflammation in the area receiving local anesthesia to the University of New England Dental Hygiene Clinic and to arrange for an oral inspection at that site if necessary.

In addition to consenting to receive local anesthesia I understand that I am free to withdraw my consent for treatment at any time with written notice.

Date:_____ _____
Patient /Guardian

Dental Hygiene Treatment Team

Time:_____ _____
Dentist

Date:_____ _____
Additional Faculty/ Student

_____
Additional Signature(s)

_____
Additional Signature(s)

Radiographic / Fluoride Treatment Recommendations - 2014

Risk Category	Recare Exam	X-Rays	Saliva Testing	Fluoride
LOW	6+: Every 6-12 months <6: Annual	6+: BWX every 24-36 months <6: BWX every 12-24 months	6+ & <6: Optional at baseline exam	6+ Home: OTC toothpaste 2x daily 6+ In-office: F varnish optional <6 Home: OTC toothpaste; no in-office fluoride
MODERATE	6+: Every 4-6 months <6: Every 3-6 months	6+: BWX every 18-24 months <6: BWX every 6-12 months	6+ & <6: Recommended at baseline and recare exams	6+ Home: OTC toothpaste 2x day + OTC 0.05% NaF rinse daily 6+ In-office: Initially 1-3 applications F varnish & at recare appt. <6 Home: OTC toothpaste 2x day
HIGH 1 or more cavitated lesions is considered high risk	6+: Every 3-4 months <6: Every 1-3 months	6+: BWX every 6-18 months <6: Anterior PAX & BWX every 6-12 months	6+ & <6: Required at baseline and recare exams	<6 In-office: F varnish initial visit & recare Caregiver: OTC NaF rinse 6+ Home: 1.1% NaF toothpaste 2x day 6+ In office: Initially 1-3 applications F varnish & at recare appt. <6 Home: OTC toothpaste 2x day <6 In-office: F varnish initial visit & recare Caregiver: OTC NaF rinse
EXTREME (High risk plus dry mouth or special needs) 1 or more cavitated lesions plus hyposalivation is considered extreme risk	6+: Every 3 months <6: Every 1-3 months	6+: BWX every 6 months <6: Anterior PAX & BWX every 6-12 months	6+ & <6: Required at baseline and recare exams	6+ Home: 1.1% NaF toothpaste 1-2x day & 0.05% NaF rinse when mouth feels dry & especially after eating or snacking 6+ In office: Initially 1-3 applications F varnish & at recare appt. <6 Home: OTC toothpaste 2x day <6 In office: F varnish initial visit & recare Caregiver: OTC NaF rinse

Adapted from: Jenson L, Budenz AW, Featherstone JDB, Ramos-Gomez FJ, Spolsky VW, Young DA. Clinical protocols for caries management by risk assessment. J Calif Dent Assoc. 2007;35(10):714-723.

Caries Risk Assessment Form (Ages 0-6)

Patient Name: **Score:**

Birth Date: **Date:**

Age: **Initials:**

		Low Risk (0)	Moderate Risk (1)	High Risk (10)	Patient Risk
Contributing Conditions					
I.	**Fluoride Exposure** (through drinking water, supplements, professional applications, toothpaste)	**Yes**	**No**		
II.	**Sugary or Starchy Foods or Drinks** (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups)	**Primarily at mealtimes**	**Frequent or** prolonged between meal **exposures/day**	**Bottle or sippy cup** with anything other than water at **bed time**	
III.	**Eligible for Government Programs** (WIC, Head Start, Medicaid or SCHIP)	**No**		**Yes**	
IV.	**Caries Experience of Mother, Caregiver** and/or Other **Siblings**	**No carious lesions in last 24 months**	**Carious lesions in last 7-23 months**	**Carious lesions in last 6 months**	
V.	**Dental Home**: established patient of record in a dental office	**Yes**	**No**		
General Health Conditions					
I.	**Special Health Care Needs***	**No**		**Yes**	
Clinical Conditions					
I.	Visual or Radiographically Evident **Restorations/Cavitated Carious Lesions**	**No carious lesions or restorations in last 24 months**		**Carious lesions or restorations in last 24 months**	
II.	**Non-cavitated (incipient) Carious Lesions**	**No new lesions in last 24 months**		**New lesions in last 24 months**	
III.	**Teeth Missing Due to Caries**	**No**		**Yes**	
IV.	**Visible Plaque**	**No**	**Yes**		
V.	**Dental /Orthodontic Appliances** Present (fixed or removable)	**No**	**Yes**		
VI.	**Salivary Flow**	**Visually adequate**		**Visually inadequate**	
				TOTAL:	

Instructions for Caregiver:

*Patients with developmental, physical, medical or mental disabilities that prevent or limit performance of adequate oral health care by themselves or caregivers.

Indicate 0, 1 or 10 in the last column for each risk factor. If the risk factor was not determined or is not applicable, enter a 0 in the patient risk factor column. Total the factor values and record the score at the top of the page.

A score of 0 indicates a patient has a low risk for the development of caries. A single high risk factor, or score of 10, places the patient at high risk for development of caries. Scores between 1 and 10 place the patient at a moderate risk for the development of caries. Subsequent scores should decrease with reduction of risks and therapeutic intervention.

The clinical judgment of the dentist may justify a change of the patient's risk level (increased or decreased) based on review of this form and other pertinent information. For example, missing teeth may not be regarded as high risk for a follow up patient; or other risk factors not listed may be present.

The assessment cannot address every aspect of a patient's health, and should not be used as a replacement for the dentist's inquiry and judgment. Additional or more focused assessment may be appropriate for patients with specific health concerns. As with other forms, this assessment may be only a starting point for evaluating the patient's health status.

This is a tool provided for the use of ADA members. It is based on the opinion of experts who utilized the most up-to-date scientific information available. The ADA plans to periodically update this tool based on: 1) member feedback regarding its usefulness, and; 2) advances in science. ADA member-users are encouraged to share their opinions regarding this tool with the Council on Dental Practice.

Caries Risk Assessment Form (Age >6)

Patient Name: **Score:**

Birth Date: **Date:**

Age: **Initials:**

		Low Risk (0)	Moderate Risk (1)	High Risk (10)	Patient Risk
Contributing Conditions					
I.	**Fluoride Exposure** (through drinking water, supplements, professional applications, toothpaste)	**Yes**	**No**		
II.	**Sugary or Starchy Foods or Drinks** (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups)	**Primarily at mealtimes**		**Frequent** or prolonged between meal **exposures/day**	
III.	**Caries Experience of Mother, Caregiver** and/or other **Siblings** (for patients ages 6-14)	**No carious lesions in last 24 months**	**Carious lesions in last 7-23 months**	**Carious lesions in last 6 months**	
IV.	**Dental Home**: established patient of record, receiving regular dental care in a dental office	**Yes**	**No**		
General Health Conditions					
I.	**Special Health Care Needs***	**No**	**Yes (over age 14)**	**Yes (ages 6-14)**	
II.	**Chemo/Radiation Therapy**	**No**		**Yes**	
III.	**Eating Disorders**	**No**	**Yes**		
IV.	**Smokeless Tobacco Use**	**No**	**Yes**		
V.	**Medications that Reduce Salivary Flow**	**No**	**Yes**		
VI.	**Drug/Alcohol Abuse**	**No**	**Yes**		
Clinical Conditions					
I.	**Cavitated or Non-Cavitated** (incipient) **Carious Lesions or Restorations** (visually or radiographically evident)	**No new carious lesions or restorations in last 36 months**	**1 or 2 new carious lesions or restorations in last 36 months**	**3 or more carious lesions or restorations in last 36 months**	
II.	**Teeth Missing Due to Caries in past 36 months**	**No**		**Yes**	
III.	**Visible Plaque**	**No**	**Yes**		
IV.	**Unusual Tooth Morphology** that compromises oral hygiene	**No**	**Yes**		
V.	**Interproximal Restorations - 1 or more**	**No**	**Yes**		
VI.	**Exposed Root Surfaces** Present	**No**	**Yes**		
VII.	**Restorations with Overhangs** and/or **Open Margins**; **Open Contacts** with Food Impaction	**No**	**Yes**		
VIII.	**Dental/Orthodontic Appliances** (fixed or removable)	**No**	**Yes**		
IX.	**Severe Dry Mouth (Xerostomia)**	**No**		**Yes**	
				TOTAL:	

Patient Instructions:

Indicate 0, 1 or 10 in the last column for each risk factor. If the risk factor was not determined or is not applicable, enter a 0 in the patient risk factor column. Total the factor values and record the score at the top of the page.

A score of 0 indicates a patient has a low risk for the development of caries. A single high risk factor, or score of 10, places the patient at high risk for development of caries. Scores between 1 and 10 place the patient at a moderate risk for the development of caries. Subsequent scores should decrease with reduction of risks and therapeutic intervention.

The clinical judgment of the dentist may justify a change of the patient's risk level (increased or decreased) based on review of this form and other pertinent information. For example, missing teeth may not be regarded as high risk for a follow up patient; or other risk factors not listed may be present.

The assessment cannot address every aspect of a patient's health, and should not be used as a replacement for the dentist's inquiry and judgment. Additional or more focused assessment may be appropriate for patients with specific health concerns. As with other forms, this assessment may be only a starting point for evaluating the patient's health status.

This is a tool provided for the use of ADA members. It is based on the opinion of experts who utilized the most up-to-date scientific information available. The ADA plans to periodically update this tool based on: 1) member feedback regarding its usefulness, and; 2) advances in science. ADA member-users are encouraged to share their opinions regarding this tool with the Council on Dental Practice.

University of New England Periodontal Disease Risk Assessment NAME: DATE:	Points	
Answer these questions to assess periodontal disease risk. Circle each response.		
How old are you? *Studies indicate that older people have the highest rates of periodontal disease and need to do more to maintain good oral health. However, middle-age may have the most severe cases of periodontitis.*	<40 **1**	40-65 or greater **2**
Are you female or male? *Studies suggest there are genetic differences between men and women that affect the risk of developing gum disease. While women tend to take better care of their oral health than men do, women's oral health is not markedly better than men's. This is because hormonal fluctuations throughout a woman's life can affect many tissues, including gum tissue.*	Male **1**	Female **2**
Do your gums ever bleed? *Bleeding gums can be one of the signs of gum disease. Think of gum tissue as the skin on your hand. If your hands bled every time you washed them, you would know something was wrong. However if you are a smoker, your gums may not bleed.*	NO **1**	YES **2**
Are your teeth loose? *Periodontal disease is a serious inflammatory disease that is caused by a bacterial infection, and leads to destruction of the attachment fibers and supporting bone that hold your teeth in your mouth. When neglected, teeth can become loose and fall out.*	NO **1**	YES **20**
Have your gums receded, or do your teeth look longer? *One of the warning signs of gum disease includes gums that are receding or pulling away from the teeth, causing the teeth to look longer than before.*	NO **1**	YES **10**
Do you smoke or use tobacco products? *Studies have shown that tobacco use may be one of the most significant risk factors in the development and progression of periodontal disease. Smokers are much more likely than non-smokers to have calculus form on their teeth, have deeper pockets between the teeth and gums, and lose more of the bone and tissue that support the teeth.*	NO **0**	YES **20**
Have you seen a dentist in the last two years? *Daily brushing and flossing will help keep calculus formation to a minimum, but it won't completely prevent it. A professional dental cleaning at least twice a year is necessary to remove calculus from places your toothbrush and floss may have missed.*	YES **0**	NO **2**
How often do you floss? *Studies demonstrate that including flossing as part of your oral care routine can actually help reduce the amount of gum disease-causing bacteria found in the*	Daily **0**	Weekly Seldom **10**

mouth, therefore contributing to healthy teeth and gums.		
Do you currently have any of the following health conditions? ***i.e. Heart disease, osteoporosis, osteopenia, high stress, or diabetes*** *Ongoing research suggests that periodontal disease may be linked to these conditions. The bacteria associated with periodontal disease can travel into the blood stream and pose a threat to other parts of the body. Healthy gums may lead to a healthier body.*	NO Don't Know **1**	YES **2**
Have you ever been told that you have gum problems, gum infection or gum inflammation? *Over the past decade, research has focused on the role chronic inflammation may play in various diseases, including periodontal, or gum, disease. Data suggests having a history of periodontal disease makes you six-times more likely to have future periodontal problems. Periodontal disease is often silent, meaning symptoms may not appear until an advanced stage of the disease*	NO **1**	YES **20**
Have you had any adult teeth extracted due to gum disease? *The more recent your loss of a tooth due to gum disease, the greater the risk of losing more teeth from the disease. Wisdom teeth, teeth pulled for orthodontic therapy or teeth pulled because of fracture or trauma may not contribute to increased risk for periodontal disease.*	NO **1**	YES **20**
Have any of your family members had gum disease? *Research suggests that the bacteria that cause periodontal disease can pass through saliva. This means the common contact of saliva in families puts children and couples at risk for contracting the periodontal disease of another family member. Also, research proves that up to 30% of the population may be genetically susceptible to gum disease. Despite aggressive oral care habits, these people may be six times more likely to develop periodontal disease*	NO **1**	YES **20**
Subtotal Each Column		
Total Score (Add right and left columns together)		

HIGH RISK ≥23	MEDIUM RISK 14-22	LOW RISK ≤13

Risk predicts a future disease state. Risk is determined by risk factors. Preventing disease requires treatment that reduces your risk factors. With routine dental care, tooth loss is 10 times more likely for an individual who has high risk compared to an individual who has low risk. However, by considering risk when selecting the appropriate treatment plan, bone and tooth loss can be reduced. (Adapted from: http://www.perio.org/consumer/4a.html)

The Fagerstrom Test for Nicotine Dependence

Questions	Answers	Points
1. How soon after you wake up do you smoke your first cigarette?	Within 5 minutes	3
	6-30 minutes	2
	31-60 minutes	1
	After 60 minutes	0
2. Do you find it difficult to refrain from smoking in places where it is forbidden (e.g. in church, at the library, in cinema, etc)?	Yes	1
	No	0
3. Which cigarette would you hate most to give up?	The first one in the morning	1
	All others	0
4. How many cigarettes/day do you smoke?	10 or less	0
	11-20	1
	21-30	2
	31 or more	3
5. Do you smoke more frequently during the first hours after waking than during the rest of the day?	Yes	1
	No	0
6. Do you smoke if you are so ill that you are in bed most of the day?	Yes	1
	No	0

Office Use Only Total_____

How to interpret Nicotine Dependency Score:

Score of 6 or higher: Indicates high nicotine dependency and represents individuals who would be particularly likely to benefit from tapering and/or the prescription of nicotine replacement therapy (gum or patch) to decrease nicotine withdrawal symptoms as an adjunct to standard counseling.

Score of 5 or less: Suggests low to moderate nicotine dependency and represents individuals who may be less likely to require tapering and/or the prescription of nicotine replacement therapy (gum or patch). Standard counseling is most appropriate

Continue Caries Exam

Caries Exam Date

7/10/2018 12:

Prepared By

maube

Responsible Clinician

Please select the dentist responsible for this patient's care from the list

ohis49demo ohis49demo

1 or more teeth have an exposed root

- ( ) Yes
- (•) No

How many months has the patient been without primary caries or an incipient carious lesion? Primary caries is the first carious lesion on a tooth surface, not one beneath or at the margin of a restoration.

- (•) 36 or more
- ( ) 24-35
- ( ) 12-23

○ 1 or more teeth has had caries in the last 12 months

Bacteria culture includes elevated MS and/or LB level?

○ Yes

○ No

◉ No culture or test is available

Please answer the following questions (exclude third molars)

How many erupted teeth are present in the oral cavity?

28 # of teeth

How many natural teeth have any type of restoration, including crowns and veneers?

0 # of teeth

How many natural teeth currently require treatment because of caries or a defective restoration?

0 # of teeth

How many natural teeth have primary caries or an incipient caries lesion?

0 (None)

Check all that apply

Clinical Conditions

☐ Oral hygiene improvement is needed

☐ Dry mouth or inadequate saliva flow

Treatment History and Considerations

☐ Dental care frequency is NOT as regular as advised

☐ Development problems or special health care needs

☐ Teeth have been extracted due to caries in last 36 months

☐ Fluoride varnish applied in last 6 months

☐ Has orthodontic appliance, space maintainer, or obturator

Questions the patient can answer

☐ Snacks or beverages containing sugar are consumed between meals 4 or more times per day

☑ Patient drinks fluoridated water

☐ Nonprescription or prescription fluoride products other than water are used

☐ Chlorhexidine used for at least 1 week per month for last 6 months

☐ Xylitol products have been used 4 times daily for last 6 months

☐ Calcium & phosphate toothpaste have been used during last 6 months

☐ Recreational drug/alcohol use

☐ Has had a major change in health (heart attack, stroke, etc.) during the past 12 months

Information Suite (OHIS) - DEMO ONLY

Powered by PREVISER

- Browse Patients
- Create Patient
- Unfinished Assessments
- Options / Settings
- Admin / Practice Reports
- Support

Perio Exam

Perio Exam Date

7/10/2018 12:(

Prepared By

maube

Responsible Clinician

Please select the dentist responsible for this patient's care from the list

ohis49demo ohis49demo

Smoking

☑ Never Smoked

Smoke(d)

○ less than 10 cigs/day

○ 10 or more cigs/day

Smoke(d)

○ less than 10 years

○ 10 or more years

Quit

○ less than 10 years ago

○ 10 or more years ago

Diabetic Status

	Good Control	Fair Control	Poor Control
HbA1c (%)	less than 6.5	6.5 - 7.5	greater than 7.5
AM fasting plasma glucose (mg/dl)	90 - 104	105-130	greater than 130

◉ Not diabetic or unknown

○ Good diabetic control

○ Fair diabetic control

○ Poor diabetic control

Check all that apply

☐ Oral hygiene improvement is needed

☐ Scaling and root planing for any tooth has been done

☐ Furcation involvements exist

☐ Vertical bone lesions exist

☐ Dental care frequency is NOT regular as advised

☐ Periodontal Surgery for pockets has been done

☐ Subgingival restorations are present

☐ Subgingival calculus detected by x-ray or exam

Deepest Pocket Per Sextant from the Gingival Margin to the Base of the Sulcus

Upper Right

Less Than 5 mm
5-7 mm
Greater Than 7 mm
No Teeth

☐ Bleeding

Upper Anterior

5-7 mm
Greater Than 7 mm
No Teeth

☐ Bleeding

Upper Left

5-7 mm
Greater Than 7 mm
No Teeth

☐ Bleeding

Lower Right

5-7 mm
Greater Than 7 mm
No Teeth

☐ Bleeding

Lower Anterior

5-7 mm
Greater Than 7 mm
No Teeth

☐ Bleeding

Lower Left

5-7 mm
Greater Than 7 mm
No Teeth

☐ Bleeding

Xray Distance from CEJ to Bone Crest

Measured	Visual
less than 2 mm	Normal bone height
2-4 mm	Between normal and excessive
greater than 4 mm	Excessive bone loss

Upper Right

2-4 mm
Greater Than 4 mm
No Teeth

Upper Anterior

2-4 mm
Greater Than 4 mm
No Teeth
No X-Ray

Upper Left

2-4 mm
Greater Than 4 mm
No Teeth

Lower Right

2-4 mm
Greater Than 4 mm
No Teeth

Lower Anterior

2-4 mm
Greater Than 4 mm
No Teeth
No X-Ray

Lower Left

2-4 mm
Greater Than 4 mm
No Teeth

PreViser Oral Health Information Suite (OHIS) - DEMO ONLY

- Browse Patients
- Create Patient
- Unfinished Assessments
- Options / Settings
- Admin / Practice Reports
- Support

Create Oral Cancer Exam

Oral Cancer Exam Date

7/10/2018 12:(

Prepared By

maube

Responsible Clinician

Please select the dentist responsible for this patient's care from the list

ohis49demo ohis49demo

Has History of oral cancer

☐ Has History of oral cancer

Cigarette Smoking

☑ Never Smoked

Smoke(d)

○ less than 10 cigs/day

○ 10 or more cigs/day

Smoke(d)

○ less than 10 years

○ 10 or more years

Quit

○ less than 10 years ago

○ 10 or more years ago

Pipes/Cigars

☑ Never Smoked

Smoke(d)

○ less than 1 cigar or pipes/day

○ 1 or more cigar or pipes/day

Smoke(d)

○ less than 10 years

○ 10 or more years

Quit

○ less than 10 years ago

○ 10 or more years ago

Smokeless (Chewing) Tobacco

☑ Never Used

Use

○ Occasionally Use

○ Daily Use

Use

○ less than 10 years

○ 10 or more years

Quit

○ less than 10 years ago

○ 10 or more years ago

Alcohol Use (Average number of drinks consumed in the past year)

Note: 1 drink equals		
Beer	12 ounces or 355 milliliters	5% alcohol
Wine	5 ounces or 150 milliliters	12% alcohol
Spirits	1.5 ounces or 45 milliliters	40% alcohol

- None
- Less than 1 drink per day
- 1 drink per day
- 2 drinks per day
- 3 or more drinks per day

PreViser Oral Health Information Suite (OHIS) - DEMO ONLY

Powered by PREVISER

Browse Patients
Create Patient
Unfinished Assessments
Options / Settings
Admin / Practice Reports
Support

Create Comprehensive Exam

Exam Date

7/10/2018 12:

Prepared By

maube

Responsible Clinician

Please select the dentist responsible for this patient's care from the list

ohis49demo ohis49demo

1 or more teeth have an exposed root

- ( ) Yes
- (•) No

How many months has the patient been without primary caries or an incipient carious lesion? Primary caries is the first carious lesion on a tooth surface, not one beneath or at the margin of a restoration.

- (•) 36 or more
- ( ) 24-35
- ( ) 12-23
- ( ) 1 or more teeth has had caries in the last 12 months

Bacteria culture includes elevated MS and/or LB level?

- ( ) Yes
- ( ) No
- (•) No culture or test is available

Please answer the following questions (exclude third molars)

How many erupted teeth are present in the oral cavity?

28

How many natural teeth have any type of restoration, including crowns and veneers?

0

How many natural teeth currently require treatment because of caries or a defective restoration?

0

How many natural teeth have primary caries or an incipient caries lesion?

0 (None)

Check all that apply

Clinical Conditions

- [ ] Oral hygiene improvement is needed
- [ ] Dry mouth or inadequate saliva flow

Treatment History and Considerations

- [ ] Dental care frequency is NOT as regular as advised
- [ ] Development problems or special health care needs
- [ ] Teeth have been extracted due to caries in last 36 months
- [ ] Fluoride varnish applied in last 6 months

☐ Has orthodontic appliance, space maintainer, or obturator

Questions the patient can answer

☐ Snacks or beverages containing sugar are consumed between meals 4 or more times per day

☑ Patient drinks fluoridated water

☐ Nonprescription or prescription fluoride products other than water are used

☐ Chlorhexidine used for at least 1 week per month for last 6 months

☐ Xylitol products have been used 4 times daily for last 6 months

☐ Calcium & phosphate toothpaste have been used during last 6 months

☐ Recreational drug/alcohol use

☐ Has had a major change in health (heart attack, stroke, etc.) during the past 12 months

Has History of oral cancer

☐ Has History of oral cancer

Cigarette Smoking

☑ Never Smoked

Smoke(d)

○ less than 10 cigs/day

○ 10 or more cigs/day

Smoke(d)

○ less than 10 years

○ 10 or more years

Quit

○ less than 10 years ago

○ 10 or more years ago

Pipes/Cigars

☑ Never Smoked

Smoke(d)

○ less than 1 cigar or pipes/day

○ 1 or more cigar or pipes/day

Smoke(d)

- ( ) less than 10 years
- ( ) 10 or more years

Quit

- ( ) less than 10 years ago
- ( ) 10 or more years ago

Smokeless (Chewing) Tobacco

- [x] Never Used

Use

- ( ) Occasionally Use
- ( ) Daily Use

Use

- ( ) less than 10 years
- ( ) 10 or more years

Quit

- ( ) less than 10 years ago
- ( ) 10 or more years ago

Alcohol Use (Average number of drinks consumed in the past year)

Note: 1 drink equals		
Beer	12 ounces or 355 milliliters	5% alcohol
Wine	5 ounces or 150 milliliters	12% alcohol
Spirits	1.5 ounces or 45 milliliters	40% alcohol

- ( ) None
- ( ) Less than 1 drink per day
- ( ) 1 drink per day
- ( ) 2 drinks per day
- ( ) 3 or more drinks per day

Diabetic Status

	Good Control	Fair Control	Poor Control
HbA1c (%)	less than 6.5	6.5 - 7.5	greater than 7.5
AM fasting plasma glucose (mg/dl)	90 - 104	105-130	greater than 130

- (•) Not diabetic or unknown
- ( ) Good diabetic control
- ( ) Fair diabetic control
- ( ) Poor diabetic control

Check all that apply

- [ ] Scaling and root planing for any tooth has been done
- [ ] Furcation involvements exist
- [ ] Vertical bone lesions exist
- [ ] Periodontal Surgery for pockets has been done
- [ ] Subgingival restorations are present
- [ ] Subgingival calculus detected by x-ray or exam

Deepest Pocket Per Sextant from the Gingival Margin to the Base of the Sulcus

Upper Right

5-7 mm
Greater Than 7 mm
No Teeth

- [ ] bleeding

Upper Anterior

5-7 mm
Greater Than 7 mm
No Teeth

- [ ] bleeding

Upper Left

5-7 mm
Greater Than 7 mm
No Teeth

- [ ] bleeding

Lower Right

5-7 mm
Greater Than 7 mm
No Teeth

- [ ] bleeding

Lower Anterior

5-7 mm
Greater Than 7 mm
No Teeth

- [ ] bleeding

Lower Left

5-7 mm
Greater Than 7 mm
No Teeth

bleeding

Xray Distance from CEJ to Bone Crest

Measured	Visual
less than 2 mm	Normal bone height
2-4 mm	Between normal and excessive
greater than 4 mm	Excessive bone loss

Upper Right

2-4 mm
Greater Than 4 mm
No Teeth

Upper Anterior

2-4 mm
Greater Than 4 mm
No Teeth
No X-Ray

Upper Left

2-4 mm
Greater Than 4 mm
No Teeth

Lower Right

2-4 mm
Greater Than 4 mm
No Teeth

Lower Anterior

2-4 mm
Greater Than 4 mm
No Teeth
No X-Ray

Lower Left

2-4 mm
Greater Than 4 mm
No Teeth

UNE UNIVERSITY OF NEW ENGLAND
Westbrook College of Health Professions

Dental Hygiene Clinic
716 Stevens Avenue
Portland, ME 04103
Phone 207-221-4900
Fax 207-221-4889

PATIENT REFERRAL

We appreciate your professional evaluation and detailed diagnosis.

was seen by a Westbrook College Campus Dental Hygiene Student on

Patient's Name

Today's Date

The following services were provided:

- ☐ Medical History / Blood Pressure
- ☐ Intra/Extra Oral Inspection
- ☐ Restorative Evaluation
- ☐ Periodontal Assessment
- ☐ Oral Hygiene Instruction
- ☐ Recall Scaling
- ☐ Periodontal Scaling / Root Planing
- ☐ Radiographs - Please provide most recent set of x-rays and date taken:
- ☐ Topical Fluoride Treatment
- ☐ Sealants
- ☐ Dietary Counseling
- ☐ Amalgam Polishing
- ☐ Impression/Study Models
- ☐ Other (Specify)

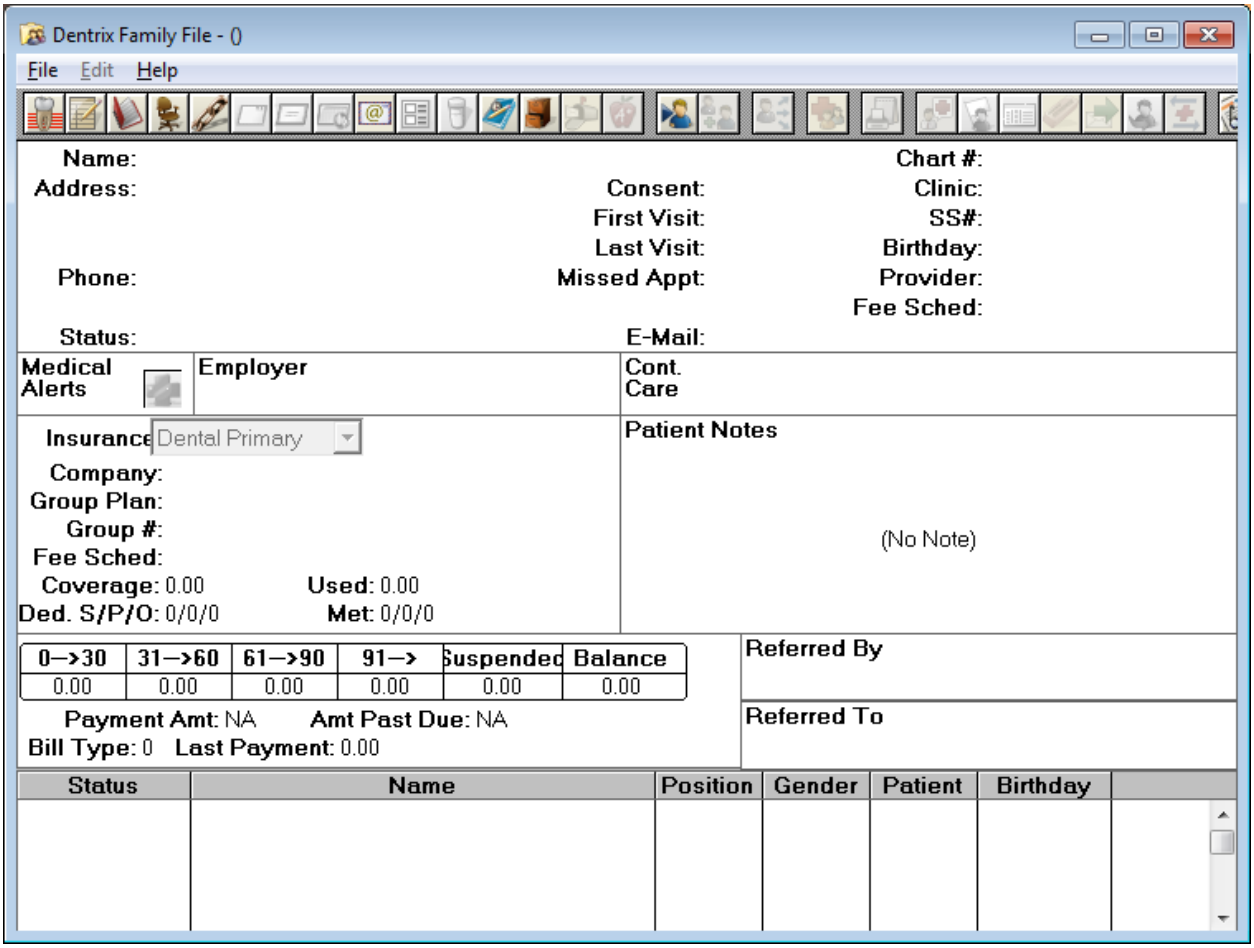
We recommend that all patients see their dentist for regular dental examinations. We have advised this individual to contact your office for an appointment. Please conduct a full dental assessment of the oral cavity with special attention to the following conditions observed during the dental hygiene appointment:

Student's Name:

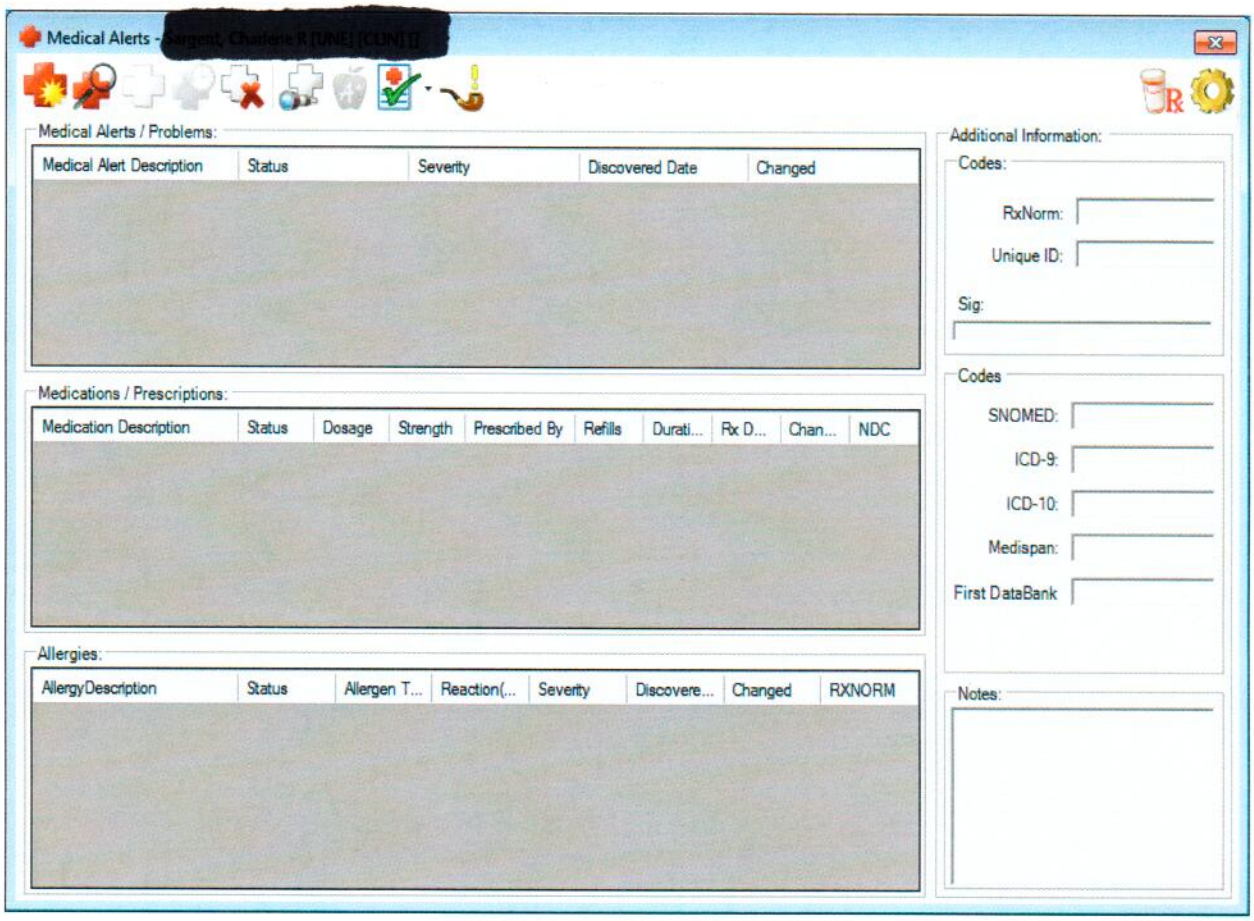
Instructor's Signature:

Patient's Signature:

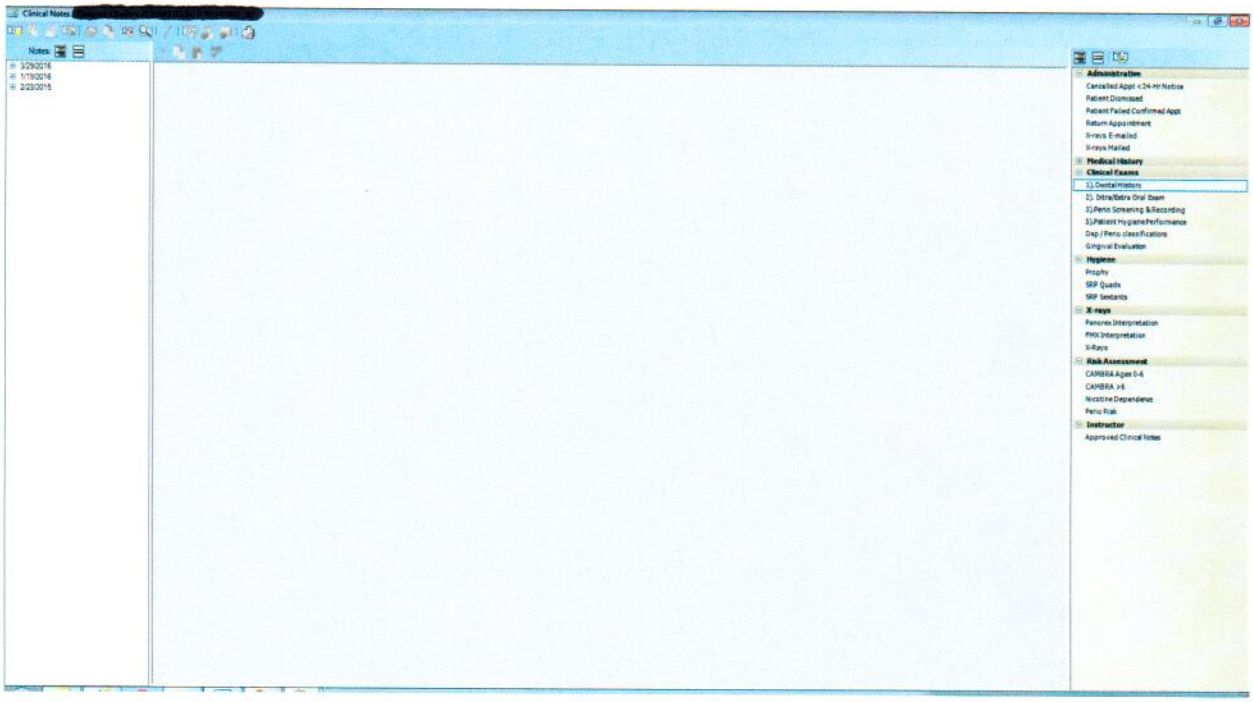
Patient contact info



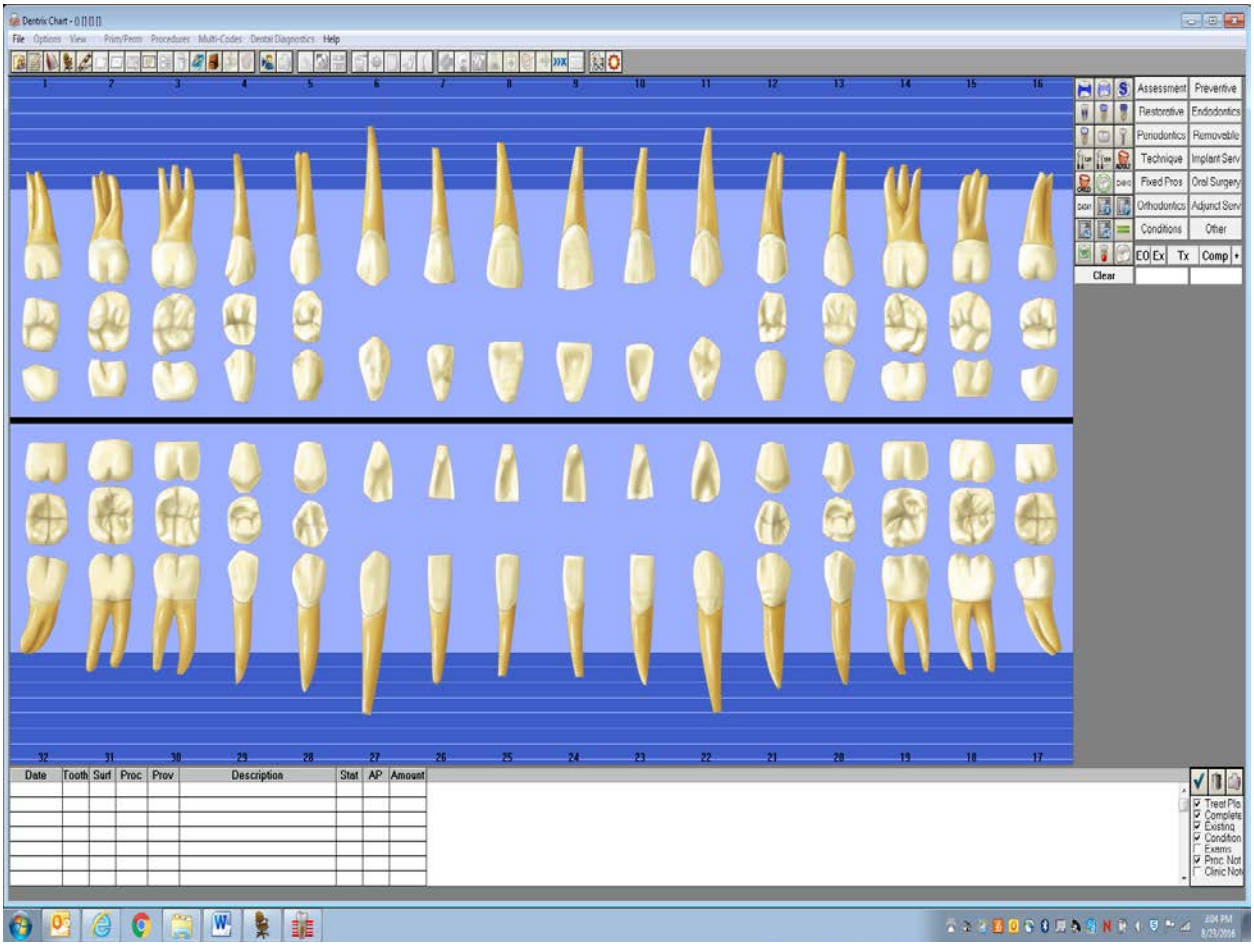
Medical history



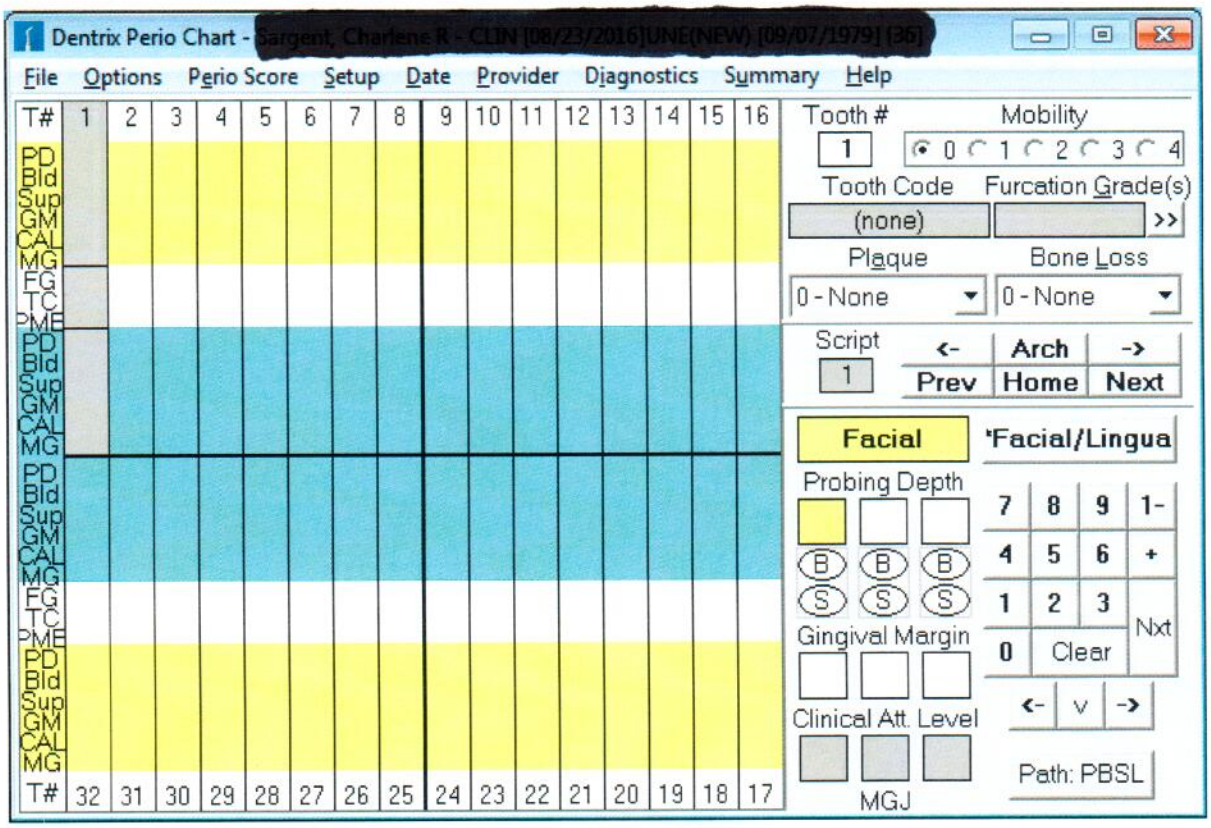
Patient Clinical Notes



Dental Chart



Periodontal Chart



UNE DENTAL HYGIENE CLINIC

Infection Control Manager – DUTIES & PERFORMANCE EVALUATION
STERILIZATION MANAGER

Student:_____ Date: _____

Infection Control Manager (ICM 1) – General Clinic Duties

1. **Arrive dressed in clinical attire, prepared to treat patient, if necessary. The ICM will administer direct patient care and documentation upon need.**

2. Arrive 30 minutes prior to patient seating

3. Run the Miele (Dental Disinfectant) from the previous clinic session. See posted detailed instructions.

4. Fill ultrasonics

5. Empty autoclaves, place contents in appropriate places . Check each item for proper sterilization markers

6. At the end of each Miele cycle, place INDICATOR strip inside cassette, wrap, label with student name, cubby number and heat indicator tape and place in the autoclave. Add an INTEGRATOR strip in the autoclave for each autoclave cycle

7. Make a list of needed supplies and give to clinical coordinator

8. Prepare ample cleansing agent for evacuation system and dispense to students at the end of the day

9. Maintain a clean and neat distribution center

10. All instrument cassettes will be given to the ICM1 and stored in cabinet above Miele until instruments can be placed in the Miele

11. At the end of each clinic session, place all cassettes in Miele and run the RINSE cycle. All other clinic supplies need to be prepared to be autoclaved
(SEE POSTED LIST FOR WHAT CAN NOT BE PLACED IN THE MIELE)

12. Prepare all hand pieces for the autoclave

13. Empty ultrasonic solution at the end of the clinic session

14. Wipe down countertop with Ajax and 3M pad to remove magic-marker marks

15. Empty trash and clean all sinks

16. Adhere to infection control protocol throughout entire clinic session

17. Check with clinical coordinator prior to leaving

_____

Clinical Coordinator

DH/Forms/Clinic/CA:: Updated 2016

UNE DENTAL HYGIENE CLINIC

INFECTION CONTROL MANAGER 2/RADIOGRAPHER (ICM2/R) – DUTIES & PERFORMANCE EVALUATION

Student: _____ Date: _____

ICM2/R – General Clinic Duties

1. Arrive dressed in clinical attire. **ICM2/R's have scheduled patients in need of radiographs only, Check schedule for radiographic patients for the day**

2. Arrive 30 minutes prior to patient seating

3. Prepare x-ray operatories for use
    a. wipe down chairs with disinfectant
    b. cover headrests with headrest covers
    c. turn on x-ray machines and computers (barrier control panels, P.I.D., Computer stand and mouse)
    d. monitor use of operatories
    e. clean after each use (disinfect, barrier)

4. Prepare computers and digital sensors

5. Review with a clinical instructor the proper way of preparing the Panorex machine

6. Report any equipment malfunction to supervising instructor immediately

7. Distribute instrument cassettes, hand pieces and other clinical supplies to the students

8. Store any sterile items for the PASS THROUGH, where the items belong. Check for indication of change in heat indicator strip.

9. Check and replenish supplies on rolling carts

10. Check lab coat closet and locker rooms and pick up hangers

11. Restock inventory in cabinets

12. Adhere to infection control protocol throughout entire clinic

13. Shut down x-ray operatories
    a. remove headrest covers and plastic wrap
    b. disinfect unwrapped surfaces
    c. turn off x-ray machines
    d. turn off computers
    e. hang digital sensors on holders on wall

14. At the end of the day, empty the PASS THROUGH and put items away

15. Check with supervising instructor prior to leaving the clinic

IF NECESSARY, THE FOLLWING DUTIES MUST ALSO BE SUCCESSFULLY COMPLETED:

1. Refill paper towel containers

2. Refill soap containers

3. Restock needed supplies from clinic supply closet

_____

Clinical Coordinator

DH/Forms/Clinic/ICM2/R2016: Updated Fall 2016

D1110- Prophy Code-Preventive procedure

- Normal tissue tone—no signs of disease activity present
- No clinical attachment loss
- All probing depths are less than 4mm

D4346-Gingivitis Code- Therapeutic procedure

- Use with gingival inflammation- redness, edema, glazing, bleeding on probing
- Gingival pockets, with no bone loss (absence of periodontitis)
- No clinical attachment loss—probing depths will be variable due to gingival edema
- Can go back to the prophy code if resolution occurs at the recall visit

D4355-Debridement Code

- Used when probing and exploring cannot be performed effectively to determine a dental hygiene diagnosis due to excessive deposits of plaque and calculus
- Does not take the place of D1110, D4346
- Can be used if students do not finish a patient

D4341-Scaling and Root Planing 4 plus teeth per quad—Therapeutic procedure

- This is used for 4 or more teeth of periodontitis with pockets with 1+ mm of attachment loss
- If infection resolves, patient would receive Perio Maintenance at recall
- Arestin can be used if indicated, after Scaling and Root Planing (SRP)
- All non periodontally involved teeth will be completed at no additional charge

D4342- Scaling and Root Planing 1-3 teeth per quad —Therapeutic procedure

- This is used for 1-3 teeth of periodontitis with 1+ mm of attachment loss
- If infection resolves, patient would receive Perio Maintenance at recall
- Arestin can be used if indicated, after Scaling and Root Planing (SRP)
- All non periodontally involved teeth will be completed at no additional charge

D4910- Perio Maintenance—Preventive procedure

- For maintenance of patients who have received D4341 or D4342
- These patients have attachment loss and therefore cannot return to the Prophy Code D1110 or Gingivitis Code D4346
- At recall appointments, patients presenting with active infection, should be retreated with D4345, D4341, or D4342

- UNE DH FACULTY, STAFF, STUDENTS – FREE except for chemotherapeutics
- UNE FACULTY, STAFF, STUDENTS – Receive 50% off all services

UNIVERSITY OF NEW ENGLAND

INNOVATION FOR A HEALTHIER PLANET

Dental Hygiene Clinic

Westbrook College Campus

Affordable Dental Hygiene Care

Appointments: 207-221-4900 September thru April

We Accept Cash, Check or Credit Card (not American Express)
Payment is expected upon completion of your appointment

Approximate Costs:

- Child Prophy (Ages 0 – 12) $16
- Adult Prophy (Ages 13 – 61) $36
- Senior Prophy (Ages 62 & over) $25
- Fluoride $5

Additional Services (May include additional $10 Fee without a cleaning):

- New Patient Screening Assessment $13
- Full-Mouth Series X-Ray (FMX) $35
- Panorex X-Ray $35
- Bitewing X-Ray (4 film) $8
- Bitewing X-Ray (2 film) $5
- Sealants (per tooth) $8
- Quadrant Scaling (per quadrant) $36 Adult / $25 Senior Cit.
  - All non-periodontally involved teeth will be completed at no additional charge
- Periodontal Maintenance $36 Adult / $25 Senior Cit.
  - 3-month recall after quad scaling has been done
- Sending out X-rays $5
- Edentulous Patient (Dentures) $10 (exam/ultrasonic denture clean)
- Periodontal Debridebment $10

We do not offer services for: Bleaching Trays, Night Mouthguards, Extractions, Restorations or Fillings, Root Canals, Denture Repair, or Emergency Services.

Updated Fall 2018

INDIVIDUAL BLOOD GLUCOSE TEST VALUED RELATED TO CONTROL OF DIABETES

STATUS	FPG	PP	HBA1C
Healthy, well controlled	<126 mg/dL	<160 mg/dL	< 6%
Moderate control	<160 mg/dL	160-200 mg/dL	6-7%
Uncontrolled	>160 mg/dL	>200 mg/dL	> 8%

If unable to obtain complete and accurate information from a patient, or if diabetes is not well controlled, a consultation between dental professional and physician is necessary before treatment.

Adapted from: Esther M. Wilkins Bs, RDH, DMD (2009) Clinical Practice Of The Dental Hygienist, 10th ed., Baltimore, Lippincott, Williams & Wilkins, (August 2009)

Grade Entry

print report

Include Inactive Students Edit Existing Grade:

Edit Header

Date:
Recall Date:
Recare:
Treatment Phase:

Patient:
Quad / Sextant: all
Patient Complete:
Recare appointment

Instructor:
Clinic: IIIB
ASA: II

Calculus Class: I
Perio Level: I
Special Needs:
Critical Error: 0.00
Extra Credit: 0.00

Comments: Student left an hour early without permission and without having the patient's record signed.

Assessment 1 - 44 **Planning 45 - 53** **Implementation 54 - 108** **Evaluation 109 - 140**

Assessment

Save Grade

New Grade Delete Record

* Items specified as CRITICAL under SETUP LISTS - COMPETENCY SUB CATEGORIES, will appear in Red below.

Risk

SubCompetency		±	√	X	N/A
Further QUESTIONS Findings	1	◉	○	○	○
USES references	2	◉	○	○	○
Vital Signs (TAKES THEM)	3	◉	○	○	○
NOTIFIES Instructor of risk factors before check-in	4	◉	○	○	○
Documents appropriately in medical alert box	5	◉	○	○	○
Documents medications and contraindications	6	○	○	○	◉
Documents lifestyle RISK factors	7	○	○	○	◉
Documents a concise statement "summary of health"	8	◉	○	○	○
UPDATES history at successive and recall appts	9	◉	○	○	○

Eoio

SubCompetency		±	√	X	N/A
Technique - visual, palpation, auscultation, order	10	◉	○	○	○
I.D. ABNORMALITY, measures, describes, DOCUMENTS	11	◉	○	○	○
Assessment UPDATE at successive and recall appts.	12	◉	○	○	○

Occl

SubCompetency		±	√	X	N/A
Angle's classification	13	○	◉	○	○
Overjet - Underbite	14	◉	○	○	○
Overbite - Openbite	15	◉	○	○	○
Crossbite	16	○	○	◉	○
Deviations	17	◉	○	○	○
Parafunctional habits	18	○	○	○	◉
Study Models: interpretation	19	○	○	○	◉

Perio

SubCompetency		±	√	X	N/A
Gingival description: condition, color, size, shape, texture	20	◉	○	○	○
Recession measurements	21	◉	○	○	○
Pocket measurement accuracy	22	◉	○	○	○
C.A.L. Measures zone ofattached gingiva, notes clinical attachment level	23	◉	○	○	○
Bleeding points noted	24	◉	○	○	○
Mobility accurately classified and documented	25	○	○	○	◉
Furcation involvement (symbols on chart)	26	○	○	○	◉
Etiological Factors	27	○	○	○	◉
Accuracy of summary statement of perio status documented	28	◉	○	○	○

Rad

SubCompetency		±	√	X	N/A
PRESCRIPTION prior to taking radiographs	29	○	○	○	◉
APPROVAL prior to taking retakes	30	○	○	○	◉
Interpretation/correlation: EO/IO perio + hard tissue exam	31	○	○	○	◉
NAME/DATE on radiographs computerized records	32	○	○	○	◉
Technique/ process	33	○	○	○	◉
CONFERS with Dr. on diagnosis	34	○	○	○	◉

Hrd tis

SubCompetency		±	√	X	N/A
Missing teeth I.D.	35	◉	○	○	○
Restoration I.D.	36	◉	○	○	○
Caries I.D.	37	◉	○	○	○
ABNORMALITY I.D., rotations, versions, migrations	38	◉	○	○	○
UPDATES at successive and recare appointments	39	◉	○	○	○

Dep

SubCompetency		±	√	X	N/A
Supra underassessed /overassessed	40	◉	○	○	○
Sub underassessed/overassessed	41	◉	○	○	○
Soft deposit assessment and indices	42	◉	○	○	○
Assessment of stain	43	◉	○	○	○
UPDATES AT SUCCESSIVE APPOINTMENTS	44	◉	○	○	○

Grade Entry

print report

Select a Student: Edit Existing Grade:

Edit Header

Date: Patient: Instructor: Calculus Class: I
Recall Date: Quad / Sextant: Clinic: IIIB Perio Level: I
Recare: all Patient Complete: ASA: II Special Needs:
Treatment Phase: Recare appointment Critical Error: 0.00
Extra Credit: 0.00
Comments: Student left an hour early without permission and without having the patient's record signed.

Assessment 1 - 44 **Planning 45 - 53** **Implementation 54 - 108** **Evaluation 109 - 140**

Planning

Save Grade

New Grade Delete Record

* Items specified as CRITICAL under SETUP LISTS - COMPETENCY SUB CATEGORIES, will appear in Red below.

TP

SubCompetency		+	√	X	N/A
Formulates, presents dental hygiene diagnosis	45	◉	○	○	○
Prioritizes on patient's needs, changes as needed	46	◉	○	○	○
Has realistic goals for the process of care	47	◉	○	○	○
Plans the correct number/sequence of appointments	48	◉	○	○	○
PLANS for pain control and stress reduction	49	○	○	○	◉
Plans timeframe for recare appointments	50	◉	○	○	○
Explains the need for referral to a specialty practice	51	○	○	○	◉
Explains plan, alternatives, expected outcomes, expenses	52	◉	○	○	○
Patient CONSENT of plan confirmed with signatures	53	◉	○	○	○

Grade Entry

print report

Select a Student: ☐ Include Inactive Students Edit Existing Grade:

Edit Header

Date: Patient: Instructor: Calculus Class: I
Recall Date: Quad / Sextant: all Clinic: IIIB Perio Level: I
Recare: ☑ Patient Complete: ☑ ASA: II Special Needs:
Treatment Phase: Recare appointment Critical Error: 0.00
Extra Credit: 0.00

Comments: Student left an hour early without permission and without having the patient's record signed.

Assessment 1 - 44 **Planning 45 - 53** **Implementation 54 - 108** **Evaluation 109 - 140**

Implementation
Save Grade

New Grade Delete Record

* Items specified as CRITICAL under SETUP LISTS - COMPETENCY SUB CATEGORIES, will appear in Red below.

Prev

SubCompetency		±	√	X	N/A
EDUCATES patient on conditions, needs, and commitment	54	◉	○	○	○
Overall health condition CONSIDERED in insruction	55	◉	○	○	○
Correct toothbrush and technique taught	56	◉	○	○	○
CORRECT interdental aids and techniques taught	57	◉	○	○	○
Presentation - delivery, LAY TERMS, visual aids, etc.	58	◉	○	○	○
Plaque index explained to patient	59	◉	○	○	○
Patient as plaque free as possible after OHI	60	◉	○	○	○
Tobacco cessation as NEEDED utilizing current methodology	61	○	○	○	◉
Dietary Counseling and lifestyle concerns	62	○	○	○	◉
Selective coronal polishing: explains, uses correct techniques	63	◉	○	○	○
Topical fluoride treatment: explains correct data	64	◉	○	○	○
Fluoride self care instruction as indicated	65	◉	○	○	○
Care of restorations, oral appliances, dentures	66	◉	○	○	○
Pit & Fissure sealants as prescribed, techniques, results	67	◉	○	○	○
Antibacterial placement agents (Arestin, etc.)	68	○	○	○	◉
Chemotherapeutic agents (chlorhexidine, etc.)	69	○	○	○	◉
Desensitizing indications, products, techniques	70	○	○	○	◉
UPDATES at successive and recare appointments	71	◉	○	○	○

Pain C

SubCompetency		±	√	X	N/A
INDICATIONS/CONTRAINDICATIONS - clinician's judgement	72	○	○	○	◉
EXPLAINS the need, procedure, post op. precautions	73	○	○	○	◉
SELECTION of type of local anesthetic	74	○	○	○	◉
Topical anesthetic APPLICATION	75	○	○	○	◉
Local anesthesia set up/administration TECHNIQUE	76	○	○	○	◉
Sedation: preparation/monitoring	77	○	○	○	◉
Antianxiety measures (presedation) clinician's JUDGEMENT	78	○	○	○	◉
DOCUMENTS record: type, amount, effectiveness, reactions	79	○	○	○	◉

Inst

SubCompetency		±	√	X	N/A
Appropriate indications for ultrasonics, deposits, health status, risks	80	◉	○	○	○
Explanation of procedure to patient	81	◉	○	○	○
Equipment preparation: PT/OP protections, safety/tip selection	82	◉	○	○	○
Pt/op positioning-neutral wrist, clock/handle position with ultrasonic	83	◉	○	○	○
Technique-placement and movement of ultrasonic tip/fulcrum	84	◉	○	○	○
Retraction of soft tissue, avoids spray on patients face	85	◉	○	○	○
Fluid control suction, pt. not swallowing fluid, debris during ultrasonic or hand instrumentation	86	◉	○	○	○
Pt/op positioning-neutral wrist during hand instrumentation	87	◉	○	○	○

Calc

SubCompetency		±	√	X	N/A
% supra removed	104	○	○	◉	○
% sub removed	105	◉	○	○	○
NO LACERATIONS	106	◉	○	○	○
no burnished calculus	107	◉	○	○	○
self evaluates (air, explores) states where calculus remains	108	○	◉	○	○

Retraction/indirect vision	88	◉	○	○	○
Instrument selection, correct for area (end/edge) sharpness	89	◉	○	○	○
Grasp (no split) fulcrum finger advanced, "C" thumb-index	90	◉	○	○	○
Fulcrum placement, use, pivot, not traveling	91	◉	○	○	○
Parallelism- facial/lingual(way tooth grows)	92	◉	○	○	○
Subgingival insertion at line angle, toe leads at 0 degrees	93	◉	○	○	○
Exploratory stroke first, reposition under deposit	94	◉	○	○	○
Adaptation: face of toe third on tooth	95	◉	○	○	○
Activation: whole hand as unit, press while opening	96	◉	○	○	○
Angulation 45-80 not closing on face during stroke	97	◉	○	○	○
Pressure: lt-mod scaling, very light planing, no scraping	98	◉	○	○	○
Stroke control: <2mm bite scaling/long light shave planing	99	◉	○	○	○
Vertical or oblique strokes for scaling, horizontal for planing	100	◉	○	○	○
HANDS STEADY, no visible shaking or trembling	101	◉	○	○	○
Removal of extrinsic stain and biofilm	102	◉	○	○	○
Finish by flossing, and uses subgingival irrigation PRN	103	◉	○	○	○

Grade Entry

print report

Select a Student: ☐ Include Inactive Students Edit Existing Grade:

Edit Header

Date: Patient: Instructor: Calculus Class: I
Recall Date: Quad / Sextant: all Clinic: IIIB Perio Level: I
Recare: ☑ Patient Complete: ☑ ASA: II Special Needs:
Treatment Phase: Recare appointment Critical Error: 0.00
Extra Credit: 0.00

Comments: Student left an hour early without permission and without having the patient's record signed.

Assessment 1 - 44 **Planning 45 - 53** **Implementation 54 - 108** **Evaluation 109 - 140**

Evaluation
Save Grade

New Grade Delete Record

* Items specified as CRITICAL under SETUP LISTS - COMPETENCY SUB CATEGORIES, will appear in Red below.

QA

SubCompetency		±	√	X	N/A
Organization, sequence in appointment procedures	109	◉	○	○	○
Equipment preparation set up/break down	110	◉	○	○	○
DOCUMENTATION, entries incomputerized record control	111	◉	○	○	○
No gloves at check in, gloves on at check out	112	◉	○	○	○
Reason for visit discussed & documented	113	◉	○	○	○
Treatment record page documented	114	◉	○	○	○
Patient's name/date on every page	115	◉	○	○	○
Makes certain all chart entries have signatures	116	◉	○	○	○
Completes student QA chart review	117	◉	○	○	○
Treatment plan followed to completion	118	◉	○	○	○
Student evaluation of care (treatment results documented)	119	◉	○	○	○
Continued/comprehensive care - referrals recommended	120	◉	○	○	○
Recare appointment times scheduled	121	◉	○	○	○

Ethics/Prof

SubCompetency		±	√	X	N/A
Attendance, arrives on time/does not leave early	122	○	○	◉	○
Time management	123	◉	○	○	○
Infection control and PATIENT SAFETY	124	◉	○	○	○
ALL CRITICAL Appearance, demeanor, attitude, composure, judgment	125	◉	○	○	○
Consent forms SIGNED	126	◉	○	○	○
Discretion and patient PRIVACY	127	◉	○	○	○
Patient management, rapport, compassion	128	◉	○	○	○
Teamplayer self directed, helps	129	◉	○	○	○
Accepts fair, negative feedback	130	◉	○	○	○
Recognizes the need to learn	131	◉	○	○	○
Acknowledges and CORRECTS errors	132	◉	○	○	○
Practices effective communication skills	133	◉	○	○	○
Proper grammar spoken and written	134	◉	○	○	○
Practices WITHIN LIMITS of knowledge and skills	135	◉	○	○	○
FOLLOWS, rules, laws and regulations	136	◉	○	○	○
Meets commitments	137	◉	○	○	○
Reports misconduct	138	◉	○	○	○
Completes assignments on time	139	◉	○	○	○
Makes learning a top priority	140	◉	○	○	○

Periodontal Treatment Protocol - Identifying Criteria, Assessment, Active Therapy, and Maintenance

	Gingivitis	Mild (slight) Periodontitis	Moderate Periodontitis	Severe (Advanced) Periodontitis
Most often correlates with	ADA I	ADA II	ADA III	ADA IV
Gingival Inflammation	BOP +	BOP +/-	BOP +/-	BOP +/-
PD Probing Depth	0-3 mm	3-4mm	5-6mm	≥ 7mm
CAL Clinical Attachment Loss	None	1-2 mm	3-4 mm	≥ 5mm
FI Furcation Involvement	None	Furcation involvement possible	Furcation involvement possible	Furcation involvement possible
XR Radiographic Bone Level	Bone no more than 2mm from CEJ	Bone is >2mm &/or ≤3mm from CEJ (or up to 10% of the actual root length)	Bone is >3mm &/or ≤5mm from CEJ (or up to 11-30% of the actual root length)	Bone is >5mm from the CEJ (or > 30% of the actual root length)

Adapted from Periodontal Diagnostic Guidelines@OraPharma, Inc.2008

D1110- Prophy Code-Preventive procedure

- Normal tissue tone—no signs of disease activity present
- No clinical attachment loss
- All probing depths are less than 4mm

D4346-Gingivitis Code- Therapeutic procedure

- Use with gingival inflammation- redness, edema, glazing, bleeding on probing
- Gingival pockets, with no bone loss (absence of periodontitis)
- No clinical attachment loss—probing depths will be variable due to gingival edema
- Can go back to the prophy code if resolution occurs at the recall visit

D4355-Debridement Code

- Used when probing and exploring cannot be performed effectively to determine a dental hygiene diagnosis due to excessive deposits of plaque and calculus
- Does not take the place of D1110, D4346
- Can be used if students do not finish a patient

D4341-Scaling and Root Planing 4 plus teeth per quad—Therapeutic procedure

- This is used for 4 or more teeth of periodontitis with pockets with 1+ mm of attachment loss
- If infection resolves, patient would receive Perio Maintenance at recall
- Arestin can be used if indicated, after Scaling and Root Planing (SRP)
- All non periodontally involved teeth will be completed at no additional charge

D4342- Scaling and Root Planing 1-3 teeth per quad —Therapeutic procedure

- This is used for 1-3 teeth of periodontitis with 1+ mm of attachment loss
- If infection resolves, patient would receive Perio Maintenance at recall
- Arestin can be used if indicated, after Scaling and Root Planing (SRP)
- All non periodontally involved teeth will be completed at no additional charge

D4910- Perio Maintenance—Preventive procedure

- For maintenance of patients who have received D4341 or D4342
- These patients have attachment loss and therefore cannot return to the Prophy Code D1110 or Gingivitis Code D4346
- At recall appointments, patients presenting with active infection, should be retreated with D4345, D4341, or D4342

NIDA Quick Screen V1.0[1]

Name: ..... Sex ( ) F ( ) M Age.....

Interviewer..... Date ...../...../.....

Introduction (Please read to patient)

Hi, I'm _____, nice to meet you. If it's okay with you, I'd like to ask you a few questions that will help me give you better medical care. The questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we'll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed. I'll also ask you about illicit or illegal drug use—but only to better diagnose and treat you.

Instructions: For each substance, mark in the appropriate column. For example, if the patient has used cocaine monthly in the past year, put a mark in the "Monthly" column in the "illegal drug" row.

NIDA *Quick Screen* Question: **In the past year, how often have you used the following?**	**Never**	**Once or Twice**	**Monthly**	**Weekly**	**Daily or Almost Daily**
Alcohol • **For men, 5 or more drinks a day** • **For women, 4 or more drinks a day**					
Tobacco Products					
Prescription Drugs for Non-Medical Reasons					
Illegal Drugs					

- If the patient says **"NO"** for all drugs in the Quick Screen, reinforce abstinence. **Screening is complete.**
- If the patient says **"Yes"** to **one or more days of heavy drinking**, *patient is an at-risk drinker*. Please see NIAAA website "How to Help Patients Who Drink Too Much: A Clinical Approach" http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm, for information to **Assess, Advise, Assist, and Arrange** help for at risk drinkers or patients with alcohol use disorders
- If patient says **"Yes"** to **use of tobacco**: *Any* current tobacco use places a patient at risk. Advise *all tobacco users to quit*. For more information on smoking cessation, please see "Helping Smokers Quit: A Guide for Clinicians" http://www.ahrq.gov/clinic/tobacco/clinhlpsmksqt.htm
- If the patient says **"Yes"** to **use of illegal drugs or prescription drugs for non-medical reasons**, proceed to **Question 1** of the NIDA-Modified ASSIST.

[1] *This guide is designed to assist clinicians serving adult patients in screening for drug use. The NIDA Quick Screen was adapted from the single-question screen for drug use in primary care by Saitz et al. (available at http://archinte.ama-assn.org/cgi/reprint/170/13/1155) and the National Institute on Alcohol Abuse and Alcoholism's screening question on heavy drinking days (available at http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm). The NIDA-modified ASSIST was adapted from the World Health Organization (WHO) Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), Version 3.0, developed and published by WHO (available at http://www.who.int/substance_abuse/ activities/assist_v3_english.pdf).*

Questions 1-8 of the NIDA-Modified ASSIST V2.0

Instructions: Patients may fill in the following form themselves but screening personnel should offer to read the questions aloud in a private setting and complete the form for the patient. To preserve confidentiality, a protective sheet should be placed on top of the questionnaire so it will not be seen by other patients after it is completed but before it is filed in the medical record.

Question 1 of 8, NIDA-Modified ASSIST **In your *LIFETIME*, which of the following substances have you ever used?** ***Note for Physicians: For prescription medications, please report nonmedical use only.***	**Yes**	**No**
a. Cannabis (marijuana, pot, grass, hash, etc.)		
b. Cocaine (coke, crack, etc.)		
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)		
d. Methamphetamine (speed, crystal meth, ice, etc.)		
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)		
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium,Rohypnol, GHB, etc.)		
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)		
h. Street opioids (heroin, opium, etc.)		
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)		
j. Other – specify:		

- Given the patient's response to the Quick Screen, the patient *should not indicate* **"NO"** for all drugs in Question 1. If they do, remind them that their answers to the Quick Screen indicated they used an illegal or prescription drug for nonmedical reasons within the past year and then **repeat Question 1**. If the patient indicates that the drug used is not listed, please mark **'Yes'** next to 'Other' and continue to **Question 2** of the NIDA-Modified ASSIST**.**
- If the patient says **"Yes"** to any of the drugs, proceed to **Question 2** of the NIDA-Modified ASSIST.

Question 2 of 8, NIDA-Modified ASSIST 2. In the past three months, how often have you used the substances you mentioned (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
• Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
• Cocaine (coke, crack, etc.)	0	2	3	4	6
• Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	2	3	4	6
• Methamphetamine (speed, crystal meth, ice, etc.)	0	2	3	4	6
• Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	2	3	4	6
• Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	2	3	4	6
• Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	2	3	4	6
• Street opioids (heroin, opium, etc.)	0	2	3	4	6
• Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	2	3	4	6
• Other – Specify:	0	2	3	4	6

- For patients who report **"Never"** having used any drug in the past 3 months: **Go to Questions 6-8**.
- For any recent **illicit or nonmedical prescription drug use**, go to **Question 3.**

3. In the past 3 months, how often have you had a strong desire or urge to use (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
b. Cocaine (coke, crack, etc.)	0	3	4	5	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	4	5	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	4	5	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	4	5	6
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	3	4	5	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	4	5	6
h. Street Opioids (heroin, opium, etc.)	0	3	4	5	6
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	4	5	6
j. Other – Specify:	0	3	4	5	6

4. During the past 3 months, how often has your use of (first drug, second drug, etc) led to health, social, legal or financial problems?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
b. Cocaine (coke, crack, etc.)	0	4	5	6	7
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	4	5	6	7
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	4	5	6	7
e. Inhalants (nitrous oxide, glue, gas, pain thinner, etc.)	0	4	5	6	7
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	4	5	6	7
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	4	5	6	7
h. Street opioids (heroin, opium, etc.)	0	4	5	6	7
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	4	5	6	7
j. Other – Specify:	0	4	5	6	7

5. During the past 3 months, how often have you failed to do what was normally expected of you because of your use of (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
b. Cocaine (coke, crack, etc.)	0	5	6	7	8
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	5	6	7	8
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	5	6	7	8
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	5	6	7	8
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	5	6	7	8
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	5	6	7	8
h. Street Opioids (heroin, opium, etc.)	0	5	6	7	8
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	5	6	7	8
j. Other – Specify:	0	5	6	7	8

Instructions: Ask Questions 6 & 7 for all substances **ever used** (i.e., those endorsed in the Question 1).

6. Has a friend or relative or anyone else ever expressed concern about your use of (first drug, second drug, etc)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	6
b. Cocaine (coke, crack, etc.)	0	3	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	6
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	0	3	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	6
h. Street opioids (heroin, opium, etc.)	0	3	6
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	6
j. Other – Specify:	0	3	6

7. Have you ever tried and failed to control, cut down or stop using (first drug, second drug, etc)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	6
b. Cocaine (coke, crack, etc.)	0	3	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	6
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	0	3	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	6
h. Street opioids (heroin, opium, etc.)	0	3	6
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	6
j. Other – Specify:	0	3	6

Instructions: Ask Question 8 if the patient endorses any drug that might be injected, including those that might be listed in the other category (e.g., steroids). Circle appropriate response.

8. Have you ever used any drug by injection (NONMEDICAL USE ONLY)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months

- Recommend to patients reporting any prior or current intravenous drug use that they get tested for HIV and Hepatitis B/C.
- If patient reports using a drug by injection in the past three months, ask about their pattern of injecting during this period to determine their risk levels and the best course of intervention.
  - If patient responds that they inject once weekly or less OR fewer than 3 days in a row, provide a brief intervention including a discussions of the risks associated with injecting.
  - If patient responds that they inject more than once per week OR 3 or more days in a row, refer for further assessment.

Note: Recommend to patients reporting any current use of alcohol or illicit drugs that they get tested for HIV and other sexually transmitted diseases.

Tally Sheet for scoring the full NIDA-Modified ASSIST:

Instructions: For each substance (labeled a–j), add up the scores received for questions 2-7 above. This is the Substance Involvement (SI) score. Do not include the results from either the Q1 or Q8 (above) in your SI scores.

Substance Involvement Score	Total (SI SCORE)
a. Cannabis (marijuana, pot, grass, hash, etc.)	
b. Cocaine (coke, crack, etc.)	
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	
d. Methamphetamine (speed, crystal meth, ice, etc.)	
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	
h. Street Opioids (heroin, opium, etc.)	
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	
j. Other – Specify:	

Use the resultant Substance Involvement (SI) Score to identify patient's risk level.

To determine patient's risk level based on his or her SI score, see the table below:

Level of risk associated with different Substance Involvement Score ranges for Illicit or nonmedical prescription drug use	
0-3	Lower Risk
4-26	Moderate Risk
27+	High Risk

ALPHABETIZED INDEX