

**Dental Hygiene Program Client Care Manual: 2015**



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Department of Dental Hygiene

Welcome to the client care portion of your education. This manual will provide you with many of the answers to your client care questions along with referencing the textbook of Darby and Walsh and the cdho.org website. This manual is designed to assist you in your success as dental hygiene student clinicians.

In order to be best prepared for each clinical session, please read the manual to become familiar with all clinical protocols, procedures, and evaluation techniques. If you have any questions please do not hesitate to ask any of the Dental Hygiene Clinical Faculty. Please bring this manual with you to all clinical sessions.

Thank-you and have a wonderful year!

Dr. Boris Pulec: Dean of Students

Ms. Lidia DiNicolo RDH: Business Director

Ms. Lila McIndoe RDH, B.Ed.: Dental Hygiene Program Coordinator

# TCDHA Mission Statement

# The Toronto College of Dental Hygiene and Auxiliaries Inc provides a learner centered environment enabling individuals to develop personal and professional success by offering high standards of current comprehensive dental education. These standards provide knowledge and skills that reflect current practice and promote ongoing education and research.

Mission Statement for the Dental Hygiene Program

The graduate of the Dental Hygiene Program will provide appropriate client care based on the Dental Hygiene Process of Care geared to meet the specific needs of the client. They will use their critical thinking skills to apply evidence based knowledge into their client care and they will value the importance of life long learning. They will practise ethically and responsibly according to the CDHO “Standards of Practice” and the CDHO “Code of Ethics”

# Our Philosophy

The Toronto College of Dental Hygiene and Auxiliaries Inc. believes students, clients, staff, faculty, and the community in which we live and work, need to be treated with respect and that we all need to work collaboratively to achieve high standards of dental education.

Students should recognize that clients are individuals with unique and diverse social, physical, economic, and cultural needs. They also have various demands, motivations, resources and definitions of wellness. Students therefore, must develop competence in providing professional, client-focused care to a diverse population of clients in various practice environments.

Our Accountability

We will commit ourselves to achieve our mission by ensuring high levels of current dental education for our students.

# We will ensure that our teaching facility is fully equipped with high quality and up to date equipment.

# We will ensure that the teaching faculty is competent, ethical and current with professional skills and standards as set out by the Provincial and National Regulatory Governing Bodies.

# We will continually ensure to promote and encourage educational and clinical advancements to our teaching faculty and staff.

# We will continually evaluate and revise the programs to meet with current Standards of Practice.

# We will ensure that the programs have a systematic approach of learning in place in order for students to receive high standards of current comprehensive dental education.

##### Our Goal

The goal of the Toronto College of Dental Hygienists and Auxiliaries is to promote a learning centered environment and to encourage learning to be a life long activity.

# Our Values

# We believe that students are our primary focus.

# We strive to obtain each individual’s maximum growth potential.

# We value our clients/patients and respect that they are partners in care of their oral health.

# We value our clients/patients and respect that their personal and clinical information is private and must remain confidential.

# We value and encourage the growth and learning of our students, staff and community.

We value the need for ongoing maintenance and improvement of our facility and programs.

Our Curriculum

Our curriculum is based on the following:

1. The Commission on Dental Accreditation of Canada
2. The National Dental Hygiene Certification Examination.
3. The Ministry Standards (MTCU) for Dental Hygiene Programs.
4. The College of Dental Hygienists of Ontario “Standards of

Practice” and “Best Practices”

1. TCDHA Program Learning Outcomes
2. CDHO Entry-to-Practice Competencies and Standards for Canadian Dental Hygienists (January 2010)

**1. Commission on Dental Accreditation of Canada (CDAC)**

The CDAC is the professional body responsible for accrediting Dental Hygiene Programs. This means that TCDHA has fulfilled the requirements of the CDAC to earn accreditation. TCDHA is fully accredited and participates in site visits every four years.

**2. The National Dental Hygiene Board Certification Exam (NDHCE)**

The National Dental Hygiene Board Certification Exam is a National Examination which students will write during the fourth semester, or upon completion of their Dental Hygiene Program. The exam takes place 3x per year; January, May and September. The examination is completely online. To be eligible, students must graduate within four months of the **application** date of the exam. Each cohort of students will be informed of their proposed date of writing. The program coordinator must authorize all eligible students once their application has been sent to the Board. The program coordinator has the authority to withdraw any student up until 2 weeks prior to the actual date of the written exam if it appears that the student may be at risk for not graduating within the appropriate time period. For more information please visit their website: [**www.ndhcb.ca**](http://www.ndhcb.ca)**.**

**3. Ministry of Training, Colleges and Universities (MTCU)**

Private career colleges in Ontario are regulated by the Ministry of Training Colleges and Universities. TCDHA submits their curriculum to the MTCU for approval MTCU keeps it on file. TCDHA has also made available to the MTCU curriculum mapping documents connecting the CDHO Entry to Practice Competencies and Standards for Canadian Dental Hygienists, to our curriculum. TCDHA follows all standards and protocols set by the MTCU.

**4. The College of Dental Hygienists of Ontario (CDHO)**

In Ontario Dental Hygienists are self-regulated which means we are regulated by our own regulatory body: The College of Dental Hygienists of Ontario. We have our own Code of Ethics, Standards of Practice, and Record Keeping Regulations. **All graduates of the TCDHA upon successfully completing the National Dental Hygiene Certification Board Examination must register with the CDHO in order to practice in the Province of Ontario.**

In Ontario there are two acts designed to protect the public: The RHPA or the Regulated Health Professions Act; and the Dental Hygiene Act. Both of which came out in 1991 and were proclaimed in 1993. Both of these Acts are available on the school website and will be discussed in further detail later in the program.

A **dental hygienist** is a “registered oral health professional who performs a variety of roles including therapy, health promotion, education, administration and research in a variety of environments” (CDHO Standards of Practice).

The Toronto College of Dental Hygiene & Auxiliaries Inc. uses the CDHO “Standards of Practice” as its foundation for the education of its students. The Standards of Practice and the Code of Ethics may be found on the TCDHA website and on the website of the CDHO ([www.cdho.org](http://www.cdho.org)). Our program follows “Best Practices” set by the CDHO. All of our Registered Dental Hygiene Faculty are “self-initiated”. We are registrants of the CDHO and as such run our dental hygiene clinic following all regulatory protocols and procedures.

# CDHO: Best Practices

***Guideline for Best Practice in Initiating Dental Hygiene Care***

This guideline should be read in conjunction with the *CDHO Standards of Practice, Code of Ethics, Records Regulation & Standard for Self-Initiation.* All dental hygienists, regardless of practice setting or employment arrangement, are expected to use their knowledge, skill and judgment when discussing situations in which consultation with another health care professional is indicated. The final decision to proceed with dental hygiene treatment or not to proceed with the dental hygiene treatment is the responsibility of the registrant. In documenting the reasons for proceeding, postponing treatment or referring to another health care provider, the dental hygienist should note the resources consulted and/or rationale used.

Best practice indicates that the **Dental Hygiene Process of Care** is the framework within which all dental hygiene therapy should be conducted.

**\*All students will follow the Dental Hygiene Process of Care. It is the basis for our entire program** **supported both in the didactic and clinical setting.**

**Assessment**

A thorough, detailed medical and dental history must be taken and discussed with the client or the client’s substitute decision maker. Registrants may choose to develop their own charting system or to evaluate an existing system against the Medical/Dental History Guide available on the CDHO web site. If warranted, and with the client’s consent, further discussion with the appropriate health care professional to receive a medical clearance should occur. Ideally, the clearance will be provided in writing either by fax or e-mail and included in the client’s chart. If the information is obtained over the telephone the registrant should clearly document the substance, time and date of the conversation. Areas of particular concern may be:

**i)** any cardiac condition for which antibiotic prophylaxis is recommended in the guidelines set by the American Heart Association (AHA)\*;

\*A client who has previously experienced an episode of infective endocarditis or whose physician or Nurse Practitioner [RN(EC)] has noted that prophylactic antibiotics are required, must have taken the requisite prophylactic medication in accordance with the AHA guidelines before commencement of the dental hygiene appointment.

**ii)** any other condition for which antibiotic prophylaxis is recommended or required;

Registrants should consult the guideline *Recommended Antibiotic Prophylaxis for Dental Procedures* found on the CDHO web site for additional conditions requiring prophylactic antibiotics and if there are any concerns consult with the appropriate health care professional prior to the delivery of invasive dental hygiene procedures as listed in Table 4 of the guideline.

**iii)** any unstable medical or oral health condition, where the condition may affect the appropriateness or safety of scaling teeth and root planing including curetting surrounding tissue;

Should a client present with an unstable condition, the registrant should consult with the client’s appropriate health care provider. If, in the registrant’s professional judgment, proceeding with treatment is not in the client’s best interest, then the treatment must be postponed and the appropriate referral made.

**iv)** active chemotherapy or radiation therapy;

If a client is in the process of receiving chemotherapy and/or radiation therapy, consultation with the client’s health care provider is essential prior to any dental hygiene intervention. In the case of radiation therapy, no additional routine oral radiographs should be taken even if prescribed by a dentist or physician.

**v)** significant immunosuppression caused by disease, medications or treatment modalities;

When a client is identified as being significantly Immunosuppressed the dental hygienist must decide the risk versus the benefit of proceeding with care based on the client’s current immune status. The dental hygienist should work collaboratively with the client’s health care provider/team to determine the optimal sequencing of dental hygiene therapies and interventions to ensure that the client’s oral health care needs are met safely and appropriately.

**vi)** any blood disorders;

“Blood disorders” is a very broad term and the dental hygienist should investigate the condition sufficiently to enable the registrant to make a decision based on risk as to whether to proceed or not. This investigation would involve confirming knowledge and evidence related to the condition and consulting with the appropriate health care provider.

**vii)** active tuberculosis;

If a client presents with active tuberculosis, the dental hygienist should postpone treatment until the client’s physician has indicated that the disease is no longer in the active state.

**viii)** A client who appears to be under the influence of a substance that could impair the client’s judgment or states that s/he has ingested a significant amount of alcohol prior to the dental hygiene appointment, should be rescheduled for a time when the client is aware and can participate safely in the dental hygiene care plan.

**ix)** high-risk of infective endocarditis;

A client who has previously experienced an episode of infective endocarditis or whose physician has noted that prophylactic antibiotics are required due to valve replacement surgery, must have taken the requisite prophylactic medication according to the AHA guidelines before commencement of the dental hygiene appointment. (See item i)

**x)** a medical or oral health condition with which the registrant is unfamiliar or which could affect the appropriateness, efficacy or safety of the procedure;

If in the course of taking the medical/dental history the dental hygienist becomes aware of a condition with which the registrant is unfamiliar, the registrant shall further investigate the condition using appropriate resources and evidence. This may include consulting with additional health care practitioners.

**xi)** a drug or a combination of drugs with which the registrant is unfamiliar or which could affect the appropriateness, efficacy or safety of the procedure.

If the client is taking a drug or combination of drugs with which the registrant is unfamiliar, the registrant should further interview the client as to the nature of the medication and effects. The registrant should research the drug(s) in the current *CPS, Mosby’s Dental Drug Consult* or other suitable reference and note any contraindications to proceeding with treatment. If the registrant is in doubt, s/he should consult with the appropriate health care provider.

Since the above is not an exhaustive list of concerns, the registrant should research and consult on any area with which s/he is not familiar.

**Dental Hygiene Diagnosis and Planning**

The registrant is responsible for developing an individual treatment plan for each client prior to initiating dental hygiene therapies. The dental hygiene treatment plan for each client must include:

1. a complete clinical assessment

2. a dental hygiene diagnosis

3. client centered goals/objectives

4. planned sequence of activities

5. client participation

The dental hygiene treatment plan must be documented in accordance with the *CDHO Records Regulation* and must be updated on a regular basis.

The client’s informed consent for treatment must be obtained and documented.

**Implementation**

The registrant is responsible for ensuring that dental hygiene treatment is individualized in accordance with the treatment plan presented to, and agreed to by, the client. In addition, all treatment activities, including the time spent on the procedure must be documented in accordance with the *CDHO Records Regulation*. Financial records must correlate with the actual time and procedure documented on the client’s chart.

The registrant should ensure that the client receives appropriate post-appointment instructions and recommendations for pain management. Individualized instructions in oral self-care should be based on the assessment and treatment plan.

**Evaluation:**

Clinical Evaluation of the client’s oral health progress should be done at intervals appropriate to the client and must not be dependant on third party payment schedules or those of other health care providers. A clinical re assessment is performed, the dental hygiene treatment plan is reviewed and discussed with the client and modified as required.

**Best practices in All Clinical Settings**

Refer to notations in red to determine how this manual and this DH program address Best Practices:

The office has a written policy for the collection and maintenance of client information in accordance with the *CDHO Records Regulation* and *PHIPA*.

(Refer to Pgs 23 and 24: Client Confidentiality and the TCDHA Client Chart: Pages 2-5 under Personal Assessment)

Current scientifically accepted infection control procedures are in place.

(Refer to Prevention of Disease Transmission)

Emergency protocol, emergency supplies, equipment and oxygen are in place.

(Refer to Emergency Protocols)

The registrant has proof of current CPR certification.

(Refer to Emergency Protocols)

Exposing and processing of radiographs and radiation hygiene are consistent with the *Healing Arts Radiation Protection Act* (HARP).

(Refer to Health and Safety; Client Care sequencing; Reference may also be found in the TCDHA Radiology Lab Manual).

Equipment is current and in good repair.

(Refer to Prevention of Disease Transmission; Equipment maintenance)

Equipment, instruments and supplies are sufficient to support the selection and implementation of appropriate dental hygiene services.

(Refer to Dispensary and Supplies)

The date and particulars of each professional contact with the client is documented in accordance with the CDHO *Record Keeping Regulation*

(Refer to Quality Assurance)

The registrant consults and/or refers to other health professionals as required

[Reference: *CDHO Standards of Practice*]

(Refer to section on consultative protocols)

**\*\*\*Excellent Resource: The CDHO Knowledge network offers a wealth of information on numerous medical conditions and the protocols to follow. Students have access to this information and may go to the following site and log in as a guest.**

**http://www.cdho.org/QualityAssurance/QAKnowledge.aspx.**

All students follow ADPIE: The entire process is circular each component leading to the other.

Assessment: Medical/Dental History, Intra Extra oral assessment, hard tissue charting and radiographs and periodontal assessment.

Diagnosis: A Dental Hygiene diagnosis is developed based on unmet human needs.

Planning: A series of client specific goals and interventions are prepared leading to an in depth client treatment plan.

Implementation: This is where the student implements all planned treatment.

Evaluation: Should be ongoing and evident in the client chart.

COLLEGE OF DENTAL HYGIENISTS OF ONTARIO (Reference: cdho.org)

**CODE OF ETHICS**

(Adapted from the Canadian Dental Hygienists Association Code of Ethics, 2001)

The mission of the College of Dental Hygienists of Ontario is to regulate the practice of dental hygiene in the interest of the overall health and safety of the public of Ontario. **\*\*Please note that as of 2012: The CDHA has updated their Code and has replaced “professionalism” with “integrity”. The CDHO as of yet, has not adopted this change. Please refer to the CDHA webpage for further information.**

**PRINCIPLE I: BENEFICENCE**

• Involves caring about and promoting the good of another

**Dental hygienists use their knowledge and skills to assist client’s to achieve and maintain optimal oral health and to promote fair and reasonable access to quality care.**

# PRINCIPLE II: AUTONOMY

• **Pertains to the right to make one’s own choices**

By communicating relevant information openly and truthfully, dental hygienists assist client’s to make informed choices and to participate actively in achieving and maintaining optimal oral health.

## PRINCIPLE III: PRIVACY AND CONFIDENTIALITY

• **Privacy pertains to a person’s right to control the collection, use and disclosure of personal information; the right to access and correct inaccurate information; and the right to expect that the information is kept secure.**

• **Confidentiality is the duty to hold secret any information acquired in the professional relationship.**

Dental hygienists respect the privacy of clients and hold in confidence the information disclosed to them, subject to certain narrowly defined exceptions.

## PRINCIPLE IV: ACCOUNTABILITY

• **Pertains to the acceptance of responsibility for one’s actions and omissions in light of relevant principles, standards, laws, regulations and the potential to self-evaluate and to be evaluated accordingly**.

Dental hygienists practise competently in conformity with relevant principles, standards, laws, and the regulations under the RHPA, 1991 & DHA, 1991 and accept responsibility for their behaviour and decisions in the professional context.

**PRINCIPLE V: PROFESSIONALISM**

• **Is the commitment to use and advance professional knowledge and skills to serve the client and the public good.**

Dental hygienists express their professional commitment individually in their practice and communally through the CDHO and their participation in the CDHO Quality Assurance Program.

**5. TCDHA Dental Hygiene Program Learning Outcomes**

Upon Completion of the program the graduate shall:

1. Practice as a professional following all regulatory guidelines, Code of Ethics and Standards of Practice.
2. Apply the Dental Hygiene Process of care model to provide comprehensive and individualized care.
3. Implement valid methodologies for information retrieval and communication to ensure current and evidence based practice.
4. Coordinate a healthy work environment through the application of effective management principles and strategies.
5. Collaboratively encourage open communication with other health care professionals and the community to provide optimal client care.
6. Demonstrate ability to think critically, solve problems, and develop appropriate steps of action.
7. Empower clients and the community to develop positive health behaviours through health promotion and education.
8. Apply appropriate educational frameworks to promote self-efficacy and behavioural change in individuals.
9. Contribute to the enhancement of the dental hygiene profession through leadership and advocacy.

**The outcomes describe the knowledge, skills and attitude that a graduate of the TCDHA Dental Hygiene Program will demonstrate upon graduation.**

**The above program outcomes are listed on each and every course outline for all didactic and clinical subjects.**

**TCDHA Program Outcomes are also posted in the clinic and in all manuals provided to the student.**

**6. CDHO Entry to Practice Competencies and Standards for Canadian Dental Hygienists: January 2010. This information is being taken directly from the formal document which may be found on the CDHO website: cdho.org**

Competencies are used to describe the essential knowledge, skills and attitudes important for the practice of a profession; the foundation necessary for entry into the dental hygiene profession in Canada.

The competencies are divided into 2 domains:

**Core Abilities:** The dental hygienist as a:

1. Professional
2. Communicator and Collaborator,
3. Critical Thinker
4. Advocate
5. Coordinator

**Dental Hygiene Services**: The dental hygienist as a:

1. Clinical Therapist
2. Oral Health Educator
3. Health Promoter

The competencies are woven throughout the curriculum. Students will discuss the competencies in class and will be able to identify their incorporation. TCDHA is pleased that these competencies have been developed to allow for more effective calibration amongst Dental Hygiene Programs across Canada and to facilitate communication and care between all healthcare professionals.

**Clinical Information**

Clinical Information.

College Address:

Toronto College of Dental Hygiene and Auxiliaries

300 Steeprock Drive,

Toronto, Ontario

M3J 2W9

416-423-3099

Clinical Staff**:**

1. Dentist: He/She will evaluate your hard tissue charting, prescribe and interpret all radiographic findings, administer local anaesthetic (if treatment planned), perform a clinical dental diagnosis, and assign referrals if required.
2. Dental Hygiene Faculty: The Dental Hygiene faculty are responsible for evaluating all aspects of the Dental Hygiene Process of Care. Dental Hygiene faculty are self-initiating registered dental hygienists. The clinical faculty are here to provide support to you in the learning environment.
3. Education Coordinators: There are four education coordinators (one for every semester). Education coordinators will take the role of clinic lead whenever they are in the clinic session. Any issues arising in clinic must go first to the instructor, then to the clinical lead/or education coordinator and then if needed, to the program coordinator).
4. Clinical Co-ordinator (Dispensary): Responsible for the daily operation of the Dental Hygiene Clinic. This includes the dispensary area and the re-circulation areas. Any issues with maintenance, equipment malfunction, supplies, radiographs, and/or infection control in the clinic, will be addressed by the clinical co-ordinator.
5. Reception Staff: Responsible for providing access to all charts. The reception staff will greet clients, take payments.
6. Dr. Boris Pulec (Dean of Students) is the Radiation Protection Officer and the Privacy officer.

Clinic Hours:

* Mondays-Thursdays: 8 am– 7:15 pm.
* Fridays: 8am -4 pm. (During some semesters, clinics may run on Saturdays) Hours on Saturday would be 8-11 and 12-3
* Dispensary hours will be available at the same time; however, the dispensary area will be open 30 minutes prior to clinic to allow the student time to prepare.
* Instruments must be brought to the dispensary, ready for sterilization, no later than 15 minutes before the close of clinic.
* Clients are to be dismissed 30 minutes before the close of clinic.

Clinic Fees:

The fees for the clinic will be as follows:

Adults: $27

Children: $22

Fees for the above include full dental hygiene services including a full or selective polish and fluoride or desensitization (if required: must be client specific). This is a one time fee payable by every new client and at every re care appointment.

Radiographs: (additional fee)

FMS: $35

Panorex: $35 (additional PA’s or BWs: NO additional fee)

BWS: (2) $10 (at recare appointments when required)

PA: $5

Sealants: $10 (per sealant)

Sports Guards: $30

Whitening (trays) $80 (If client has trays, additional whitening kit is $40)

Please be advised that all fees are payable before treatment is performed. If a client has dental insurance, they may request a standard form from the dispensary staff. These forms will only be completed by the DDS at the end of the treatment. Clients are to be issued a receipt for their payments, and reception staff will photocopy that receipt so that a copy may be placed in the client’s file. Students are NOT permitted to pay for a client’s treatment. A student must present a receipt to the dispensary before being dispensed radiographic plates, pit and fissure sealant material, or a whitening kit.

Please note: a client may be provided with radiographs, sealants, athletic mouth guards and whitening trays, only if treatment planned by the Dental Hygiene Student **AND** only after a complete assessment is carried out. Clients must have the implementation phase of their treatment completed and be suitable candidates for any type of laboratory work that needs to be completed. All planned treatment for the clinical session must be paid for in the first 45 minutes of the session. If there is a treatment that is prescribed by the DDS or Dental Hygiene Faculty after that time period, the student must bring a signed prescription to the front desk.

Parking:

There are 26 parking spots available to clients for no charge. Clients are expected to park in the corresponding number of your unit. Parking is available for students for a monthly fee. Please refrain from parking in visitor parking as these spots are reserved for guest speakers or service staff. Upon arrival, all clients must report to the reception desk to pick up a visitor’s pass and a parking pass for their car.

Client Charts/Records:

\*\* TCDHA uses a paperless chart. Students will be provided with a password so that they can access the client chart. Students will only be able to access the charts of their own clients. Students will only be able to access the client chart while on campus and not from home or any other location. Students will not have access to client files with the purpose to print, copy, e-mail or download any information. Any client information to be sent via internet must be encrypted or pass word protected. Wi-Fi in the clinic is fully protected and no student or faculty member is authorized to have access to client information while off school property.

Please Note: client records include not only the client chart (both paper and electronic format), but also radiographs, images, impressions, and study models.

All client records are the property of the Toronto College of Dental Hygiene & Auxiliaries Inc. However, if requested by faculty or by a client, and with signed permission from a client (Records Release form), a copy of requested client records may be sent to the client’s dentist or to the client. If such a request is made, a notation must be entered in the client’s record of care.

Client records are **never** to be removed from the clinic or reception areas without being signed out and authorized by a faculty member. Client records cannot be stored in a student’s locker or taken home. They are stored in the clinic or dental materials lab. A dental chart is a legal document and information about a client is never to be shared with anyone. Students will be provided access to the electronic client record only while on campus. Client records must be kept for 10 years once the client is no longer a patient at the TCDHA Clinic. If the client is a child then the record will be kept for 10 years after the child turns 18. Paper charts of clients who are not returning to TCDHA are stored in a locked chart room.

Please refer to the CDHO Regulations on client records found on page 129. It details what the client record must contain. Please also review the section directly below on client confidentiality.

Client Confidentiality:

To conform to provincial guidelines (PIPEDA), each client must be requested to allow TCDHA to have access to personal information. This policy is found in the client chart: personal assessment pgs. 2, 3 and 4 of 5. It is important that each student reviews the terms with the client and has them sign the form. Please note that the client is permitting TCDHA to use their clinical information as an educational tool and if the chart is to be used in that manner, than a pseudonym will be used to ensure client privacy. Every client has a right to see the TCDHA Privacy Policy, a copy of which is available in the clinic dispensary and on the TCDHA website. In this facility Dr. Boris Pulec is the privacy officer. Clients also have the right to view their chart at any time.

Cancellations:

All cancellations must be recorded on the clients “Record of Care”. Please inform the Dental Hygiene Faculty if your client will not be attending their appointment. Always plan to have a backup client in case of cancellation**. You must attend clinic even if your client does not come in!** You will be able to assist and collaborate with fellow students.

Switching Clinics:

At times it may be necessary for a student to switch clinics with another student in order to accommodate a client or to accommodate a personal situation or emergency. Students **must** record the switch in the clinic switch binder and calendar, which is located in the clinic dispensary. There is no maximum number of switches. You may only switch a clinical session with a student in the same semester as you. When faculty are taking attendance and you report that you have switched with another student, that switch will be verified to determine that documentation has been completed**. If it has not been completed you will be asked to dismiss your client and both you and the person you switched with will lose a clinical session.** There is no reason for this to happen.

NOTE: Students are NOT permitted to switch clinic times on days when they are monitors.

Transferring Clients:

As of Clinic Practice III, (from week 1) you may be granted permission to transfer your client to another student in order for that student to complete a requirement. This may be done with the permission of the Dental Hygiene Faculty and with the express permission of the client. It is very important that all clients are treated to completion, and should this become necessary, please inform the client as to why you are suggesting a transfer. Please note: clients may only be transferred for the following procedures: pit and fissure sealants, radiographs, alginate impressions, athletic sports guards, tobacco cessation and nutritional analysis. If you are performing a procedure on a client that was not your original client you must review the client chart to familiarize yourself with the client and you must meet the client personally before performing any of the above procedures. Also: if you have taken the radiographs on a client who was not originally your client, then you must review the radiographs with the student treating the client and both students must be present during radiographic interpretation. All documentation must be properly recorded in the record of care. The original student must note in the ROC the name of the student who provided the care.

\*\*Evaluation process: Retrieve a hard copy evaluation form from the dispensary. Once evaluated the student **MUST** submit their hard copy of their evaluation sheet to their clinical instructor and/or dispensary staff.

After the evaluation sheet is submitted, a clinical instructor will place the grade, if successful, in the student's master binder (*Client Summary Sheet*). The instructor will date and sign the bottom page of the evaluation sheet and indicate that the requirement has been "ENTERED" in the student's master binder. Then the education coordinator will ensure that the requirement is transferred to the student spread sheet.

Once entered, the evaluation sheet will be placed in a binder/folder, located in the dispensary, named "CLINICAL REQUIREMENTS" wherein the education coordinators will collect the sheets and give them to the TCDHA tech department to scan into the indicated students' electronic file. **\*NOTE:** Any student that is given a hard copy of an evaluation sheet **MUST** submit their sheet to the dispensary staff, or clinical instructor, BEFORE leaving the clinic.

Dispensary:

Items requested from the dispensary must be signed out and returned cleaned and in good working order. Please be sure that if required, all items must be bagged and ready for sterilization. If you require an instrument from the faculty supply, please be sure to mark “faculty” on the sterilization bag. All phosphorous plates must be requested from the dispensary. Please note, that no other plates will be issued (e.g. no retakes—unless prescribed by DDS). A sign out sheet will be in the dispensary, and students will be asked to sign the required form. \*\*Students will be held responsible for damage to equipment.

Maintenance of Equipment:

Students are responsible for their own hand pieces and air water syringe tips. Hand pieces must be lubricated and properly sterilized. Instrument cassettes must be properly maintained and signed in and out of the dispensary area. Any cassettes found unwrapped in the recirculation will result in a penalty being issued to the owner. Please be advised that the **Toronto College of Dental Hygiene & Auxiliaries is** not responsible for any missing or lost cassettes. Faulty equipment should be reported to the clinical co-ordinator. All repairs for lost or broken equipment are the responsibility of the student. It is a very good idea to engrave your initials and unit number on your cassette and your handpiece. You may also use indelible marker.

Consultative Protocols

Upon completion of assessment procedures, and with the confirmation of the dental diagnosis by the DDS, a referral may be necessary. There are two protocols to be followed. The first is to prepare the formal referral form. Students are to complete the top portion of the referral form, indicating what type of care has been provided so far and what is planned for the client. They must also sign at the bottom. The DDS will complete the rest. The second protocol is to note the referral in the client’s record of care. The DDS will sign the referral based on clinical and/or radiographic findings. If the client does not have their own dentist or specialist, a suggested list of general practitioners or specialists may be provided by the TCDHA.

If clients wish to have their radiographs sent to another dental clinic then we must have their signed authorization to do so. The client must complete the Transfer of Records form. Once completed it is then confirmed by the clinic coordinator. If the client makes the request after they have left their appointment and does not wish to return to sign the document the student can fax the document for the client to sign, or scan it. TCDHA will provide the client with a CD of their radiographs. There is a $5 fee to do so. The clinic coordinator can also copy the radiographs onto a USB stick if the client provides their own flash drive. There is no fee to do this. Please provide our clinic coordinator with sufficient notice to complete either of these tasks. Please avoid coming to the dispensary at the end of clinic asking for this to be done.

Students are not permitted to copy any client information onto a personal device, and do not have that privilege in the Consult Pro System. Radiographs can also be emailed to the client’s DDS however; this will be completed only using an encrypted password and MUST be done through our tech department.

If a client is medically compromised then the Dental Hygiene Faculty or the DDS on the clinic floor may request a medical consultation. If so, then a medical consultation request form must be completed. Please refer to the TCDHA Policy on “Care of Compromised Clients” and the appropriate forms on 179-180. Faculty will assist the student in the completion of this form. Once TCDHA receives the results of the consultation a copy will be scanned into the client chart and documentation will be noted in the Record of Care.

Incomplete clients:

If for any reason a client does not wish to return to the clinic, please make a note of it in the record of care in the client’s chart. Please list the reason the client is not planning to return. It will not be necessary to complete a recall form if the client has no intention of returning, although the status of the client should be noted in the computer as not returning. Please have faculty sign your record of care. If you have completed up to and including the treatment plan, and it has been graded, you may be eligible for partial client credit. You are eligible for any requirements completed on the client. Please refer to page 37-38 in this manual.

Continued Care Clients

All clients returning on a recall basis are to be treated with the same protocol as a new client. The only exception would be clients returning for a 3 or 4 month recall. Please see section on protocols for re-care clients. At the end of treatment students must input their client into the consult pro system. The re care team will also track your client list to ensure that they are being contacted. Upon your graduation, please do not simply give your client list to another student. It must be handed in to the re care coordinator.

Client Feedback Forms:

The goal of the TCDHA is to ensure client satisfaction. At the end of treatment please have your clients take a few minutes to complete our client satisfaction surveys. Your client feedback forms are to be submitted to either the clinic coordinator or your instructor. Once they are submitted all results are tabulated and documented. Results of client feedback are shared with students, faculty and support staff. If changes are indicated then these proposed changes will go through the appropriate channels.

**\*\*Failure to complete the client feedback form will result in a professional penalty.**

**Clinical Requirements**

Clinical Requirements

The following are the clinical requirements for each semester. Please be advised that the student will be asked to sign a clinical agreement to ensure that all aspects of the requirements are clearly understood.

**It is a privilege to be permitted to work with clients. The Registered Dental Hygienist is a respected and trusted member of the oral healthcare team.**

**\*\*TCDHA faculty will continually monitor student performance in the clinic and gauge the well-being of our clients. Faculty are expected to withdraw the privilege of client care at any time a student does not demonstrate skill and/or a level of knowledge that is necessary for the well being of client”.**

**Tracking of Clinic Credits and Requirements:**

All students must maintain a client summary sheet of their clinic credits and requirements. Students must also maintain calendars showing their appointment schedules. Your clinic advisor will also maintain a client summary sheet in the student master binder. Once a post care has been submitted and evaluated, the advisor will enter the credits and requirements into your master summary sheet. Please be advised that the summary sheet in the master binder is the one that will be transferred to the student spreadsheet so always keep your clinic advisor updated. **Students can ask to see their master binder at any time but can only do so with an instructor or your advisor present.**

Clinic Practice 1

In order for the students to be successful in the Clinic Practice I course offered at the TCDHA the student must be able to complete the following requirements:

1. Demonstrate competency with a grade of “SAT” on the following skills: (a) set up and tear down of dental unit (b) application of a rubber dam. (c) application of topical anaesthetic, on Dexters, (d) alginate impression on student partner (e) polishing and finishing restoration on dexters (f) application of oral irrigation technique, on Dexters (g) application of desensitizing agents and fluoride varnish, on Dexters (h) ultrasonic instrumentation on dexters (i) coronal polish (on Dexter)(j) fluoride application (on Dexters) (k) pit and fissure sealant on dexters and (l) placement of a temporary restoration on Dexters.
2. Complete a student partner
3. Complete one adult with a degree of difficulty of 1. (DD1). (Clients presenting with a D of D of 2 or greater will also be accepted, however, students are advised to attempt more challenging clients later in the program. Students will be provided with appropriate clinical credits for all clients seen).

The adult client will be graded only as “SAT” or “needs improvement”. Only if a student puts a client at risk or harms the client in any way would a grade of “UNSAT” be given. In such a case the student would not receive the two credits for this client. If the student is practising in an unsafe manner which would potentially harm a client they will be notified by the instructor and a note of this will go into the student clinical file. Moving forward into Clinic Practice II and III, should this happen again then a clinical status alert would be issued. Please refer to page 85.

\*\*Please note: If a student is able to begin another client who is a DD1 or DD2, these clients will be treated as SSL clients and credited towards your overall credits. Please refer to the section on the SSL client on page 32.

Clinic Practice II

In order to successfully complete Clinic Practice II and proceed to Clinic Practice III the student must successfully complete the following;

1. Minimum of 9 clients: To include:

8 DDO’s, 1’s and/or DD2’s (SSL clients are included here)

1 DD3 **\*\*students must successfully complete 1 DD3 client.**

1. Complete 25 clinical credits
2. Complete 1 Full Mouth Series.
3. Complete 1 Alginate Impression.
4. One oral self-care presentation (criteria noted in the evaluation section of this manual).
5. The student must achieve an overall average of 70% on both the assessment/diagnosis/planning page and the implementation/evaluation page of the client evaluation sheets. If the student does not achieve a 70% on either section they will **not** receive credit for the client. In other words, the student must pass the client in order to receive credit for the client. (**Unless the client is a SSL client in which case full credits will be granted) Please see below for details on the SSL program.**
6. The student must demonstrate safety and competency on each client. If a student has been identified as not being consistently competent (ie causing tissue trauma due to improper instrumentation, a pattern of low grades on debridement, inadequate infection control procedures, consistent inaccurate documentation or a display of behaviour which is considered unprofessional ), it may be grounds for dismissal from the program.

**\*students will be permitted to work with a partner only in the documentation of periodontal probing. If a student requires additional assistance from a student partner it must be authorized by faculty.**

**Please be advised all of the above clients are to be adults or young adults.**

**Assignment of credits:**

Each client will represent a different degree of difficulty. Please see page 107 for degree of difficulty chart. The following chart indicates how credits will be assigned.

|  |  |
| --- | --- |
| Client Degree of Difficulty | Credits Assigned |
| 0 or additional paedo clients | 1 |
| 1 | 2 |
| 2 | 3 |
| 3 | 4 |
| 4 | 5 |
| 4-6 week re evaluation client completed  Or 4+ | 1 additional credit  1 additional credit |

**Please Note:** In the above section it notes a minimum of 9 clients including 2 student supported learning clients. Please see below for information on SSL clients.

**Student Supported Learning Program:**

Student supported learning (**SSL**) clients means the following: It is important that the student of Dental Hygiene be supported as they begin their clinical journey of learning. During Clinic Practice I or II, each student will be graded numerically on their clients. Should they not be successful on any **one** of their DD1 or DD2 clients they can choose to claim the client as an SSL client and receive full credit for the client. This means that each student can claim **1** DD1 client and **1** DD2 client during clinic practice II as their SSL client. The only time this would not apply is if the client was put at risk by the student’s behaviour or actions. This privilege does NOT apply to Clinic Practice III.

**Clinic Practice II: Calendars and Updates**

All clinical students will be expected to maintain monthly calendars showing their appointment schedule and plans for client completion. **During weeks 6 and 15 all students will need to update their clinical advisors as to their status.** All students must have their clinic calendars available for review at this time.

**Clinic Practice II Interviews:**

**\*** At the end of Clinic Practice II (Year 2-semester 3), or during the first week of the fourth semester, each student will meet with their **education coordinator** to discuss their clinical status. These meetings are mandatory and each student must bring to the meeting: their client summary sheet and their plan for client completions. The purpose of this meeting is to provide advice and feedback for student success. Letters of Permission for the upcoming semesters will be issued at this time.

Clinic Practice III

In order to successfully complete semester Clinic Practice III, the student must complete the following requirements:

1. 12 Adult clients: To include a minimum of:
   * + - 1. 3 DD3’s
         2. 1 DD4

**\*\*To clarify: each student must complete 3 DD3’s and 1 DD4**

1. Successfully complete 35 credits.
2. Successfully complete one oral self-care presentation.
3. Successfully complete a dietary analysis of two clients. One analysis can be the 24 hour and the other a 3 day analysis. (Evaluation criteria may be found in the evaluation section of this manual).
4. Successfully complete 1 tobacco cessation program with a client. (Evaluation criteria may be found in the evaluation section of this manual).
5. The student must demonstrate safety and competency on each client. If a student has been identified as not being consistently competent (ie causing tissue trauma due to improper instrumentation, a pattern of low grades on debridement, inadequate infection control procedures, consistent inaccurate documentation or a display of behaviour which is considered unprofessional ), it may be grounds for dismissal from the program.
6. The student must achieve an overall average of 70% on both the assessment/diagnosis/planning and the implementation/evaluation sections of the client care. If the student does not achieve a 70% on either section they will **not** receive credit for the client. In other words, the student must pass the client in order to receive credit for the client.

Additional Requirements:

In order to graduate from the Toronto College of Dental Hygiene, the student must complete the following requirements in addition to the above criteria.

1. Successfully complete 1 paedo client over the course of all three semesters. Paedo clients refer to children between the ages of 3-13 years of age. Clients who fall in the age category of 14-17 may present as a DDO (youth client with minimal deposits, a minimal challenge) or in some cases they may have extensive deposits making them a possible DD2 or DD3. Any youth 14 -17 will be given a degree of difficulty based on the amount of deposits. Depending on their classification, the student will be assigned the appropriate degree of difficulty and will be assigned the appropriate amount of client care credits. \*\*Regarding paedo clients: Parents **must** accompany all clients ages: 3-17 to their dental appointments to sign their medical histories and their treatment plans. If the child is 3-13 the parent **must** remain onsite with the child for the duration of each appointment. For clients who are 14-17: they need not have their parent with them on subsequent appointments (although it is preferable), as they are able to update their medical history on their own, providing they are capable of understanding the medical history questions and can provide informed consent. \*\*However if the health of any child 14-17 is compromised in any way than the parent must remain onsite for the duration of all visits.
2. Successfully complete 3 sets of alginate impressions, on three separate clients, with a minimum grade of 3 out of 4. (Please note 1 alginate impression must be completed in Clinic Practice II). Students are to pour up study models for all alginates taken and must show them to faculty in order to receive credit for this requirement. Students must provide a rationale to the Dental Hygiene Faculty as to why alginates are required.
3. Successfully fabricate one athletic sports guard.
4. Successfully complete a minimum of 2 sealants. This requires a minimum of 1 sealant on two separate clients. If a client requires more than one sealant it will still be equivalent to one requirement. All sealants must be performed as treatment planned. (Minimum grade of 3 out of 4). \*\*Students are encouraged to assess whether a client may be a suitable client for sealants. Once it has been determined by the DDS that the client is free of decay then students may treatment plan for sealants, if appropriate the dental hygiene faculty will then assess the client and authorize the student to proceed.
5. Successfully expose and interpret 3 panoramic radiographs as prescribed by the DDS on staff. (Minimum grade of 3 out of 4). The student must pass both the technique and the interpretation sections of the evaluation.
6. Successfully complete 3 full mouth series of radiographs as prescribed by the Dentist on staff, with a minimum grade of 3 out of 4. (Please note that 1 Full mouth series must be completed in Clinic Practice II). The student must pass both the technique and the interpretation sections of evaluation.
7. Successfully complete 5 sets of Bitewing radiographs. (Minimum grade of 3 out of 4) The student must pass both the technique and the interpretation sections of evaluation.

**Please note: The student will have Clinic Practice I II and III to complete the above requirements unless otherwise specified. Client care is to be specific at all times. Should a client require any type of dental hygiene intervention, it is up to the Dental Hygiene student to provide that intervention. Client care is based on client need, NOT student need to complete specific requirements.**

Additional Information:

**Evangel Hall Rotation**

All students in good standing in the clinic will be providing dental hygiene care off site at Evangel Hall Mission. Successful completion of this placement will provide the student with **5** clinical credits and will also be counted as two community placement credits. Depending on the degree of difficulty of the clients treated, a student **may** be granted credit for a DD3 or DD4 client. Students may also be granted credit for requirements. The instructor on site will track which clients may qualify towards a clinical requirement or numerical credit. Students should also track clients who may qualify as a clinical requirement and should discuss it with the instructor onsite.

The students may complete their paedo requirement, at any time during Clinic Practice II or III.

The Dental Hygiene Faculty makes every effort to calibrate our evaluation methods. Meetings are held on a regular basis to ensure consistency. However, at times there may be minor discrepancies that may occur due to the varied nature of clinical experiences. If at any time a difference of opinion is experienced between a student and a faculty member, a second faculty member may be called in to verify the findings.

**As in Clinic Practice II students will submit updates to their clinical advisors on their status. These will be submitted at weeks 5, 11 and 16. Please have your scheduling calendars and client summary sheet updated.**

If a student is unsuccessful in meeting credits and requirements the matter will go before the Dental Hygiene Program Committee for discussion. All students are assessed on an individual basis. Please see section on failure to meet clinical credits and requirements below.

**Completion of Clinic Practice III protocols;**

* **At the end of the clinic practice III all student clinical files will be reviewed. Students must have submitted all of their post cares for review. Once all files and documentation have been reviewed the education coordinator will sign off on this information and submit that information to the program coordinator. This will be confirmation that the student has passed Clinic Practice III. This information will be forwarded to the Dental Hygiene Program Committee and pending successful completion of all didactic subjects the student will be recommended for graduation.**
* **Students must complete a list of all their clients both returning and not returning and provide such list to the Client Recare Coordinator. Students must ensure that the recare interval for their clients is clearly noted and that if the client is NOT returning to TCDHA, that fact is noted in the client ROC and in the Consult Pro System.**
* **Students must clean and disinfect their units and clear any and all personal items from their clinical station.**
* **Students must pick up their instruments and handpieces from the dispensary and sign for them (unless they are participating in remedial sessions). They must then be picked up once the last session has been completed.**

Completion of clinical credits and requirements:

**Accelerated Clinical Sessions:**

If a student has completed a minimum of **50** credits before the end of Clinic Practice III, they will be permitted to use an accelerated chart. **They still must have all aspects of client care evaluated. No accelerated chart may be used on a paedo client.**

If the student has reached **60** credits: the student will follow all aspects of the Dental Hygiene Process of Care, yet they are only to sign up to have the medical history verified and authorization to proceed, and the Dental Hygiene Care Plan authorized. There will be no grades assigned, however feedback will be provided on debridement skills. The purpose of this is to have the student become better prepared for private practice. The accelerated chart can be accessed through consult pro.

Partial Credits:

TCDHA recognizes the fact that at times clients are unable to return. Students who have clients who are not returning may be eligible for partial credits. In order to receive partial credits, the student must be passing the client and must have successfully completed up to and including the treatment plan. A post care must still be completed for the client. A successfully completed assessment/treatment plan on a DD1 or DD2 client may be eligible for 1 or 1.5 credits respectively and a successfully completed assessment on a DD3 or DD4 may be eligible for 2 or 2.5 credits. If a student has completed partial debridement, they may be assigned 1 or 2 additional credits, depending upon the degree of difficulty and depending on how much debridement was completed. Each situation will be assessed on an individual basis.

\*\*Only a maximum of three clients may be presented for partial credit and may be used during Clinic Practice II or III.

\*\*Students will receive credit for any successfully completed requirements on a partially completed client.

To clarify: If a student wishes to use 3 clients for partial credit in Clinic Practice II, they would then **not** be able to claim partial credit for any additional clients in Clinic Practice III.

If a client has been transferred from one student to another for completion then each student may be eligible for partial credit. This would be assessed by the clinical lead or education coordinator and an equitable solution to both students would be presented. Please refer to page 25 for more information on transferring clients.

Failure to complete all requirements/credits:

All situations regarding failure to complete requirements or credits will go before the Dental Hygiene Program Committee. TCDHA understands that at times there can be issues that arise when dealing with clients. TCDHA will treat all situations on an individual basis and will do our best to provide a fair and equitable learning environment for all.

If upon the completion of any semester, the student is unsuccessful in completing all credits or requirements, the following may occur.

Letters of Permission:

1. The student will be allowed to continue on a **Letter of Permission**. This letter states the conditions on which the student is being allowed to continue to the following semester. If a student has not completed previous credits, they will be added to the requirements of the following semester. Please note: there will be a time frame given for the student to complete the necessary requirements.

In Clinic Practice I students will be provided with an additional 3 weeks to complete their adult client.

In Clinic Practice II; students **above** the minimum of 15 credits will be provided with 4 weeks to meet any outstanding credits or requirements; students **below** the minimum of 15 credits will be given 2 weeks to obtain the minimum of 15 credits and then an additional 2 weeks to complete all outstanding credits and requirements. If the terms of the Letter of Permission are not met then the following would apply:

Failure to Complete the Terms of the Letter of Permission:

1. **Upon completion of Clinic Practice I:** If a student does not complete one adult by the end of the first three weeks into the 3rd semester, it may be grounds for release from the program. The student must provide evidence of extenuating circumstances which affected student performance: (serious illness or serious issues with client management). Seven (7) weeks of client care (or 17 clinics) is more than sufficient to complete one adult client. If such a situation does exist, then the student will be placed on **clinical probation** and the outstanding requirement, will be added to their credits and requirements for clinic practice II.
2. **Upon completion of clinic practice II**; If a student has not met the credits and requirements stated in their letter of permission by the assigned due dates, then they will be placed on **clinical probation** and allowed to continue to clinic practice III.

\*\*If a student has consistently lacked effort and motivation, exhibited by: poor attendance, poor attitude and behaviour (lack of professionalism), the matter would go before the Dental Hygiene Program Committee and the student may be released. If a student exhibits consistently poor clinical skills or behaves in any manner which may put the client at risk, the matter would go before the Dental Hygiene Program Committee and the student may be released. Please be advised that if there were issues with any student, meetings would be held to address these issues in order to provide the student with opportunities to make positive changes before the situation should reach this point.

1. **Upon completion of Clinic Practice III:**

If a student does not meet all credits and requirements at the end of clinic practice III and is not eligible for remedial clinics, then they must apply to return to complete either a ½ semester of clinical sessions or a full semester of clinical sessions, depending on their clinical status. Please see below for criteria:

**Remedial Week:**

The Toronto College of Dental Hygiene and Auxiliaries understands that at times unforeseen circumstances may result in the student falling **slightly** behind in their clinical sessions. To address this situation, the TCDHA offers a week of **6 clinical sessions** to provide a chance for the student to complete all necessary credits and requirements. This is a privilege being offered to the student and is simply a chance for students to complete existing clients and requirements.

This is **not** a time period to begin new clients. The only exception would be for paedo clients. Students must have **completed 53 credits and all clinic practice II requirements, as of their final clinical session. They must provide evidence that completion of the remedial clinics will allow them to complete all Clinic Practice III credits and requirements. There is a fee for these clinics since remedial week falls outside of the regular Dental Hygiene Program Course hours.**

The Dental Hygiene Program Committee will decide if a student will be granted permission to participate based on the recommendations of the education coordinator(s).

**Repetition of 1/2 semester or a full semester**: Students must formally apply to repeat either ½ semester or a full semester. Applications will be available and students must provide evidence of their clinical plan to meet all credits and requirements.

Students can apply for either a ½ semester or a full semester. If a student applies for a ½ semester, and does not meet all credits and requirements, then they must apply again to repeat an additional ½ semester. The student cannot simply request 1 or 2 or any specific number of additional clinics. This is not a “pay as you go system”. Should a student need an additional ½ semester, it would go before the Dental Hygiene Program Committee for a decision.

Students must understand that they may be in competition for the available clinical chairs. Please see next page for criteria that will be used to assess all applications. It if turns out that a clinical chair is not available for the semester requested, then students may be placed in an upcoming semester. There is a fee to repeat either ½ or a full semester, since this falls outside of the regular Dental Hygiene Program course hours.

Additional Information:

\*If a student is granted permission to repeat a clinical semester then all unmet credits and clinical requirements **must** be completed in the additional semester. **No further clinic time will be offered and the student will not graduate.** Any repeated clinical semester will be reflected on the student transcript as: Clinic Practice II (RP) or III (RP). TCDHA will treat each student situation on an individual basis, and their student status will go before the Dental Hygiene program Committee. All decisions of the TCDHA program committee will remain as final. Students may, if they wish, make a formal appeal. Please refer to student policy and procedures manual.

Please be advised that if a student has fallen too far behind with client care, it may not be possible for the student to make up the time. It is imperative that each student demonstrate competency on a various group of clients. It is also imperative that the student successfully complete 22-25 clients. If a student is consistently falling below the required 70%, or is shown to be practising incompetently in any way, he/she will not be permitted to move to the next semester or to graduate.

The Toronto College of Dental Hygiene and Auxiliaries has a responsibility to the College of Dental Hygienists of Ontario, to the public of Ontario and to us to produce graduates who are ethical, competent and professional. We take these responsibilities very seriously.

**Criteria for students applying to return to program**:

The Dental Hygiene Program Committee will assess the following: Please also refer to the student policy and procedure manual: page 73.

1. Student clinical status (overall clinic performance, any outstanding clinic status alerts for the student).
2. Student didactic status (must be passing all didactics).
3. Knowledge, skills and attitude of the student.
4. Letter written by the student, explaining how they plan to be successful by being offered a chance to repeat a clinical semester.
5. The student must have completed 35 credits and all Clinic Practice II requirements, if applying for a ½ semester. If applying for a full semester the student must have completed all Clinic Practice II credits (25) and requirements. **This is not to include the 5 credits from the Evangel Hall placement.**

There must be a clinical chair available in order for the students to apply for an opportunity to repeat a clinical semester. Should there be more applicants than the number of chairs available; students will be evaluated based on their professionalism, and their final standing in the clinic. They will be placed in a ranking order and placed when a chair becomes available. This could mean that a chair may be offered to a student in an upcoming semester.

There is a fee to repeat a ½ or full clinical semester

**Should a student NOT meet the eligibility criteria listed above then they will be released from the program and will not be allowed to apply for any further clinical semesters to meet the eligibility criteria. TCDHA feels that students have been provided with ample time and opportunity.**

Part time students wishing to return as a full time student

Any student who has been withdrawn from the program in order to complete didactic courses must demonstrate competency before being accepted back into the clinical setting.

Students wishing to return to Clinic Practice I must show evidence of the following:

* A minimum of 18 practice hours in the pre-clinical lab. Students must sign in and out of the clinic to provide documentation of participation. Please note required hours may vary due to student situation.
* Re-evaluation of all instruments to be successfully completed to determine competency.

Students wishing to return to Clinic Practice II or III must show evidence of the following:

* A minimum of 18 practice hours in the pre-clinical lab. Students must sign in and out of the clinic to provide documentation of participation. Please note required hours may vary due to student situation.
* Re-evaluation of all instruments to be successfully completed to determine competency.
* Evidence of participation in 5 clinical sessions to provide assistance to other students and observe client care protocols
* Successful completion of a DD1 or DD2 client.

Please note: all requests to return as a full time student will go before the Dental Hygiene Program Committee for review. Students must pass the didactic course(s) in which they were not successful and they must complete all criteria listed above. **There is no guarantee that the student will be permitted to return.** Decisions are based on the knowledge, skills and attitude of the student. Their performance throughout the semester will be evaluated and their final mark in the repeated course assessed. The committee would review their attendance and hear input from faculty. All students requesting a return to full time status will be asked to submit a letter explaining what they would do differently to be successful.

Decisions are also based on the number of clinical chairs that are available.

The DHPC will assess all applications and will place the applications in priority sequencing. \*\*If there are not enough clinical chairs to offer a student a position, in the most current, upcoming semester, then the student can remain on the waiting list for the next available chair in the next semester.

Programs in Support of Student Success/Clinical Remediation

Please keep in mind that student success is our number one priority. Please keep all lines of communication open. If you require assistance please take advantage of the following programs;

1. **Student supported learning program**. This program was implemented to provide guidance and support to the students. It provides dialogue and feedback to the student allowing the student to be supported. Starting client care is a stressful time and having a situation where students will receive credit for a client regardless of the grade they receive helps to prepare the student for the evaluations which lie ahead. Please refer to page 32 of this manual for further details.
2. **Scaling for success program**. The pre clinic is open for supervised practice sessions for 2 hours every other week. Both an instructor and a student mentor are available for assistance. When a student is experiencing difficulty with hand skills it is beneficial to “go back to the basics” and review your techniques. This program is helpful to students in all semesters and is open to all students. The pre clinic lab also available for 2 hours for unsupervised practice time. Please note each student will be asked to sign in and out of the pre clinic lab sessions. If during client care, an instructor notices that a student is having difficulty, then they will refer the student to the scaling for success session. The instructor in the scaling for success will complete a formal report to verify attendance. This report will be scanned into the student file.
3. **Radiography Lab Support**. Exposing radiographs on clients for the first time presents the student with many new challenges. Please do not hesitate to ask the faculty for assistance as it is important to keep client exposure time to a minimum. Students will be observed formally for their first BWs, Panorex and FMS. However faculty are always available for support in the client care clinic. In addition, the radiography lab at Lodestar is open for continued practice. There is a supervised session. Please note all students will be asked to sign in and out for all radiography lab practice sessions. Please note that the radiography lab instructor or the clinic instructors may choose to refer you to the rad practice sessions. This will happen if you are struggling with your radiographic lab technique. In this case, students must provide evidence of attendance in the lab session.
4. **Clinical Advisor Program**: All students will be assigned a clinical advisor as of the start of Clinic practice II and III. Your advisor is here to support you and provide advice as needed. Your advisor will expect updates from you at weeks 6 and 15 during Clinic practice II and at weeks 5, 11 and 16 during Clinic practice III. Please have your tracking sheets and scheduling calendars up to date prior to meeting with your advisor. In addition, when you are submitting a post care, you must sign up with your advisor to evaluate your post care. If further assistance is required please schedule an appointment with your clinical advisor if you are having difficulties. If necessary a further meeting will be set up with the education coordinators. If you are in Clinic practice I and are experiencing difficulties please contact the education coordinator and she will organize the support you need.
5. **Student Assistance Program**: Please sign up on the “Student Requires Assistance” section of the Dental Hygiene Faculty sheet. For example: if you are having difficulty with debridement during your clinical session, please sign up and an instructor will come over and assist you. If it is determined that you need more help then the faculty member will have you complete the “Student requires assistance” form. (see 6 below). You may also choose to complete a form for more assistance.
6. If further additional assistance is required, please do not hesitate to complete “Student Requires Assistance” forms located in the clinic. They are then to be handed in to a faculty member and a time will be scheduled for the assistance to take place. This may require more intense one on one support.
7. **Clinic Remediation Program:** Throughout the client care portion of the program student progress will be tracked. Each student will have their own “Clinical Tracker Form” which will be maintained by faculty. This form is NOT the same form used by student to track their completed credits and requirements (“Client Summary Sheet“). Students having difficulty with any segment of ADPIE, resulting in a failing grade, will be identified and tracked.

The process is as follows: When a student is unsuccessful in any skill it will be noted on the tracker form.

If it is noted that a student has a deficiency in the same skill 3x then the student will meet with an education coordinator for remediation. The coordinator will identify the areas of concern and guide the student to the appropriate resources for support. Examples might be: referral to rad lab or scaling for success or additional practice sessions for taking alginates. It could also be as simple as one on one observation during a clinical session. If the student experiences difficulty a fourth time, then once again the coordinator will meet with the student to provide assistance. There are no fees for this additional support.

If it occurs once again (for the 5th time) a letter of warning will be issued and a formal tutoring session will be scheduled (there would be a fee to the student for this tutoring)

If it occurs for the sixth time then the student will receive a clinical status alert. More than one alert to any student may result in dismissal from the dental hygiene program.

**\*\*If client safety is compromised in any manner then a meeting with the education coordinator will take place after the first occurrence.**

**Awards and Recognition:**

**Student Mentor Program: (Formal and Informal)**

After the mid-point of Clinic Practice III, students will be assigned to act as student mentors. Student mentors will provide feedback to other students on all facets of client care. Student mentors will not assign grades, but are there to provide support in the learning environment. Participation in this process is not mandatory for the student; however, this experience has proven very beneficial to all involved.

Students who are part of the formal mentoring program will assist first year students in the pre clinic, radiography lab and dental materials lab. Please note participation in both mentoring programs is entirely on a volunteer basis. It is not an expectation of the learning environment.

**Golden Scaler Award:**

This award is presented to the student who has the “magic touch” with the scaler. It is presented to the student who consistently demonstrates thorough and safe instrumentation with all instruments.

**Clinical Excellence Award:**

This award is presented to the top overall clinic student. It is presented to the student who has exceeded the clinical requirements, maintains an overall clinical average of 90% or better, and who displays the spirit of teamwork and professionalism at all times.

**Professionalism Award:**

This award is presented to the student who displays ethical behaviour and who consistently presents themselves in a professional manner, both in the didactic, and the clinical setting.

**Evaluation Criteria**

Clinical Evaluation Procedure

The components of the evaluation process are as follows**:**

Assessment

1. Daily Care Plan Log
2. Medical/Dental Assessment
3. Cultural and Lifestyle Assessment
4. Extra/intra oral examination
5. Extra/Intra Oral Photos
6. Hard Tissue Charting
7. Radiographic Technique
8. Radiographic Interpretation
9. Complete Periodontal Assessment
10. Nutritional Assessment
11. Alginate Impressions

Dental Hygiene Diagnosis and Treatment Planning

1. Determination of Unmet Human Needs.
2. Client Goals, dental hygiene interventions
3. Treatment planning
4. The Daily Care Plan

Implementation:

1. Oral self-care education
2. Periodontal Debridement
3. Prophylaxis. (Full or selective)
4. Fluoride Treatment
5. Desensitization
6. Nutritional Analysis
7. Tobacco Cessation
8. Alginate Impressions
9. Fabrication and fitting of athletic sports guards
10. Fabrication and fitting of whitening trays
11. Pit and Fissure Sealants

Evaluation:

1. Post Care Evaluation
2. 4-6 week post care evaluation
3. Student Reflection
4. Chart Audit

As a general guideline: the grading system for each component of client care is as follows:

* 1. Excellent: performs all criteria consistently and accurately. No more than 1 error in the accepted criteria.
  2. Satisfactory: performs all criteria at an acceptable level. Requires minimal assistance from faculty member. No more than 2 errors from the accepted criteria.
  3. Unsatisfactory: skill requires improvement. Student requires substantial assistance from a faculty member. One major or 3 minor deviations from the accepted criteria.

1. Inadequate performance. Major improvement in the skill is required. Client care compromised due to student’s performance.

**Please note:**

There are seven components of the evaluation that will be issued a **minus** mark only.

They are the:

* medical history,
* prophylaxis (either selective or full),
* fluoride treatment,
* the daily care plan,
* the post care evaluation,
* student reflection and,
* the chart audit.

The criteria for all components will be listed in detail in the following pages.

**Evaluation for Clinic Practice 1 Partner Care and First Adult Client**

As noted previously in this client care manual, students will have opportunity during Clinic Practice, for their partner and 1st adult client), to complete clients without numerical grading. They will however be identified as being “SAT”, “Needs Improvement” or “Unsat”. Students will receive full credit for these clients unless it is determined that client care or safety has been compromised in any manner.

Students must still refer to the criteria on the following pages however instead of a numerical grade they will receive the following:

Satisfactory”

The student is able to complete the task with minimal assistance from the instructor. Student is able to critically think and engage in questions to promote learning. Is able to make decisions independently and can modify decisions if required Student practises safely and ethically following all protocols. Student presents themselves in a professional manner at all times to both the instructor and the client.

“Needs Improvement”

The student is able to complete the task but requires ongoing assistance and feedback from the instructor. Student needs help in decision making and may understand some points but not others. Critical thinking skills not as well developed. Student practises safely and ethically following all protocols. Student presents themselves in a professional manner at all times to both the instructor and the client.

“Unsat”

Student demonstrates that they are unable to complete the task. Student is lacking the skill to complete the task. Student is unable to think critically and is unable to make decisions; student behaviour and actions compromises client safety or care. Student does not practise ethically or present themselves in a professional manner.

**Daily Care Plan Log**

* Student completes daily care plan at each appointment for every client.
* Student has daily care plan available for instructor when the instructor arrives at the unit.
* Student sets out a goal(s), for each appointment.

-1 Student neglects to have daily care plan completed. Entries are hastily written.

-2 Student fails to have daily care plan ready for a second time on the same client.

**Medical /Dental Health History**

**Cultural and Lifestyle assessment**

* Student signs all forms. \*\*
* Performs a new complete medical history if it has not been done in 12 months or longer.
* Student recognizes the need for an interpreter to be present.
* Student recognizes when dental hygiene care should NOT proceed. \*\*
* Student reviews all information with the client. \*\*
* Records all information accurately, leaving no blank responses. Elaborates on all “yes” answers. \*\*
* Completes medical history update at each appointment: asks all update questions.\*\*
* Medical alerts are tagged appropriately \*\*
* Client has signed the medical history and all updates. \*\*
* Student signs the medical history and all updates. \*\*
* All vital signs are taken and recorded. \*\*
* All medications are noted, with dosage and frequency. All potential contraindications are noted.\*\*
* Follows up with the client’s physician if required. \*\*
* Client chart has been signed by self-initiating Dental Hygienist and authorization to proceed is noted in the Record of Care. \*\*
* All direction provided to student for client care is properly noted in the Record of Care: (Examples: but not limited to: INR numbers, Pre medication, taking of blood pressure)\*\*
* Cultural assessment is completed and all pertinent information applied in the process of care.

-1 Student neglects to record or perform **any one** of the above criteria.

-2 Student has 1 major error in the above criteria that may impact client care or safety. Or fails to perform 2 or more of the above

criteria. A major error is missing criteria that are noted above as \*\*.

All medical histories will be reviewed by the Dental Hygiene Faculty. If the client’s health is compromised in any way, the Registered Dental Hygienist may collaborate with the DDS on the clinic floor or with the family physician. If a student proceeds without having the client’s health history reviewed and authorization to proceed documented by the Dental Hygiene Faculty, then an automatic mark of -2 and no clinical credits will be provided to the student. This applies both to the initial medical history and any medical history updates.

**Intra/Extra Oral Examination**

* Uses a systematic approach to examination and questions client upon all findings observed.
* Student is able to discuss all findings with Dental Hygiene Faculty.
* Notes any changes in client’s record of care at each appointment.
* Uses correct terminology to describe any and all findings.
* Reviews findings at each and every appointment.
* At the 3 or 4 month recare interval reviews findings and documents that they have been reviewed at the bottom of the IO/EO page and in the ROC.
* Notes any variations from normal, taking care to measure and document effectively.
* Recognizes the need for consult and/or referral.
* Takes appropriate intra/extra oral client photos. Photos are clear and diagnostically acceptable. Takes both pre op and post op photos.

4- Excellent: performs all criteria consistently and accurately. No more than 1 error in the accepted criteria.

3- Satisfactory: performs all criteria at an acceptable level. Requires minimal assistance from faculty member: no more than 2 errors from the accepted criteria.

2- Unsatisfactory: skill requires improvement. Student requires substantial assistance from a faculty member. Three or more errors from the accepted criteria: OR Fails to note any type of obvious finding which may impact the client’s oral or overall health. Examples would be obvious masses, or pathologies.

1- Inadequate performance. Major improvement in the skill is required. Client care is compromised due to student’s performance.

Fails to note any type of obvious lesion which may impact the client’s oral or overall health.

**Hard Tissue Charting**

* Follows a sequence and properly records all findings.
* Has completed a caries risk assessment for the client.
* Odontogram is an accurate representation of the mouth.
* Student is able to discuss all findings.
* Correctly identifies all restorations.
* Correctly notes furcations and mobilities.
* Correctly notes bone levels
* Correctly notes any pathologies or artefacts
* Records occlusion and all anomalies.
* Notes suggested caries only; to be verified by DDS.
* Records all findings of the DDS at the side of the odontogram and then adds the appropriate symbols to the form.
* Ensures that all radiographic findings are transferred to the odontogram.
* Ensures that charting is signed by DDS
* For the 3 month and 4 month continued care appointments, student has noted in the ROC that all previous findings have been reviewed and list any changes which have taken place.

4-Excellent: performs all criteria consistently and accurately. No more than 1 error in the accepted criteria.

3-Satisfactory: performs all criteria at an acceptable level. Requires minimal assistance from faculty member. No more than 2 errors from the accepted criteria.

2-Unsatisfactory: skill requires improvement. Student requires substantial assistance from a faculty member. One major or 3 minor deviations from the accepted criteria.

1-Inadequate performance. Major improvement in the skill is required. Client care compromised due to student’s performance.

**TCDHA recognizes that it is not in the scope of practice of the Dental Hygiene Student to diagnose dental conditions. However, it is important for the student to recognize that these conditions exist and bring it to the attention of the DDS. It is an opportunity for mutual dialogue and critical thinking.**

**TCDHA recognizes that some clients present with a degree of difficulty that is harder than others. Faculty will take that into account during the evaluation process.**

**\*\***\*\*Students are encouraged to assess whether a client may be a suitable client for sealants. Once it has been determined by the DDS that the client is free of decay then students may treatment plan for sealants, if appropriate. The dental hygiene faculty will then assess the client and authorize the student to proceed.

\*\*The registered dental hygienist can make the decision to proceed with dental sealants. He/she does not require a DDS to approve or authorize them.

**Radiographic Technique**

* Student provides rationale to DDS as to why radiographs should be exposed and has completed the radiographic needs assessment form in the client chart, complete with all signatures.
* Student has prescribed order from DDS for radiographs.
* Student has discussed the need for radiographs with the client.
* Student explains radiographic procedure to client.
* Student follows all safety protocols for the exposure of radiographs. Lead apron must be on client. \*\*failure to do so will result in automatic grade of 1
* Required images are displayed.
* No elongation or foreshortening.
* No interproximal overlap.
* No cone cut.
* Occlusal plane is positioned across the centre of the film (BW).
* Tooth is centred on the film (periapicals).
* Panoramic film is properly positioned and images are diagnostically acceptable.
* Radiographs are diagnostically acceptable

4- Student requires no assistance from a faculty member.

Radiographs meet all criteria listed above with no more than 1 criteria missing, and are diagnostically acceptable.

3- Satisfactory: performs all criteria at an acceptable level. Requires minimal assistance from faculty: no more than 2 criteria missing. Radiographs are diagnostically acceptable.

2- Student produces radiographs that fail to meet 3 or more

criteria listed above. Radiographs are diagnostically

unacceptable.

1- Radiographs are of unacceptable quality. 4 or more of the above criteria are missing: OR Client safety is compromised by unsafe radiographic protocol.

**TCDHA recognizes that some clients present with various challenges when exposing radiographs. Faculty will take that into account during the evaluation process.**

**\*\*Please note that all students will be observed during their first exposure of BWS, FMS and a panorex. This is to provide support to the student. Please see next page. This is not an evaluation form, simply a record of the observation.**



Radiography Observations

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

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Exposure (please circle): BW FMS PAN

|  |  |
| --- | --- |
| Operatory is prepared prior to client arrival. |  |
| Appropriate infection control barriers are placed. |  |
| Student seats client and explains procedure. |  |
| Student places lead apron. |  |
| Student places film correctly. |  |
| Student uses critical thinking skills when faced with challenges during film placement. |  |
| Chooses appropriate exposure time. |  |
| Client is dismissed and escorted back to dental hygiene chair. |  |
| Student scans image following proper infection control procedures. |  |
| Student maintains constant and appropriate communication skills during procedure. |  |

Instructor Name:\_\_\_\_\_\_\_\_\_\_\_ Instructor Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Radiographic Interpretation**

* Student is able to identify anatomical landmarks in both the dentition and the surrounding structures.
* Student is able to discuss any radiographic errors and provide the explanation for their occurrence.
* Student is able to discuss how to correct any errors.
* Student is able to discuss with the dentist any pathological conditions.
* Student is able to recognize bone loss and connect their radiographic findings to their clinical findings.
* Student is able to incorporate their findings into the Dental Hygiene diagnosis.
* Student transfers their radiographic findings onto the odontogram.

4- the student interprets the radiographs following all criteria listed above, with no more than 1 criteria missing from the above list.

3- the student has a satisfactory understanding of radiographic

interpretation. No more than two errors in the above criteria is permitted.

2- Student is unable to interpret the radiographs without assistance from the dentist. The student fails to recognize or record obvious abnormalities that may affect the diagnosis of the client.

1- Student is unable to interpret the radiographs. Unable to detect anomalies that could put the client at risk.

**TCDHA recognizes that some clients present more complex radiographic findings. Faculty will take that into account during the evaluation process.**

**Periodontal Assessment**

* Accurately records the location of all soft and hard deposits.
* Accurately records the plaque index.
* Accurately records all probing depths (to within 1 mm).
* Determine the need for pain control.
* Accurately records all points of bleeding and determines the bleeding index.
* Records all findings of CAL four and above in red.
* Accurately records all areas of recession and gingival overgrowth on the Gingival Margin Line.
* Properly assesses and records loss of attached gingiva.
* Records tooth mobility and furcation involvement.
* Recognizes and accurately records all changes in colour, consistency, texture, contour and bleeding with the gingiva.
* Recognizes the need for a consult and/or referral.
* Accurately records a suggested gingival and periodontal condition.
* Suggested condition matches assessment findings
* Determines appropriate periodontal case type (based on the American Academy of Periodontology Classification of Periodontal Disease)

4- Excellent, thorough assessment. Performs all criteria accurately with no more than 1 missing criteria. All probing depths recorded to within 1mm of clinical instructor.

3- Student requires minor assistance from faculty member. No

more than 2 missing criteria from the list above.

2- Student requires major assistance from faculty to complete assignment. Three or more of the above criteria are not met. More than 3 probing depths are inaccurately recorded (greater than >2 mm).

1- Student unable to complete assignment. Client care is at risk

due to misinterpretation of the data. Findings are generalized

inaccurate.

**TCDHA recognizes that some clients present with a degree of difficulty that is harder than others. Faculty will take that into account during the evaluation process.**

**Dental Hygiene Diagnosis**

**Goals and Treatment Planning**

* Identifies client’s oral health priorities in conjunction with the client, addressing all cultural values and beliefs.
* Has completed a caries risk assessment for the client.
* Identifies the client’s human needs in order to create a Dental Hygiene Diagnosis.
* Involves the client at all times.
* With the assistance of the client, develops a series of client-centered goals.
* Develops an individualized treatment plan with the client.
* Provides appropriate dental hygiene interventions to meet set client centered goals.
* Develops appropriate treatment sequencing and clearly notes the type of OSC to be provided at each appointment.
* Notes any adjunctive treatment in plan: Eg: use of ultrasonics or topical anaesthetic.
* Does not note all required appointments (inclusive of 4-6 week re-evaluation appointment)
* Modifies the treatment plan if required and is able to explain the rationale behind the treatment plan.
* Explains the treatment plan and ensures that the client understands the treatment plan in order for the client to provide informed consent and/or informed refusal. \*\* see below
* Both the student and the client sign treatment plan\*\* see below
* Faculty has signed the proposed treatment plan. \*\* see below
* All revisions have been signed by client, student and faculty.
* Shows evidence of ongoing evaluation in treatment plan.

4- Excellent: performs all criteria consistently and accurately. No errors in above criteria

3- Satisfactory: performs all criteria at an acceptable level. Requires minimal assistance from faculty member: No more than 1 error in the accepted criteria.

2- Unsatisfactory: skill requires improvement. Student requires substantial assistance from a faculty member. Two or more errors in the accepted criteria.

1- Treatment plan is unacceptable and fails to address the client’s needs. Client or student does not sign treatment plan.

**\*\*If student proceeds without signatures from client or faculty, they will automatically be given a grade of “1” and will not receive credit for the client. Or if it appears that the client does not understand what is being said to him/her and the student has had them sign the treatment plan knowing the client does not understand, a grade of “1” will be given. Regardless of penalties or loss of credit assigned the student must complete all care planned for the client.**

**Implementation**

* The implementation section will focus on the student’s ability to detect and remove the calculus deposits.
* Consideration will be given to the degree of difficulty that the client presents. Additional factors such as sensitivity, accessibility, amount of stain, and client cooperation will be taken into account.
* Consideration will also be given to the student’s ability to detect the calculus and to discuss strategies used to remove the calculus.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Degree of Difficulty | Grade  4 | Grade  3 | Grade  2 | Grade  1 |
| Pieces of Calculus Remaining  DDO/DD1  (per ½ mouth) | 2 | 3 | 4 | 5+ |
| Pieces of Calculus Remaining  DD2  (per quad) | 2 | 3 | 4 | 5+ |
| Pieces of Calculus Remaining  DD3 (per quad) | 3 | 4 | 5 | 6+ |
| Pieces of Calculus Remaining  DD4  (per sextant) | 3 | 4 | 5 | 6+ |

To be considered as a full credit, the client must have a minimum of 15 teeth. If less than 15, the client will be considered as a ½ credit.

If there is tissue trauma, an additional -1 will be deducted from the implementation grade. If there is excessive or undue trauma, an additional -2 will be deducted from the student’s implementation grade. Students will also be expected to attend scaling for success to review instrumentation techniques. A professionalism penalty may also be issued.

**Coronal Polish**

* Reviews the client’s health history for any contraindications.
* Performs coronal polish on an individualized basis (either selective or full polish)
* Explains coronal polish procedure to the client.
* Chooses an appropriate prophylaxis paste.
* Removes all surface stain.
* Flosses all polished proximal surfaces.
* Does not produce any trauma to the tissue.
* Follows all protocol for proper handling of the handpiece/client operator positioning and fulcruming.

0 Excellent polish. No areas of stain remain.

-1 Student requires minimal assistance. No more than 2 areas of

Easily removed stain remains. Improper technique is utilized.

-2 Requires ongoing assistance from faculty. More than 3 areas of easily removable stain remains. Tissue was traumatized or clients medical history contraindicated a selective polish. Student does not use a proper fulcrum, or is running the handpiece at a speed which was inappropriate.

For clarification on how technique is evaluated in the partner care clinic please refer to following page.



**Coronal Polishing Competency Evaluation**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Partner Care Evaluation: □

|  |  |  |  |
| --- | --- | --- | --- |
| **Criteria** | **Faculty Comments** | **Sat** | **Unsat** |
| 1. Student has explained procedure to client and has determined whether a full or selective polish is required. |  |  |  |
| 2. Student has prepared proper armamentarium for the procedure |  |  |  |
| 3. Student demonstrates proper client/operator positioning. |  |  |  |
| 4. Student hold handpiece and mirror in a modified pen grasp |  |  |  |
| 5. Proper use of fulcrum is demonstrated. |  |  |  |
| 6. Speed of the polishing cup is controlled. |  |  |  |
| 7. Adaptation of the polishing cup allows for access to inter proximal surfaces. |  |  |  |
| 8. Student uses short overlapping strokes with a moderate pressure. |  |  |  |
| 9. Student follows a logical sequence. |  |  |  |
| 10. Student utilizes appropriate evacuation techniques |  |  |  |
| **Student must meet all criteria to receive a “SAT”**  **in coronal polish.**  **Instructors Signature** |  |  |  |

**Fluoride Treatment**

* Accurately determines the need for a fluoride treatment.
* Selects the correct size of tray and type of fluoride.
* Explains the benefits and procedure to the client. \*\*
* Client is seated in an upright manner. \*\*
* Dries the teeth in an appropriate manner.
* Isolates the teeth.
* Uses proper oral evacuation.
* Places the trays to allow for proper uptake of the fluoride.
* Places the mandibular tray first and then the maxillary tray.\*\*
* Constantly supervises the client.
* Removes all the fluoride effectively.
* Provides the client with post-operative instructions.

-1 Performs the procedure with one minor error in the above

Criteria which would not affect the effectiveness of the

procedure. Minor errors are \*\*above.

-2 any omission of the above criteria that would affect the

effectiveness of the procedure.

.



**Fluoride Treatment Competency Evaluation**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Partner Care Evaluation: □

|  |  |  |  |
| --- | --- | --- | --- |
| **Criteria** | **Faculty Comments** | **Sat** | **Unsat** |
| 1. Assembles equipment |  |  |  |
| 2. Seats client in upright position. Reiterates benefits. |  |  |  |
| 3. Tries tray of appropriate size. Complete dentition must be covered, including areas of recession. |  |  |  |
| 4. Loads fluoride gel into trays with appropriate amount based on client. |  |  |  |
| 5. Dries teeth with air syringe or 2x2 gauze (client specific) |  |  |  |
| 6. Inserts lower tray then upper tray to reduce moisture. |  |  |  |
| 7. Presses trays against teeth, and asks client to close mouth and bite gently on trays. |  |  |  |
| 8. Places saliva ejector over mandibular tray. Set timer for 4 minutes. Never leaves client unattended during procedure. |  |  |  |
| 9. Instructs client not to eat, drink, smoke, or rinse for 30 minutes. |  |  |  |
| 10. Tilts chin down to remove trays. |  |  |  |
| 11. Suctions excess fluoride from the mouth; asks client to expectorate. |  |  |  |
| **Student must meet all criteria to receive a “SAT”**  **in Fluoride Treatment.**  **Instructors Signature:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |  |

**Alginate Impressions/Study Models**

* Provides rationale for taking alginates
* Proper tray selection.\*\*
* Explains procedure to client.
* Tuberosity and retro molar pad area is included. \*\*
* Peripheries display rolled borders.
* Voids or air bubbles are not present.
* Tray metal should not be exposed.
* Tray was seated properly. \*\*
* Proper use of utility wax on border of trays\*\*
* Client management was effective.

SAT Excellent impression, fulfilling all of the above criteria OR No more than one error in the accepted criteria.

UNSAT: Unacceptable impression. 2 or more errors in the accepted criteria OR one error in the criteria which would compromise the quality of the impression. Errors which would compromise quality are \*\* above.

\*Trays will be graded together by the Dental Hygiene Faculty. **Also: You will be graded on your first set of impressions.**

If one of the impressions is NOT diagnostically acceptable then a grade of UNSAT will apply.

**\***Taking alginates is not a controlled act and it is up to the student to determine when taking alginates may be appropriate. Alginates can be a valuable tool during the assessment phase of client care, or of course in preparation for the fabrication of an athletic mouth guard or whitening tray. Please discuss your rationale for taking alginates with the dental hygiene faculty and be sure to treatment plan for them.

\*Please note that students must pour up the study models and submit them to the DH faculty in order to be given a requirement credit for alginates.

**Pit and Fissure Sealants**

* Explains the treatment to the client.
* Student maintains a dry operating field.
* Sealant is applied correctly.
* Follows manufacturer’s instructions.
* Sealant does not overflow into the interproximal areas.
* Sealant does not interfere with occlusion.
* Student checks occlusion

4- Student performs all criteria without error.

3- Student performs sealants of an acceptable quality. Minor

adjustments may be required to reduce an overfill of the

material.

2- Sealant is diagnostically unacceptable. Voids are present,

or student fails to recognize an overfilled sealant.

1- Sealant is diagnostically unacceptable. Student neglects to

follow manufacturer’s instructions. Sealant may be removed

from the tooth with an explorer.

TCDHA Policy on Sealants:

Students should be actively evaluating a client’s dentition to determine if they would be a suitable candidate for pit and fissure sealants. Once it has been determined by the DDS that there is no decay present on the proposed teeth then please discuss your treatment plan with the RDH faculty and of course your client. Be sure to treatment plan for them and have your client sign your treatment plan.

\*\*The registered dental hygienist can make the decision to proceed with dental sealants. He/she does not require a DDS to approve or authorize them.

**Sports Guard**

* Presents properly trimmed, horse shoe shaped model (single pour), labelled with client’s name and date.
* Adapts tightly to study model without distortion.
* Fits sports guard over client’s dentition and assesses for proper fit.
* Trims sports guard to ensure adequate protection of tooth structure.
* Ensures that sports guard does not impinge on frena.
* Assesses stability and balance on sport guard.
* Adjusts sport guard as necessary.
* Discusses home care for sports guard with client.
* Documents treatment in client chart as per all regulatory guidelines.
* Performs procedure without compromising client safety.

For each competency noted above students receive a mark of:

S=2

NI=1

U=0

SAT: Student performs this task with a minimum grade of 14/20

UNSAT: Student performs this task with a total grade of 13 or less.

**Please refer to evaluation form for Sports Guards on the following page.**

**\*\*Please note: when fabricating a sports guard, students must complete the procedure from start to finish. For example: a student cannot have another student complete only the alginate portion of a sports guard fabrication.**

**SPORT GUARD (SG) COMPETENCY EVALUATION FORM FOR CLINICAL PRACTICE II &III**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Criteria | S | NI | Unsat | Comments |
| 1. | Presents properly trimmed, horse shoe shaped, model (single pour), labelled with client’s name and date. | 2 | 1 | 0 |  |
| 2. | Adapts tightly to study model without distortion | 2 | 1 | 0 |  |
| 3. | Fits Sports Guard over client’s dentition and assesses for proper fit. | 2 | 1 | 0 |  |
| 4. | Trims Sports Guard to ensure adequate protection of tooth structure (Facial is about 10 mm from the gingival margin. Lingual is about 15 mm from the gingival margin) | 2 | 1 | 0 |  |
| 5. | Ensures that sports guard does not impinge on frena. | 2 | 1 | 0 |  |
| 6. | Assesses stability and balance of occlusion on Sports Guard | 2 | 1 | 0 |  |
| 7. | Adjusts Sports Guard as necessary. | 2 | 1 | 0 |  |
| 8. | Discusses home care for Sports Guard with client. | 2 | 1 | 0 |  |
| 9. | Documents treatment in chart as per all regulatory guidelines. | 2 | 1 | 0 |  |

**Clients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 10. | Performs procedure without compromising client safety. | 2 | 1 | 0 |  |

**Instructor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Total: \_\_\_\_/20 (>14 Sat)**

**Whitening Tray Competency**

* Checks client’s medical/dental history for contraindications.
* Advises client to begin whitening at conclusion of full mouth debridement.
* Presents properly trimmed, horse shoe shaped, model (single pour), labelled with client’s name and date.
* Whitening trays are trimmed with scalloped borders following the gingival margins.
* Trays adapt tightly to study models with no flared edges.
* Trays are smooth and clean. No jagged edges, pen marks or trimming debris.
* Trays are fitted over the client dentition and assessed for proper fit. Trays should extend over teeth, just to the gingival crest, and adapt tightly to the teeth.
* Opens whitening kit and explains how to fill trays as per manufacturer’s instructions.
* Reviews procedure, expected outcomes and potential side effects.
* Reviews strategies for sensitivity/gingival trauma treatment.
* Ensures client understands instructions and sets up appropriate follow up.
* Pre-treatment shade taken and documented in ROC.

For each competency noted above students receive a mark of:

S=2

NI=1

U=0

SAT: Student performs this task with a minimum grade of 17/24

UNSAT: Student performs this task with a total grade of 16 or less.

\*\*\*Fabricating a whitening tray is not a required clinical competency in the TCDHA clinic setting. The evaluation form is provided to allow the student to be aware of the criteria for a properly fitting tray. If the tray does not fit properly students must re fabricate the tray for the client. Please refer to form on the following page.

**WHITENING COMPETENCY EVALUATION FORM FOR CLINICAL PRACTICE II & III**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Criteria | S | NI | Unsat | Comments |
| 1. | Checks client’s medical/dental history for contraindications. | 2 | 1 | 0 |  |
| 2. | Advises client to begin whitening at conclusion of full mouth debridement. | 2 | 1 | 0 |  |
| 3. | Presents properly trimmed, horse shoe shaped, model (single pour), labelled with client’s name and date. | 2 | 1 | 0 |  |
| 4. | Whitening trays trimmed with scalloped borders following the gingival margins. | 2 | 1 | 0 |  |
| 5. | Trays adapt tightly to study models with no flared edges. | 2 | 1 | 0 |  |
| 6. | Trays are smooth and clean. No jagged edges, pen marks or trimming debris. Facial and lingual of trays have scalloped margins. | 2 | 1 | 0 |  |
| 7. | Trays fitted over client dentition and assessed for proper fit. Trays should extend over teeth, just to the gingival crest, and adapt tightly to teeth. | 2 | 1 | 0 |  |
| 8. | Opens whitening kit and explains how to fill trays as per manufacturer’s instructions. | 2 | 1 | 0 |  |
| 9. | Reviews procedure, expected outcomes and potential side effects. | 2 | 1 | 0 |  |
| 10. | Reviews strategies for sensitivity/gingival trauma treatment. | 2 | 1 | 0 |  |
| 11. | Ensures client understands instructions and sets up appropriate follow-up. | 2 | 1 | 0 |  |
| 12. | Pre-treatment shade taken and documented in ROC. | 2 | 1 | 0 |  |

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Instructor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Total**: \_\_\_\_/24 (>17 Sat)**

**Oral Health Education evaluation form:**

|  |  |
| --- | --- |
| ORAL HEALTH EDUCATION EVALUATION  Student: Group:  Date: Client: | |
| Component | Criteria |
| **Communication Skills** | □ Communicates at eye level with client  □ Applies effective listening skills  □ Culturally sensitive  □ Assists client in decision making process  □ Clarification: asks open ended questions to client, answers questions appropriately in a proper tone of voice using appropriate terminology for the client’s level of understanding |
| **Assessment** | □ Establishes client’s chief concern  □ Identifies client’s current OSC practices  □ Identifies client’s human needs deficit  □ Determines client’s goal for oral health  □ Ascertains new client-centered oral hygiene practices |
| **Theory** | □ Presents client’s current oral condition  □ Provides accurate disease theory  □ Uses appropriate visual aids  □ Informs client of potential outcomes (for example radiographs, but not limited to this)  □ Informs client of potential outcomes if changes are not made  □ Identifies short and long term goals |
| **Skills Enhancement** | □ Provides rationale for new techniques or aids  □ Uses disclosing solution  □ Demonstration provided intra-orally (model used ONLY when required for asepsis)  □ Client demonstrates technique in own mouth (mirror provided)  □ Clinician modifies technique as necessary |
| **Effective Teaching**  **Methodology** | □ Information presented incrementally  □ Uses positive re-enforcement and assists with motivation  □ Asks for feedback continually from client (determines client’s comprehension of all information, using the learning ladder).  □ Remains in dialogue with client. |

Satisfactory

1. All aspects of the assessment, theory, skills enhancement, teaching methodologies and communication skills are used.

2. No/minimal assistance from the instructor is required. This includes correction of incorrect information.

3. OHE delivered in an appropriate client-centered manner.

Unsatisfactory

Student fails to integrate 3 or more criteria. Faculty Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nutritional counselling evaluation form: 24 hour Diary**

**Please let faculty know that you wish to have Your nutritional counselling evaluated. They will complete the evaluation and save it in your student E file this form must be completed in oredr to receive credit for the requirement.**

**clients Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**students name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| **Criteria** | **Faculty Comments** | **Sat** | **Unsat** |
| 1. Recognizes factors in clients health & dental history that indicates need for nutritional counselling |  |  |  |
| 2. Student utilizes and includes Canada’s Food Guide for diet analysis and is able to categorize foods eaten into the proper food groups. |  |  |  |
| 3. Student considers social and cultural factors when making recommendations during nutritional counselling |  |  |  |
| 4. Student includes a nutritional assessment summary |  |  |  |
| 5. Incorporates client-centred goals that are measurable &/or observable in treatment plan. |  |  |  |
| 6. Includes a nutritional counselling plan by appointment and is appropriate |  |  |  |
| 7. Utilizes appropriate communication skills |  |  |  |
| 8. Provides an appropriate time frame and measures for continued evaluation. |  |  |  |
| 9. Accurately records appropriate information in client chart (ROC) |  |  |  |
| 10. Completes a summary and future need for a 3 day analysis. |  |  |  |
| **4 or more criteria not met is considered unsat**  **Total Score / 10**  **Instructors Signature / Date** |  |  |  |

**Nutritional counselling evaluation form: 3 Day Analysis**

**Please let faculty know that you wish to have Your nutritional counselling evaluated. They will complete the evaluation and save it in your student E file this form must be completed in oredr to receive credit for the requirement.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Criteria** | **Faculty Comments** | **Sat** | **Unsat** |
| 1. Recognizes factors in clients health & dental history that indicates need for nutritional counselling |  |  |  |
| 2. Student utilizes and includes Canada’s Food Guide for diet analysis and is able to categorize foods eaten into the proper food groups (includes 3 day diary) |  |  |  |
| 3. Student considers cultural factors when making recommendations during nutritional counselling |  |  |  |
| 4. Student includes a detailed nutritional assessment, conclusions, and a list of recommended foods or a menu plan for one day. |  |  |  |
| 5. Able to clearly discuss current &/or potential oral health deficits as related to the human needs theory. Identifies cariogenic foods. Provides explanations of which food are/not cariogenic in their carbohydrate analysis. |  |  |  |
| 6. Incorporates client-centred goals that are measurable &/or observable |  |  |  |
| 7. Includes a nutritional counselling plan by appointment and is appropriate |  |  |  |
| 8. Utilizes appropriate communication skills |  |  |  |
| 9. Provides an appropriate time frame and measures for continued evaluation in ROC |  |  |  |
| 10. Accurately records appropriate information in client chart |  |  |  |
| **4 or more criteria not met is considered UNSAT. Total Score: /10**  **Instructors Signature** |  |  |  |

**TOBACCO CESSATION EVALUATION FORM**

**Please let faculty know that you wish to have Your tobacco cessation program evaluated. They will complete the form and save it in your student e file. this form must be completed in oredr to receive credit for the requirement.**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| **Criteria** | **Faculty Comments** | **Sat** | **Unsat** |
| 1. Assesses clients need for tobacco cessation based on medical and dental health history. |  |  |  |
| 2. Has client complete a tobacco cessation assessment form. |  |  |  |
| 3. Accurately recognizes the clients’ stage of readiness for change. |  |  |  |
| 4. Able to clearly discuss current and or potential oral health deficits as related to the human needs theory. |  |  |  |
| 5. Incorporates client-centred goals with appropriate time frames. |  |  |  |
| 6. Includes a tobacco cessation treatment plan by appointment and is appropriate. |  |  |  |
| 7. Able to discuss withdrawal symptoms and suggest coping strategies. |  |  |  |
| 8. Utilizes appropriate communication skills. |  |  |  |
| 9. Provides an appropriate time frame and measures for continued evaluation. |  |  |  |
| 10. Accurately records appropriate information in client chart. |  |  |  |
| **Recommendation : > 7/10 Satisfactory Total # of Sat: /10** | | | |
| **Instructor Signature:** | | | |

**Student reflection form**

* Student self-assesses themselves according to criteria listed on the reflection form.
* Student submits 1 clinical reflection on each client experience. Please see specific criteria on following page.

-1 Student neglects to submit a reflection with the post care.

Please refer to reflection form on the following page.



**Clinical Reflection: Please complete 1 per client and submit with post care;**

Date: \_\_\_\_\_\_\_\_\_\_\_ Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_D of D: \_\_\_\_\_

Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What moment(s) during the treatment of this client would you consider the most beneficial in your learning process?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. What measures could you have implemented for a more positive experience for your client? for yourself?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. What did this experience teach you and how can you connect this experience to what you have learned in the Dental Hygiene Program? Which program outcome(s) do you feel that this experience has enabled you to reach?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Faculty Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Faculty Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Post Care Evaluation**

* Student submits post care within 10 business days of client’s last visit.
* Student has performed all post care indices (plaque and bleeding) and determines success of treatment plan.
* Student determines if all goals were met, partially met or not met. Explains why goals were partially or not met.
* Student reassesses client’s oral self-care.
* Student determines if a 4-6 evaluation is required.
* Student has performed a new recording of probing depths to determine outcome. (This is done at the 4-6 week revaluation)
* Student explains to client all results and further dental hygiene recommendations.
* Student selects appropriate continuing care interval for the client and is able to provide the client with the rationale of the decision.
* Student works with the client at all times to keep them involved in the evaluation process.
* Student discusses any follow up treatment or referrals required.
* Student reports on client satisfaction.
* Student submits client feedback form.

-1 Student is unable to make clear connections between pre and post care indices. Goals are not identified as having been met. Post care evaluation form is incomplete. Re care interval is not appropriate for client.

-2 Student fails to complete post care evaluation for the client.

Student fails to understand the rationale behind required

future needs of client. Student fails to complete all post-care indices.

**Students must submit their post care within 10 business days of the client’s final visit: failure to do so will result in a loss of all credits for the client. If there are extenuating circumstances, students are to inform their clinical advisor.**

**Chair side Chart Audit**

* Student is ready at the end of each appointment to have the chairside audit completed.
* Student recognizes when a criteria has not been met or is not applicable.
* Student is able to identify deficiencies in the client care chart and offer solutions to make the necessary corrections
* Student ensures that ALL signatures in the client chart are in place.
* Upon submission of post care: student has signed the chart audit.
* Upon submission of the post care and completed audit: Once deficiencies in a client chart have been identified by faculty the student makes the necessary corrections within appropriate time period.
* Student follows CDHO guidelines for record keeping

-1 Student submits the audit without signing it: OR there is 1 deficiency in the client chart NOT recognized by the student.

-2 Student submits the chart audit failing to note 2 deficiencies in

the client record.

-3 Student does not follow CDHO guidelines for recordkeeping; 3 or more deficiencies in the client chart. Complete lack of adherence to record keeping guidelines. Authorization for controlled acts is not indicated in the client ROC. Student fails to note the time in minutes for all DH interventions.

In addition to chairside audits student will have **random chart audits** performed by the TCDHA chart audit team. Should a random audit reveal further deficiencies not identified chairside by the student, the student will be notified and a clinical professionalism penalty may be issued. Please refer to next page for random chart audit criteria.

Name of Auditor:



Random Chart Audit

Client: Complete: □

|  |  |  |  |
| --- | --- | --- | --- |
| **Assessment Guideline for Identified Deficiencies** | **Yes** | **No** | **Comments** |
| An initial medical history and updates are in client record. |  |  |  |
| The clinical assessment is complete and supports the dental hygiene diagnosis. \* client interviews, health, cultural, dental and pharmacological history, clinical (IO/EO and Perio Assessment) and radiographic examination. |  |  |  |
| An individual dental hygiene treatment plan has been established and includes:   1. goals/objectives 2. sequence of activities 3. client participation |  |  |  |
| The client’s informed consent for treatment has been obtained. |  |  |  |
| The date and particulars of each professional contact with the client is documented in accordance with the CDHO proposed record keeping regulation |  |  |  |
| A clinical re-assessment is performed and the dental hygiene treatment plan is reviewed and modified as required |  |  |  |
| The client has received appropriate recommendations and instructions in oral self-care |  |  |  |
| The registrant consults and/or refers to other health professionals as required |  |  |  |
| Other |  |  |  |

Satisfactory: □ Needs Improvement: □

Unsatisfactory: □ Student to meet with auditor? Yes: □ No: □

Further Charts to be audited: yes: □ no: □ Revision’s to be handed in by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Audit successful yes no

**Chart Audit Criteria;**

**Considered Satisfactory:**

1. **Initial medical history and updates are in the client record.**
2. **Clinical assessment is complete and supports the DH diagnosis.**
3. **Student addresses all client unmet human needs creation of their DH diagnosis.**
4. **An individual DH treatment plan has been established and includes: sequence of activities and client participation.**
5. **Informed consent has been obtained both in initial treatment plan and in treatment revisions.**
6. **The particulars of each professional contact with the client are documented in accordance with CDHO record keeping regulation.**
7. **A clinical re assessment has been performed and the DH treatment plan is reviewed and modified as required.**
8. **The client has received appropriate recommendations and instructions in home care.**
9. **The student has consulted with Dental Hygiene Faculty on the clinic floor and with the DDS to provide appropriate consults or referrals as needed.**

**Needs Improvement (minor changes needed):**

1. **Missing signatures or dates (that do not impact client care; examples would be student signature on referral form, or missing faculty signature on learning journal. 2 or more missing considered unsatisfactory)**
2. **Clinical assessment contains 1 or 2 minor errors in documentation.**
3. **DH treatment plan although established does not meet all the needs of client.**
4. **Client record does not note all discussions with the client.**
5. **Ongoing evaluation is not evident.**
6. **Clinical re assessment has not been completed effectively; recommendations do not meet the client’s needs.**
7. **Recommendations or instructions for client are not client specific.**
8. **Record of care is not completed in detail; including oral self care given**
9. **Sequence of care in treatment plan does not correspond with record of care**

**Considered Unsatisfactory:**

1. **Initial medical history and updates are NOT in the client record.**
2. **Clinical assessment is incomplete and does not support the Dental Hygiene Diagnosis. Errors could affect the potential care of the client.**
3. **An individual DH treatment plan is evident but does not meet the needs of the client.**
4. **Informed consent not obtained.**
5. **The particulars of each client contact are not evident in the client record.**
6. **No evidence of post treatment indices or evaluation of the tissues to indicate that a clinical re assessment has been completed. Student fails to modify the treatment if required.**
7. **Continuing care interval is not appropriate for the client.**
8. **Recommendations and instructions for home care are not appropriate for the client.**
9. **Referrals and consults NOT provided when required.**
10. **Authorization to proceed under self initiating DH not evident.**
11. **2 or more missing signatures of any type in client chart.**
12. **Treatment recorded in care plan not implemented or recorded in record of care**
13. **Treatment implemented is not recorded in treatment plan, record of care or made as a revision**
14. **Client safety or care has been compromised by student treatment.**

**Professionalism Penalties**

**Clinical Professionalism Penalties**

It is expected that each and every student will behave in a professional and ethical manner during all clinical sessions. Penalties will be issued on a per client basis if applicable and also if the student does NOT have a client in the chair. The first penalty will result in a -1 deduction and each additional penalty will result in a loss of -2. The student may be issued a warning instead of a penalty if it is a first occurrence in an otherwise unblemished history. Penalties imposed will be at the discretion of the faculty member. Any student that has a difference of opinion with the faculty member may address it with the faculty member **after the clinical session has ended.** If it is still not resolved, the student may address the issue with the coordinator of the program.

**\*\*\*\*\* Please note: Any student who communicates with faculty, classmates or clients in a way that is considered to be unprofessional will immediately be given a three day suspension. If the student discusses a grade with a faculty member in front of a client, they will be given a three day suspension and will receive “0” credits for the client. There is zero tolerance for this serious matter.**

**Clinical Penalties will be tracked for all students.**

**If a student has accumulated 3 penalties then 1(one) clinical credit will be removed from the student credit standing. To clarify; 3 penalties is equal to -1 clinical credit. There is NO reason why this should happen to any student. Take your time and follow all protocols.**

**Tracking of Clinical Penalties:**

All penalties will be tracked on the student’s individual clinic tracker form. This form will be maintained by faculty however, a student may ask to see their form at any time.

**Penalties may result in the following areas:**

* Professionalism
* Clinical Decorum and Infection Control
* Documentation/Client Records
* Client Management and Time Management

**Professionalism:**

1. Does not present with a positive outlook.
2. Refusing to work as a team player, assisting fellow students when necessary.
3. Does not perform all monitor duties as requested.
4. Is not accountable and responsible for his/her own actions.
5. Does not communicate effectively with faculty, clients and classmates.
6. Arrives late for clinic sessions without appropriate notice.
7. Absent for clinic sessions without valid documentation OR notification of a faculty member.
8. Schedules a client during their monitor session. \*\*clients who show up when a student is a monitor will be released OR given to another student so that their care can be continued.
9. Submits a client postcare with any aspect of the evaluation form not completed by faculty.
10. Does not maintain client confidentiality.
11. Does not complete all proposed care for client.
12. Not prepared for all clinical sessions.
13. Brings cell phones or other personal electronic devices into the clinic setting.
14. Does not accept feedback in a positive manner.
15. Failure to complete the client feedback

**Clinical Decorum and Infection Control: (refer to protocols found in this manual):**

**Student fails to do the following:**

1. Student follows all protocol for attire in the clinic. Lab coat must be removed when in the hallways, classrooms and common areas in the college. Scrubs and/or Lab coats are not to be worn outside the college.
2. Monitors failing to note decorum issues on classmates are subject to a professional penalty.
3. Clean and disinfects entire unit, including running all the water and suction lines at the beginning and end of each day.
4. Place all appropriate barriers.
5. Maintains a clean work area, disposes of all refuse in the proper manner. Work area is neat and organized.
6. Maintain all equipment: lubricates handpieces, sharpening stones, cavitron tips etc.
7. Follow all protocols when in the re circulation area or the dental materials laboratory section of the clinic.
8. Follow all protocols in regarding infection control as found in this manual.
9. Provides protective eyewear for themselves and the client.
10. Wear mask, in the clinical areas.
11. Remove gloves or clients bib are as needed.
12. Use over gloves to prevent cross contamination.
13. Follow all guidelines for safety in the clinic as outlined in the client care manual.
14. Implement Standard Precautions while in the clinic.

**Documentation/Client Records:**

**Student fails to do the following:**

1. Ensure that all records are signed by faculty and clients in the appropriate sections. This includes but is not limited to: medical history, radiographic prescription, hard tissue charting, periodontal assessment, post care evaluation, the chart audit, and any other pertinent documentation. Please note the consult pro system will automatically date any entry made in the client chart. As new information is added, or updated, earlier forms will be archived. All archived forms are always readily available for viewing.
2. Ensure that all referral forms must be signed by the DDS and the student. Students must complete the top part of the form regarding treatment performed and planned AND the bottom section regarding information on client records.
3. Ensure that documentation noted in the client record of care follows the CDHO guidelines for recordkeeping.
4. Ensure privacy of client records. **\*\*This will result in complete loss of clinical credit for the client. \*\*students cannot keep client records in their locker or take them home. They cannot copy information from the client record.**

**Client Management and Time Management:**

**Student fails to do the following:**

1. Explain all suggested treatment and benefits.
2. Ensures that client understands and signs the proposed treatment plan.
3. Recognize the need for a translator.
4. Treats patient safely and competently adhering to the CDHO Standards of Practice.
5. Avoid tissue trauma. (First incident will be a warning only; further incidents will result in professional penalties and a referral to the scaling for success program)
6. Fails to remove calculus after detection by a faculty member.
7. Perform ongoing evaluation of the client and records findings.
8. Attend to the client during the appointment: (does not leave the client for an extended period of time without reason)
9. Address all client concerns.
10. Treats the client as an individual with kindness, dignity and respect.
11. Makes most efficient use of time in the clinic.
12. Time spent on specific clients is reasonable. (a student who has a DD1 client in for more than 3 appointments would be a possible example of poor time management).
13. Student does not keep their chair filled during clinical sessions.
14. Fails to return calls from clients.
15. Fails to accept or complete a client assigned to them.
16. Fails to complete and submit a client feedback form.
17. Fails to complete the client reflection form.
18. Fails to complete a daily care plan for any appointment of the client care.

**Clinical Status Alert:** If a student is having difficulty, is falling behind with credits or requirements or is not practicing competently or professionally, a clinical status alert form will be issued. A clinical status alert could be issued for the following: tissue trauma due to improper instrumentation, a pattern of low grades on debridement, inadequate infection control procedures, consistent inaccurate documentation or a display of behaviour which is considered unprofessional). This form will identify areas of weakness and strategies to implement to become successful. Students may be requested to attend mandatory “scaling for success” hours, radiography practice hours, or may be requested to complete an evidence based assignment. All clinical status alert forms will be reviewed in detail with the Dental Hygiene Program Coordinator. A follow up on these forms will take place no later than 2-3 weeks later. If more than one alert is given to a student, the matter will be referred to the Dean of Students, and may result in failure to successfully complete the semester or dismissal from the program. The Dean may also decide to impose a clinical suspension depending upon the severity of the alert.

**\*\*\*Receiving a clinical status alert is a serious matter. The goal of the alert is to notify the student of the issues and then provide guidance. However, a student must be able to show that they are addressing the concerns.**

**Clinical Protocol,**

**Client Care Protocol & Procedure**

Clinic and Radiography Lab Protocol and Conduct

Failure to abide by these protocols will result in a professional penalty deduction. Please refer to page 83 of this manual.

Attire

1. Full uniform is required for all clinical sessions. Dental Hygiene students will be wearing blue scrubs and will have a long sleeved white lab coat. Lab coat is to be buttoned up during the clinical session and students are not permitted to “roll up their sleeves” The lab coat must be removed when outside the clinic as it acts as a barrier for the student. Tattoos: TCDHA respects the student’s freedom of expression. During clinical sessions all visible tattoos are to be covered. This can be easily achieved since the student will be wearing a lab coat. If a tattoo contains any type of racial slur or profanity, then it must be covered at all times while on college property.
2. Shoes must be fully enclosed with a heel. No clogs will be allowed. White leather running shoes will be permitted and laces must be clean.
3. Name tags must be worn. Name tags are your computerized id tags.
4. Hair must be kept neat and up off the shoulders. If hair is long enough then a “bun” is mandatory. Hair clips or pins need to be fairly neutral and must be worn to control fly away strands of hair. No large hair accessories to be worn. All hairbands are to be white only. Male students are to be clean shaven (preferably, or have their facial hair neatly trimmed and covered during client care).
5. Socks must be white and calf or knee length. No sport socks will be allowed. White hose may also be worn. Undergarments need to be white or neutral in colour.
6. Jewellery must be very simple. Earrings are to be simple studs or no larger than 1” hoops. Only one earring per ear will be permitted. Necklaces or bracelets are not permitted, however a watch is allowed. Body piercings are to be removed during clinical sessions or any off-site field placements. Jewellery worn for religious purposes must be thoroughly covered by white tape (from the dispensary), or by the student lab coat, during the clinic session. A student is permitted no more than 2 piercings in total in the clinic setting.
7. Nails must be manicured and fingertip length. No polish or false nails will be allowed. Only a wedding band is permitted.
8. Makeup is to be used sparingly. Please do not wear perfume. We are a scent free environment. Please inform your clients as well. Maintain a high standard of personal and oral hygiene.
9. Prescription or safety glasses must be worn in the clinic at all times.

\*\* Please note that faculty will ensure compliance with this policy through the use of a decorum checklist which will be completed at the beginning of each clinical session by the monitors. Students not following decorum protocols are subject to professional penalties, which may impact their grading in the clinical setting.

Conduct:

1. All students are expected to handle themselves in a professional manner while in the clinic.
2. No food/drink will be allowed in the clinic or radiography areas. Gum chewing is not permitted.
3. No personal items such as purses, backpacks are to be brought into the clinical area or radiography rooms. Please leave them in your lockers.
4. No cell phones are permitted in the clinic. Students may contact their clients on their phones while outside of the clinic, and then the phone must be left in their locker.
5. No voices are to be raised in the clinic. If you need to communicate with someone please address him or her within arm’s length.
6. Every student, faculty member and client is to be treated with dignity and respect.
7. Clinics begin promptly on the hour. It is important that the student arrives 30 minutes prior to the start of clinic to prepare their unit. If you are unable to attend clinic the faculty member must be notified before 8 a.m. to explain the absence. If you are ill, you must have a doctor’s certificate to explain the absence. **Be advised that missed clinics may affect your success in the program. Refer to pg. 89.**
8. A professional student of dental hygiene shows willingness to accept suggestions for improvement gracefully. The faculty is here to promote your learning.
9. Respect for privacy is imperative. All information exchanged between student and faculty, student and client is privileged.

Professionalism

Dental Hygienists are a talented group of health professionals. This professionalism must begin in the learning environment and continue throughout a lifetime. The student must therefore develop the knowledge, skills, and attitudes associated with being a professional.

Attendance, Participation and Teamwork:

Attendance in Client Care Clinics:

Attendance is mandatory in all client care sessions. TCDHA recognizes that all students are adults but failure to attend will result in falling behind with your clinical requirements and professionalism penalties being issued. **To clarify you will receive 1 professionalism penalty if you miss your clinic session.** Regardless, if you are unable to attend your clinic session you must still notify the Education Coordinator through email prior to your missed session.

Penalties for missed clinic will not be issued if a student is sick, or under extenuating circumstances such as bereavement in the immediate family. Penalties will not be issued if the student is taking a personal day.

If you are sick you must provide a doctor’s note or evidence of a visit to the doctor (such as a prescription or requisition for lab work) for the missed session and you will not be penalized. You are also expected to contact your education coordinator

**\*\*Missed clinics will not be made up or returned to the student. If there are extenuating circumstances (such as an extended serious illness) the matter can be brought to the Dental Hygiene Program Committee for review.**

TCDHA does recognize that there may be times when a student may need to be absent from school and does offer personal days. Please see below.

Personal Days:

1. \*\*Students are permitted personal days for clinic absences. Personal days can mean time to attend to appointments, illness, or family issues requiring attention. Penalties for missing clinic will not be issued as long as the student notifies the education coordinators **prior** to the clinic session. Simply email the instructor to let them know that you are taking a personal day. Failure to do so will result in a professional penalty being issued. All personal days will be tracked. Personal days cannot be taken by a student if they have monitor duties assigned to them otherwise a professional penalty will be issued. If a student is taking a personal day for illness then a doctor’s note is not required.
2. Each student is permitted 2 missed clinics in Clinic Practice I. These are not to be taken if any type of evaluation or demonstration is planned for that day.
3. During Clinic Practice II and Clinic Practice III students are allowed 3 missed clinics in each of these courses.
4. Students will not have these clinics returned to them. Clinics missed for personal reasons cannot be accumulated or carried over between semesters.

Participation and Teamwork in clinical sessions;

1. Students are expected to participate in ALL clinical activities. There are a certain number of requirements the student must complete in each semester in order to proceed to the following semester. Please see the section on requirements and evaluation for clarification.
2. Each student will be expected to be working during the entire clinical session. Time management is essential to make the most of your learning experience. If a student should complete an assigned task ahead of schedule, he/she will be expected to assist others.
3. If your chair is not filled for a clinical session you are expected to assist the monitors with any and all duties.
4. It is a courtesy to explain to all perspective clients that our clinical sessions run for a period of 2.5 hours, and that they may require several appointments. Let them know, that this is an educational facility, and that there will be times when waiting for a faculty member will be inevitable.
5. Provide each client an appointment card, and ensure that they know your full name and the number at the clinic. Inform them that you will need 48 hours’ notice of cancellation. Always have a back-up client available. Lost clinic times may affect your clinical success.

You are still required to attend clinic if you don’t have a client. Please spend your time performing screenings, assisting other students or re-stocking the clinical areas. Professional readings are permitted and certain skills can be practiced. Please speak to faculty in the clinic for assignment of tasks.

Empty Clinic Chairs

It is important that students have a backup client in case their originally scheduled client does not show up. Loss of chair time may result in a student not meeting all requirements and credits of the program.

Student E Files

Each student is provided with a student e file which will contain all of their evaluation forms. A spread sheet is also maintained so that a student can meet with their clinic advisor or a faculty member to review their status. Students may review the spread sheet to ensure all client completions have been entered or to review evaluation forms. Students must schedule a time with their clinical advisor to do so. Students are NOT permitted to review the spreadsheet on their own.

Client Assignment Policy

Clients are available from a number of sources. It is important for the student to always be seeking clients. The Toronto College of Dental Hygiene & Auxiliaries Inc. will advertise to inform the community of the services the students will provide. A client pool is available to all students and at the beginning of client care semester, each student will be provided with a base list of available clients.

Additional sources:

1. Friends and family.
2. Referrals from friends and family.
3. Community service and presentations.
4. Advertising. (Church groups, community centres etc).

Protocol for obtaining clients:

1. Students will be provided with a list of potential clients at the beginning of Clinic Practice I and II. (Clients will remain in their care until the student graduates). (If students need further clients in Clinic Practice III they can approach the client re care coordinator for more potential clients)

2. Students will sign documentation confirming that they have received the list.

3. Student must contact the client within 5 business days to let them know that they will be taking over their care. Even if the client is not due, it is a courtesy to connect with the client and let them know when they will be seen. Please note the re care coordinator will run a scan of appointments booked and will contact the student to determine if indeed a client has been booked. If an appointment is not evident, then the re care coordinator will call the client.

4. Student is responsible to let the client re care coordinator (CRC) know if the client decides not to return. The coordinator will provide the student with another client name if available.

5. The student is also responsible to inform the CRC if they are unable to see the client. This will allow the CRC to assign the client to another student.

\* Almost daily we have potential clients calling the school to obtain appointments. The names of these clients will be provided to the client continuing care coordinator to be inputted into our continuing care program and to be distributed. TCDHA aims to be fair to all students and as such documentation will be kept to ensure that all students are provided an equal opportunity to be given clients.

It is important to understand the value of good client communication. Students often end up with more clients than they need. If you treat your clients with kindness, dignity, professionalism and respect, they will refer other clients to you. Students must be accountable for the care and the effort they put into the Dental Hygiene Program and ultimately are responsible for their own clinical success.

Please be advised that in order to have comprehensive client experiences, students are expected to treat a variety of clients. No more than 8 or one third of your client completions should be family members. Students will be tracked to ensure compliance with this policy.

**CDHO Policy on treatment of significant others in the dental clinic:**

\*\*Important: students are not permitted to treat their spouse or their boyfriend/girlfriend. Under the Regulated Health Professions Act this is prohibited and although legislation has been passed, changing the law, the CDHO has not changed their directive on the treatment of spouses. This will be discussed further in your ethics and professional role course and your clinic theory course. Students are NOT permitted to treat any client with whom they are in a relationship. No souses/boyfriends/girlfriends/common law partners to be seen as a client in our clinic.

TCDHA Policy on Contacting Clients/Client Transportation/Payments

By Phone:

In order to ensure client privacy and to protect the student, all students are advised to contact their clients only while on TCDHA Premises. Students may use phones located in the lunchroom or in the library and computer rooms.

If it is absolutely necessary that you contact your client from your personal cell phone or home phone please block the call (by dialling \*67) so that your client cannot have access to your home or cell phone number.

Email:

Students are not advised to contact their clients through their personal email accounts since once again it permits the client to have potential access to personal information about the student. Please use only your TCDHA school email accounts. Any posters or pamphlets provided to the community must contain only the -student’s school email address and contact information.

Please remember that all communication between the student and the client must be conducted in a formal manner and the communication must be documented in the record of care. Once you have been provided with the name of a potential client, or in treatment with a current client, you are responsible to note any type of contact in the record of care.

***Please keep in mind that these policies are in place for your safety.***

Client Transportation:

Students are advised NOT to provide transportation for their clients. If you are involved in a car accident, no matter how minor, you would be held accountable and responsible by the client. Providing transportation for the client also puts the student at risk for a possible assault. Do not put yourself in this position. Clients are responsible for finding their own transportation to and from their appointments. Parents must accompany their children to and from the appointment, and must remain with the child during the appointment. Please refer to section on paedo clients.

Client Payment:

Students are NOT to pay for their client services. Clients are responsible for paying for their own accounts. Students will be tracked by the front desk to determine if the students are following these guidelines. Receipts will only be issued in the client’s name and with the client present at the reception desk. If a client is unable to pay then this matter must be discussed with the clinical faculty prior to starting treatment.

Tracking of Clinical Experiences

All clinical experiences will be tracked. When your client is in the chair, take a minute to note if the client is a paedo, adult, senior or special needs client. (Please refer to Darby and Walsh for clarification on special needs). Also note the client source. Is the client a student source (someone you found on your own), a family member, or a client provided by the TCDHA? It just takes a second to note this on your evaluation page and it will be formally tracked by the program.

Client Screening Clinics:

As clients are added to our client pool they may be asked to come in to our clinic for the screening process. This occurs more frequently in Clinic Practice III as students are seeking more difficult clients. The purpose of the screening clinics is to assess the degree of difficulty the client will present. In order to be fair to all students, clients will be assigned to those students requiring a specific type of client, or to a student who may be having difficulty obtaining clients. Clients are to be informed that the appointment should last no more than 30 minutes HOWEVER, if there is a student without a client for that particular clinic, the screening client could be asked to remain for the entire clinic. It is wise to inform them of this when you speak with them on the phone.

Screening clinic protocol:

1. Clean and disinfect your unit. Apply all barriers.
2. Request your exam cassette from the dispensary.
3. Access the client file on consult pro.
4. Complete a medical/dental history assessment. Be sure to leave no blank spaces and elaborate on all “yes” responses.
5. Sign up to have the Hygiene Faculty review the medical history and authorize you to proceed.
6. Proceed to perform a brief soft tissue assessment only; the purpose of this exam is to determine the degree of difficulty. Take a minute to probe at least 2 areas to assist you in your classification.
7. Have a faculty member confirm the degree of difficulty.
8. Please complete the client screening form and return it to the dispensary staff. Once the client has been assigned OR if it is determined that the client is not suitable, then the screening form will be cross shredded and appropriate notes written in the record of care.
9. Thank the client for their time and let them know a student will notify them to set up an appointment.

NB! It is the responsibility of all students to be available to screen clients, even if the client will not be theirs. There is no fee to the client to be screened. If the client wishes to become a client of the clinic then a fee will be assigned at that time.

Client Appointment Planning Protocol:

1. If you are given a name through the school client pool, please call the client within **5 business days**. If the client is a friend or family member please issue the same courtesy. If you cannot reach the client after several attempts, return the client name to the front desk and the TCDHA continuing care team will follow up with the client.
2. Inform them as to who you are and why you are calling.
3. Inquire if there are any medical history concerns and explain why you are asking. Remind them to bring a comprehensive list of any medication they may be taking and all pertinent medical information. Unfortunately, there may be some clients that we will be unable to treat, due to poor health. (Please refer to the section on prevention of disease transmission, or compromised clients) If in doubt, please check with a faculty member.
4. Inquire about radiographs: inform the client that in order to be treated in our facility they must have radiographs which have been taken in the past three-five years. Please request that the client brings the radiographs with them. **Process: If the client tells you that they do have radiographs the first thing you need to do is complete the Record Release (In coming form). Please provide your client with a copy of this form. The client must complete the form and give it to their dentist. If the clients x-rays are electronic then they can be emailed to the email address provided on the record release form. Please be sure to tell your clients to include their full name in the email correspondence AND note the date on which the x-rays were taken. The clinic coordinator, will make sure that the x-rays are transferred into the client consult pro file. If the x-rays are NOT digital, then tell the client to bring the x-rays to the appointment with them. Place the x-rays on the view box and take a photo of them. You will then need to upload the photo to the client’s consult pro file, however, be sure to note the date the x-rays were exposed NOT the date that you are uploading the picture.**
5. Schedule the appointment and make a note of it in your appointment book.
6. Confirm the appointment at least two days in advance.
7. It is important for each student to have his or her own appointment book, be it an electronic record or hard copy. Please mark in your book any statutory holidays, exam periods etc, when the clinic will not be running. Include the client’s name, address and telephone numbers where they can be reached. It is the student’s responsibility to make sure all appointments are entered properly. Please be sure that the client has your full name and a contact number for you. Do not give out your home address. An email address contact is preferable.
8. Students will be provided with appointment cards that they can give their clients.

Challenging Clients

From time to time there may be clients that present unique and unsettling challenges to the students. If you feel that you are being harassed in any manner by a client please let the faculty know. We are ethically bound to treat our clients, however, in situations where we feel harassed we can inform the clients they need to go elsewhere. Please speak to a faculty member first before you dismiss a client. Should it be determined that a client can no longer be seen then we will provide them with the names of other facilities where they can seek care. Regarding clients with medical issues who cannot be seen please refer to disease transmission in this manual.

**Client Care Sequencing**

**Procedures and Protocols**

# Client Care Sequencing

Preparation for client arrival:

It is expected that each student will arrive at the clinic at least 30 minutes prior to the client arrival. Failure to do so will result in a professional penalty.

* Please follow all protocols for cleaning/disinfecting and preparing your units.
* Obtain necessary supplies from the re-circulation area or dispensary as needed.
* Obtain instrument cassette from the dispensary.
* Log in to consult pro and access your client chart.
* Have instrument cassette set up. Keep it wrapped until client is in the chair.
* Present yourself in a professional manner at all times.
* SMILE!!!

\*all evaluation forms required during Clinic Practice sessions can be found in the forms section of the student e-file.

\* Always inform before you perform!! Please explain all treatment to clients. Explain why it is important and respond to any questions they may have. If you are unable to answer a question from a client, please speak to a faculty member.

Client Arrival/ Personal and Health Assessment

* Once fees have been paid for the new patient exam, please have your electronic chart activated. Bring your receipt for fees paid to the clinical coordinator and she/he will scan it into the client chart.
* \*\*students are permitted to request that a chart be activated prior to the client’s first visit, so that students can access the chart to complete the medical history over the phone.
* Greet the client and escort them to your unit.
* Thank them for coming to see you and tell them that you appreciate their support.
* Take a minute to tell them something about yourself and our dental clinic procedures.
* Complete your daily care plan and be ready to discuss it with your instructor.
* Complete the **personal assessment** information, and be sure to review the privacy regulations with your client and have them sign it. In addition, you will find the client consent to treatment. Be sure to have it signed. Answer any questions they may have.
* Take a **detailed medical history** and be sure all areas are completed. There are to be no blank spaces and remember to elaborate on any yes, or not sure answers. Provide all information required on any medications the client may be taking. If you need more room to note the medications use the additional medications form found in the electronic chart. Take vital signs. If the BP is slightly elevated you may wish to wait a few minutes and take it again. Blood pressure may become elevated if a client has been rushing to the appointment or is nervous. If the second reading is still elevated, wait for the faculty to review the history and perhaps take it again if required. Guidelines for blood pressure are clearly noted in this manual on pages: 177-178.
* If the client’s medical history appears compromised in any way, we may need clearance from the family physician or specialist. If this is the case, faculty will ask you to utilize a “**Medical Consultation Request Form”** found in the electronic chart. There are 2 different forms: one is specifically or blood pressure and is a referral to the family physician should the BP readings warrant a consult. The second medical consult form is for all other conditions, diseases or illness.
* **If it has been more than a year since the last complete medical history was done, then it must be redone. If not then an update will suffice, however, students must be sure to review the original medical history and quickly review the original responses with the client. For all medical history updates there are specific questions to be asked which is found on the medical history update page.**
* Complete the **cultural and lifestyle assessment** section: this provides the student with an overview of a client’s lifestyle habits, beliefs and practices. It offers the student a chance to determine two things: (i) a possible connection between the client’s oral or general health and their lifestyle or culture, and (ii) to determine if there is an unmet human need which needs to be addressed. Please discuss your thoughts and your rationales with the Dental Hygiene faculty. If it is a continuing care appointment then you can simply update the form at the bottom of the page.
* If the client is a continuing care appointment; review the medical health questions with the client and sign the medical update page. Have the client sign this page as well. At this time, update the dental history and the cultural and lifestyle assessment. If there are no changes please note that at the bottom of the existing dental history and cultural lifestyle assessment forms. If there have been changes, check the appropriate box and note the changes in the ROC.
* **STOP!! DO NOT PROCEED UNTIL THE MEDICAL HISTORY HAS BEEN CHECKED.** Once it has been checked the Dental Hygiene Faculty will authorize you to proceed. Faculty will sign your medical history and will note in your record of care; “Authorized to proceed and the computer will automatically note the name of the instructor. If the client health is compromised and there are special instructions the faculty will note the special instructions on the last page of the medical history. Please refer to section on documentation.
* Continue now with the extra/intraoral assessment procedures. **Please have the client perform a “pre rinse” for 30 seconds at every appointment before going intra orally.**

Intra/extra oral assessment/Radiographs

1. Please take extra/intraoral photographs and upload them to the client file. There are 6 intra oral photos and 6 extra oral photos. The photos serve several purposes. They aid in client identification, they can identify concerns, and they are a wonderful resource for client education. Students are also expected to take “after” treatment photos (only 3) to demonstrate gingival response. There is a sample posted on the computer demonstrating the different photos to be taken. There are also examples in this manual. Please ask for cheek retractors and the digital camera from the dispensary. If you require assistance on how to upload your photos please do not hesitate to ask. Be sure to crop your photos. At the continued care interval it is only necessary to take 6 intraoral photos (3 before and 3 after). There is no need to take extra oral photographs unless there is a drastic change in the client’s appearance or if there is an extra oral lesion which looks suspicious. Please be advised that you must have your post-operative photos checked before the client is dismissed from the clinic.
2. Radiographic Assessment: Upon completion of a thorough medical and dental history, intra oral examination, and upon probing a quadrant, students will perform a preliminary needs assessment for radiographs. This is an opportunity for the student to use their critical thinking skills so that when the DDS comes to their unit they are prepared to provide a rationale as to which exposures they feel may be required. Ask the client when they last had radiographs taken and what type of radiographs they were. Speak in layman terms since often a client may not understand what a “bitewing, fms or panorex” really means. Assess their stage of growth and development, and their overall oral health. TCDHA is not asking the student to prescribe the radiographs but to learn how to work collaboratively with the client and the DDS to provide the best care possible. The DDS will come to your unit and perform a brief intra oral scan. He/she will then listen to your rationales before making the formal prescription. **It is important that the student realize that only the DDS can write a formal prescription for radiographs.** Please refer to the Radiographic Needs Assessment page 1 of 1 in the client chart. It is also important to realize that once debridement begins, the student may feel that the client is more difficult than originally thought, or that more radiographs may be required. If this is the case please discuss this with the DDS on the clinic floor and of course with your client. \*\*important: students will be observed, and a checklist completed during their first exposures of BW’s, FMS, or panorex on a client. Please see form on page 56 of this manual.
3. **TCDHA** **Policy on exposing radiographs**: If the client is a new client to our clinic and has not had a full mouth series of radiographs or a panoramic radiograph in the past 3-5 years then one will be prescribed. The type of exposure prescribed will depend on the condition of the client’s oral cavity, the length of time since the last radiographs were taken and the types of radiographs the client has had in the past. All radiographs are client specific; if a client does have existing radiographs they must be diagnostically acceptable. If the client is a recare client then only BW’s may be needed (assuming of course a pan or a full mouth series is already on file). BW’s may be prescribed every 6 months-every 2 years dependent upon the condition of the client’s oral cavity. **TCDHA is a learning facility and as such all clients who are seen in our clinic must either bring with them diagnostically acceptable radiographs or have them taken here.** Clients must bring the radiographs with then to the first appointment. Please refer to page 96 of this manual for protocols. Please note if a client is pregnant or has been undergoing radiation treatment for cancer treatment or if they have been exposed to a significant number of radiographs recent to the dental appointment, then the DDS may wish to postpone radiographs until a later date. Once again this is client specific. Since radiation to the head and neck can cause severe dental problems, the risk of the radiographs may be miniscule compared to the risks of not taking the radiographs.
4. **You must expose and interpret your radiographs before the DDS comes to your unit to evaluate your hard tissue charting.** Once the DDS prescribes radiographs, you must sign up to use one of the radiography rooms. Please remember to clean and disinfect the radiography room and place the appropriate barriers. (Refer to your radiology manuals). Request the plates from the dispensary before bringing your client into the radiography room. Remember, you must provide the dispensary with a receipt for the films before they will be dispensed to you. Important: be sure to document the number of exposures that you take. This includes the panoramic radiographs. There is a form directly beside the scanner for this purpose. This is part of our quality assurance program. Faculty will be observing your technique and are available for feedback.
5. The student will perform a complete extra-oral and intra oral exam. Follow a systematic approach and be sure to document all findings in the client chart. When you have completed the intra/extra oral exam please sign up to have it checked. **You may continue with the hard tissue charting while you are waiting to have the intra extra oral exam evaluated.**
6. Upon completion of the extra/intra oral exam, the student will complete the examination of the hard tissues (and all necessary charting), and the soft tissues. **Remember: You must have the radiographs ready for the evaluation of the hard tissue. You must have mounted them in a template and you must have completed the radiographic interpretation.**
7. In preparation for the DDS coming to your unit: have your hard tissue documentation ready to go and your radiographs on the screen.
8. The DDS will check the hard tissue charting only upon having the necessary radiographs. Before doing so he/she will review the medical history and sign the odontogram. The student will expose and develop the radiographs and have them ready for the DDS to assess at the time of the clinical exam. Radiographs must be interpreted by the students prior to the DDS arrival, as both the clinical exam and the radiographic exam will take place at the same time. Once a diagnosis is confirmed please be sure to complete your caries risk assessment. This assessment is done for every client. Once the exam is completed and radiographs have been interpreted, the DDS will provide a referral if required.

Periodontal Examination

1. This will include the plaque and bleeding indices, complete periodontal probing, measurement and drawing of the gingival line, determination of CAL and a general assessment of the periodontium. You will also require your radiographic interpretation to be completed as radiographs are an integral part of the periodontal assessment. Student will determine a “degree of difficulty” (see page 107), and determine a suggested gingival and periodontal condition for the client, based on clinical and radiographic findings. **Once you complete the periodontal assessment you can begin writing your client centered goals and treatment plan while waiting for it to be evaluated. Be sure that the hard tissue evaluation has been completed by the DDS.**

Nutritional Analysis

\*\*this section can fall under both Assessment and Implementation

1. If a nutritional analysis is required for the client please have the client complete either a 24 hour or “3 day diary” and relate the nutritional status in your client centered goals. Requirements dictate 1- 24 hour and 1-3 day analysis. However, **all clients** must be assessed to determine if they require a nutritional analysis. In the interest of time, a one day diary may be used. Students can provide the client with a short assessment, relating their diet to their oral health. They can also provide resources from the Canada’s Food Guide. It offers the student an opportunity to connect the client’s diet with both oral health and systemic health.

Referrals

\* Upon completion of your assessment it may be determined that the client will require a referral to a general practitioner, dental specialist or a medical doctor. It is the ethical responsibility of healthcare professionals to inform clients when their needs might be beyond our scope of practice. The DDS’s on the clinic floor will provide referrals and the protocol for this is located on page 26 of this manual. Please remember to document the referral in your ROC. Please remember to complete the entire form.

Dental Hygiene Diagnosis/ and Dental Hygiene Care Plan

The process now begins whereby the student will review all assessment findings to create the dental hygiene diagnosis and develop a care plan.

Client Goals & Interventions:

After the assessment process is completed, it is now time to formulate your dental hygiene care plan. The student must now analyze and interpret the data to formulate a dental hygiene diagnosis. The dental hygiene student will work in conjunction with the client to form a plan.

* Work with the client to set achievable goals. The student and the client must work together to agree on a logical sequence of care. Well written goals use a variety of verbs and **must** be measurable. Try to aim for higher levels of verbs and do not always use the same verb for every client. Goals must also include a time frame.
* Plan your dental hygiene interventions. (For example; client education, complete debridement, selective polish, fluoride: all interventions are to be noted in the client chart in minutes). All of your interventions become part of your dental hygiene care plan.
* Develop your treatment plan; your treatment plan should list what is to be done at each and every appointment. Treatment plans must be specific (example; do not simply write “oral self-care”, please list what type of education you will provide during that session. Ongoing evaluation should be evident. List how you plan to check tissue response after each session of debridement. When listing polish or fluoride please be detailed, telling which type of polish (full or selective, type of fluoride and method). If you plan to use topical or local anaesthetic it must be noted in the client treatment plan. If you plan to use ultrasonics they must also be noted. If the client is a DD3 or DD4 and will require a 4-6 re-evaluation it should be noted in the treatment plan. Clients are more compliant when they are informed prior to committing to the plan.
* **Have client sign your Dental Hygiene Treatment Plan. If this is not signed, treatment may not proceed!! If your treatment plan has not been signed by the client and you proceed with treatment, you will not receive clinical credit for the client.**
* Revisions: if it turns out that you will not complete your client in the allotted time or wish to add an additional item to your plan, then a revision to the treatment plan must be completed. If you do not have the client sign a revision, then it is the same thing as proceeding without written consent. Failure to have signed revisions in the client chart will result in a -1 penalty for each occurrence.
* **Please remember that all consent must be informed consent. Your client must be provided with all treatment options and must understand all options. A client also has the right to refuse any aspect of the treatment plan. If you are unsure that the client understands then you must not have them sign the document. If a translator is required then one must be brought in. A student cannot translate for their client. It is a conflict of interest.**

Please sign up to have a faculty member check your plan. Hygiene Faculty may mark your periodontal assessment and your goals and treatment plan at the same time. DO NOT PROCEED WITH IMPLEMENTATION UNTIL THIS HAS BEEN CHECKED.

\* In Clinic Practice III a student in good standing may proceed with debriding up to ½ of the mouth without the treatment plan being checked by the instructor. They must of course, have signed authorization from the client. The student will complete no more than half the mouth without being checked by an instructor.

Implementation

Determining the Degree of Difficulty

This is a process by which we classify our clients. Each client will present to our clinic with different periodontal conditions. \*Please keep in mind that the chart is a guideline only. The final decision will be that of the faculty member.

Please refer to the next page for the Degree of Difficulty chart.

\*\*If the student begins debridement and then feels that the client is more of a challenge than originally thought, they can ask an instructor to re assess the client.

Please be aware that different factors can influence the level of difficulty. A client with a high bleeding index or heavy stain is two examples of when a level may be increased. Sometimes a client experiences extreme sensitivity and does not wish local anaesthetic and in such a situation the degree of difficulty might be raised.

|  |  |  |  |
| --- | --- | --- | --- |
| Degree of Difficulty | Client Description | Completion Time  Sem. III | Completion  Time  Sem. IV |
| Paedo Client | * Age range 3 – 13 years old | 2 clinics | 1 clinic |
| D.D. O (14-17) D.D. 1 | * Stain present/not present * Minimal calculus * Plaque present/localized or generalized * Scanty supra mandibular anterior or distal of maxillary molars. * Scanty scattered sub | 2-3 clinics | 1-2 clinics |
| D.D. 2 | * Stain present/not present * Sub/supra calculus formation * Supra calculus located mandibular anteriors, maxillary molars and scattered scanty-moderate sub gingival calculus.   4mm CAL may be present with evidence of early bone loss | 3-4 clinics | 2-3 clinics |
| D.D. 3 | * Stain present/not present * Generalized Scanty-Moderate sub & supra gingival calculus * Localized moderate rings with thickness which is readily discernible, is visible on radiographs. * Early - Moderate bone loss * CAL >4 generalized | 5-6 clinics | 4-5 clinics |
| D.D. 4  \*\*if client is a heavy DD4 client, student may be provided with 1 additional credit. | * Stain present/not present * Moderate to abundant supra & sub gingival calculus * Periodontal status –advanced involvement * CAL depths: gen >5-6mm | 6-9 clinics | 8 clinics |

Implementation of Dental Hygiene Treatment:

1. Depending on your plan, as few as one or as many as 9 clinics may be spent on debridement.
2. Please sign up for a debridement check according to your assignment and treatment plan. Paedo clients will be marked upon completion of de plaquing and selective polish (if required). DD1 clients will be marked once half the mouth is completed. DD2’s and DD3’s will be checked upon completion of one quad, while DD4’s will be evaluated after each sextant. **N.B. you may continue with the rest of the mouth while waiting for Dental Hygiene Faculty to evaluate your debridement techniques.** If you feel there is calculus remaining, please note it on a scrap piece of paper. Faculty will review what you have noted and then make their notations. Once the remaining areas have been removed, please sign up to have it re-checked. Faculty will check off the remaining pieces and mark the quadrant or sextant as complete. The debridement may not be marked as complete until all calculus is removed. When the client returns for subsequent appointments please be sure to review the tissues and check the tissue response in the previous quads. This shows evidence of ongoing evaluation. If calculus has re-formed you are responsible to remove it. \*\*Please note that once you have signed up for evaluation then the faculty will grade you on what you have done.
3. Feedback Clinic Practice I or II: If you wish assistance or feedback while debriding, faculty will be happy to assist you. Please sign up and faculty will come to your unit. During Clinic Practice I or II, faculty will provide generalized feedback on the quadrant or sextant. Faculty will note on your evaluation sheets that feedback has been provided. They will provide you with tips on calculus removal and will observe your technique. Please be advised that students will only have generalized feedback once per client. To clarify, the object is to provide initial assistance and not to tell you where the calculus remains on subsequent quadrants or sextants.
4. Feedback Clinic Practice III; Faculty will only provide feedback on 1- 2 teeth, depending on the degree of difficulty. They will ask you if calculus remains and evaluate your calculus detection, they will also provide feedback to you and if needed, watch your technique to provide assistance. Students cannot expect faculty to give them feedback on an entire quadrant or sextant.
5. Oral hygiene instruction must be completed or reviewed at each appointment and be sure to note in the Record of Care which instruction was provided. Also note the client response to any new techniques. Show evidence of ongoing evaluation with oral hygiene instruction. Be aware that there are times when clients will not follow instructions or choose not to implement an oral health care protocol. Discuss this with your client; find out why they are not compliant. This is when your communication skills really come into play. Have rationales for why you are suggesting certain home care protocols. If the client is adamant that they do not wish to floss and will never floss, then it may be time to change your strategy. Please be advised that two oral hygiene presentations will be observed and graded by Dental Hygiene Faculty, one during Clinic Practice II and one during Clinic Practice III. (A copy of the evaluation form can be found in the evaluation section of this manual). Be sure to note the number of minutes spent on oral hygiene instruction in the client record of care.
6. Please note that instructors will check debridement skills no later than 30 minutes before the completion of the clinic even if the student has signed up before that time.

If you are experiencing difficulty with calculus detection or removal, and need help, please sign up under “student requires assistance”.

Special considerations for debridement:

1. Use of the cavitron: Please notify faculty of the need to use a cavitron. Obtain the necessary equipment from the dispensary. **If you have not used ultrasonics before, you must sign up for assistance and be evaluated.** You may then use ultrasonic technology on subsequent appointments as needed as long as you have noted it in your treatment plan. Please refer to the form on the following page.

**Instrumentation with a Magnetostrictive Ultrasonic unit Competency Evaluation**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Partner Care Evaluation: □ Client Care Evaluation: □

|  |  |  |  |
| --- | --- | --- | --- |
| **Criteria** | **Faculty Comments** | **Sat** | **Unsat** |
| 1. Sets up and connects ultrasonic unit correctly, including bleeding of the lines. |  |  |  |
| 2. Chooses appropriate tip, applies and adjusts the water and power to desired setting. |  |  |  |
| 3. Operator –client position is adjusted accordingly. |  |  |  |
| 4. Uses light pen or modified pen grasp for handpiece and mirror |  |  |  |
| 5. Employs conventional, opposite arch, cross arch, or other fulcrum. |  |  |  |
| 6. Applies insert tip at no more than 15º angle to surface |  |  |  |
| 7. Stays adapted at all times only using appropriate surfaces. |  |  |  |
| 8. Keeps insert moving at all times with; quick, controlled eraser-like motion, overlapping, multi-directional, light lateral pressure. |  |  |  |
| **Student must meet all criteria to receive a “SAT”**  **in Magnetostrictive Ultrasonic.**  **Instructors Signature:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |  |

1. **Pain management:** topical anaesthetic. It is the responsibility of the Dental Hygiene student to determine the type of pain management the client may require. This may depend on various factors. Please refer to the TCDHA Policy on use of anaesthetic in dental hygiene care on the following page. Once a student determines the type of anaesthetic needed they must discuss their findings and rationale with the Dental Hygiene faculty on the clinic floor. The dental hygiene faculty will authorize its use (if applicable) and if topical anaesthetic is required, they will observe the student during its application and assist if needed. Once the student has been observed for one application of topical, and demonstrates competency with the technique, they will not be observed in the future unless they require or request further assistance.
2. **Local anaesthetic** may be required if it appears that the topical anaesthetic might not be sufficient to adequately ensure effective pain management. Once again discuss it with your client and with the RDH instructor on the clinic floor. If it is determined that local anaesthetics is indeed indicated then please prepare the proper armamentarium and sign up for the dentist to administer the local anaesthetic.
3. **Application of sub gingival irrigation** (Chlorhexidine). If a student feels that a client may benefit from sub gingival irrigation, he/she must discuss it first with the Dental Hygiene faculty to provide rationale. All armamentarium can be provided by the dispensary staff. Please inform the faculty of your intention to use Chlorhexidine.
4. **Documentation:** Please remember that when planning to use any adjunct to client care you must document it both in your treatment plan and in your record of care. Sometimes a student will begin treatment and then realize that topical or local anaesthetic is needed, or that irrigation with Chlorhexidine may prove beneficial. If that is the case then revise your treatment plan and remember to have your client sign it. When documenting the use of any of these adjuncts you must note the name of the medicament used, the concentration or dosage, and who applied the therapy. In the case of the local anaesthetic, the DDS will note in the record of care that it was administered.

TCDHA Policy: Client Management: Use of Local Anaesthetics:

In order to provide safe and effective implementation of debridement use of local anaesthetics may be indicated. Anaesthetics may also decrease the client anxiety level, increase client comfort level and increase operator confidence. Please refer to the chart below and to the Darby and Walsh (2014) textbook on page 533 for further clarification. **Please understand that the following chart recognizes concerns that may need to be addressed and that simply falling into one of these categories does not indicate the use of local anaesthetic.**

Upon a thorough assessment students will determine whether the use of local and or topical anaesthetic may be indicated. Students will then discuss their findings and present their rationale to the Dental Hygiene faculty on the clinic floor.

If the dental hygiene faculty determines that the use of anaesthetics is indeed indicated then student must treatment plan for their use. If the student has already begun debridement and determines that local anaesthetic may be indicated then they must enter a treatment revision. The request will then go to the DDS on the clinic floor to administer the anaesthetic. Please be ready to discuss the client’s health, the type of local required (block or infiltration), with the DDS. Have the syringe and carpules prepared.

Reference: Hodges, K. *Concepts I nonsurgical periodontal therapy.* As referenced in Darby and Walsh (2014, p. 533).

Coronal Polish (Selective or Full):

Not all clients require a coronal polish, however if it is necessary, please sign up upon completion for it to be evaluated by a faculty member. Please note: a polish whether selective or full is only indicated for clients with stain. Please determine if it is to be a selective polish or full polish. Please remember to floss after your polish. Please note: The faculty may choose to observe your polish at any time. Please refer to section on evaluation to view the assessment form which will be used by the faculty if the student is observed.

Fluoride Treatment or Desensitization:

If required, please sign up for a dental hygiene faculty member to observe. Fluoride treatments will be graded on an individual basis. Please note: The faculty may choose to observe fluoride treatments at any time. Please refer to section on evaluation to view the assessment form which will be used by the faculty if the student is observed.

TCDHA Policy on Pit and Fissure Sealants:

Students should be actively evaluating a client’s dentition to determine if they would be a suitable candidate for pit and fissure sealants. Once it has been determined by the DDS that there is no decay present on the proposed teeth then please discuss your treatment plan with the RDH faculty and of course your client. Be sure to treatment plan for them and have your client sign your treatment plan Students must successfully complete a minimum of 1 sealant on two different clients in order to meet their clinical requirements of 2 sealants.

TCDHA Policy on Alginate Impressions:

Taking alginates is **not** a controlled act and it is up to the student to determine when taking alginates may be appropriate. Alginates can be a valuable tool during the assessment phase of client care, or of course in preparation for the fabrication of an athletic mouth guard or whitening tray. Please discuss your rationale for taking alginates with the client and with the dental hygiene faculty and be sure to treatment plan for them. Please note that students must pour up the study models and submit them to the DH faculty in order to be given a requirement credit for alginates. If the alginate is part of the sports guard competency then the original alginates must also be taken by the same student.

Nutritional Assessment: 24 hour and 3 Day

Dental Hygiene Faculty will assess your nutritional analysis. Please sign up to let faculty know that you wish to be evaluated. Please be advised that the faculty will be speaking with your client so your client must be present. Although the requirements of the program indicate that each student must complete a minimum of 1 24 hour diary and 1 3 day diary, students must complete a nutritional assessment for any client if indicated. To clarify: all care is client specific and is not done simply because a student “needs a requirement”.

Process:

There are a series of forms to be completed when completing a dietary analysis. All forms must be completed PRIOR to the student signing up for an evaluation of their dietary analysis:

24 Hr:

Nutritional Analysis Questionnaire

Caries Risk Assessment: (Part One) \*\*this form is completed for all clients.

Caries Risk Assessment: (Part two)

Completion of a Food Guide Servings Tracker and a Food Intake tracker:

3-Day:

Nutritional Analysis Questionnaire

Caries Risk Assessment: (Part One) \*\*this form is completed for all clients.

Caries Risk Assessment: (Part two)

Completion of a Food Guide Servings Tracker and a Food Intake tracker:

Carbohydrate Analysis

Menu Planning Record

Sample evaluation forms can be found in the evaluation section of this manual so that each student is aware of the grading criteria.

Tobacco Cessation

Dental Hygiene Faculty will assess your tobacco cessation program. Please sign up to let faculty know that you wish to be evaluated. Please be advised that the faculty will be speaking with your client so your client must be present.

Sample evaluation forms can be found in the evaluation section of this manual.

Record of Care: ROC

All procedures must be recorded in the record of care. Please refer also to the CDHO guidelines for recordkeeping on page 130 of this manual.

Please include the following in your ROC:

1. Date (the computer will automatically note this for you)
2. Medical and Dental History information and all updates.
3. Cultural and lifestyle assessment (note if it was done)
4. Authorization to proceed in record of care at each appointment.
5. Authorization for controlled acts.
6. Time in/out. (computer will note this for you)
7. Dental hygiene treatment performed.
8. Amount of time (in minutes) spent on dental hygiene interventions.
9. If Local anaesthetic is used: then amount/type must be noted by the DDS.
10. Condition of the tissues (evidence of on going evaluation)
11. Oral hygiene instructions (be specific) and include the number of minutes spent on this intervention.
12. Referrals issued and any discussions with other specialists or DDS.
13. Prescriptions given to client by the DDS.
14. Any soft and hard tissue updates.
15. Any client response to treatment.
16. Any discussions between client/student, client/instructor, student/instructor. This is to include pre and post op instructions.
17. Any contact with the client be it electronic, by telephone or in person.
18. Identification of the student providing the care. (The computer will automatically record name of student and DH or DDS faculty. \*\*if the client was transferred to another student for a requirement then the original student must note the name of the student providing the care.

The client chart is a legal document. With the consult pro system, the computer records every entry with date and time and identifies the operator. If you wish to make an addition to an entry, please date the entry with the current date and then note that the entry is in regards to a previous date. Refer to the entry as “omitted entry”.

\*\*Although each student will have a signed treatment plan providing consent, it is also a good idea to note: VIC or verbal informed consent at each appointment.

Evaluation: Ongoing and Post Care

At each and every appointment the student must evaluate their findings, treatments, and recommendations. This provides evidence of ongoing evaluation. Any comments/changes are to be noted in the record of care. Upon completion of treatment a post care evaluation is performed.

Post Care Evaluation:

1. Perform new plaque indices.
2. Did you meet your client-centered goals? If not, why not?
3. What was the client response to treatment?
4. What are the future needs for this client? What will their recall interval be?
5. Review the chart to be sure all sections are completely filled out and **that all signatures are in place**. \*\*If you are missing a signature, please sign up in the post care binder, under the appropriate instructor and they will make sure that your documentation is signed.
6. Review your record of care; you cannot change original entries but you may need to clarify an entry. If so, go into the ROC and enter it as an omitted entry.
7. Complete your clinical reflection journal.
8. Complete and sign the chart audit.
9. Sign up in the post care binder under your clinical advisor to have your post care reviewed. Be sure to fill out all required information.
10. Once the post care has been completed and entered in the computer your advisor will initial and date the completion. If there is a deficiency in your chart they will note it in the post care binder. Once you have corrected the deficiency please note that they have been corrected in the post care binder.
11. It is up to the student to review the status of their post cares.
12. Students submit post cares within 10 business days of client’s last visit.

**Please note: As a follow up, clients may need to return in 4-6 weeks for a post care evaluation. This will allow time for the tissues to heal, and will allow the student to perform a new periodontal screening to determine tissue response and re-evaluate his/her debridement. As a general rule clients who present with a degree of difficulty 3 or above will need to return. However, a DD1 client with generalized bleeding would benefit from a 4-6 re-evaluation as well. The student must be prepared to present a rationale for the return of the client. \*\*If your client is a DD3 or DD4 and will require the 4-6 re-evaluation it must be noted in the original treatment plan. If the client is a DD1 or DD2 and once you begin debridement or run into potential challenges and wish to have the client return in 4-6 weeks, then you must do a revision to your treatment plan to show the 4-6 week appointment.**

**If you are completing a 4-6 re care appointment you will complete the appropriate page in the client chart and you will complete the final post care evaluation page. You will submit the chart for evaluation by a faculty member AFTER the 4-6 week re-evaluation is done.**

Completion of Clinic:

1. Have faculty member sign you out of clinic. Faculty will perform a quick scan of the client’s oral cavity to ensure that all is ok.
2. Be sure to escort your client to reception.
3. Ensure that all entries are completed and that the record of care meets documentation standards of the CDHO.
4. Complete the applicable sections of the chart audit.
5. Wait until your instructor reviews your ROC and completes your chart audit.
6. Turn off your computer.
7. Clean and disinfect your entire unit following all protocols. Bring your instrument cassette to the re circulation area to prepare for sterilization.

Procedures for Subsequent Appointments:

1. Update the client’s medical history and have them sign it. Client’s vitals must be re taken if reading was above normal at previous appointment or if client has returned for a 3, 4 or 6 month re care appointment. After reviewing your medical history the instructor will perform a quick intra oral scan to determine status of the oral cavity.
2. Review all previous findings.
3. Update the client’s dental history and their cultural/lifestyle assessment.
4. Always let your instructor know what your daily plan will be.
5. Review your intra/extra oral exam and note any changes in the record of care.
6. Check tissues of areas previously treated and review oral hygiene instructions. Review overall periodontal status.
7. Complete appointment as per student treatment plan.

Protocols for 4-6 Week Re-Care Clients

**For 4-6 week re-evaluation clients:**

* Update medical history. **Have it signed by an instructor: Instructor will perform a quick intra oral scan and if all is ok; authorize you to proceed in the ROC.**
* Always perform a quick intra/extra oral exam and note any changes in the record of care. Please note: this should take a maximum of 5 minutes.
* Complete a new plaque index and record your findings. Please record it on the plaque index page in the client chart. In addition list the plaque index on the 4-6 post care evaluation page. Note if the oral self-care level is excellent, good, fair or poor.
* Complete a full periodontal charting to include; probing depths (and bleeding upon probing), furcations, mobilities, gingival margin line, and CAL. Please note your new bleeding index on the evaluation page and interpret your findings. Record the gingival and periodontal statement.
* Compare your baseline indices with the indices you found today. Assess the client’s overall periodontal health. Has the bleeding been reduced? Is gingivitis still present? Is there any change in the tone of the tissues?
* Assess the client’s oral self-care routine. Have they been compliant with your recommendations? Have they noted any changes: such as reduced bleeding, no more bad taste in their mouths? Any comments they may have.
* Record any further recommendations you may have for the client. You may wish to modify an oral self-care technique or recommend more intense debridement.

**Do I debride at the 4-6 week re-evaluation appointment?**

You may need to do some localized periodontal debridement. If supra has reformed ....then remove it. Once again use your critical thinking skills....you note an area of bulbous, red, inflamed tissue. Pick up your explorer is there an obvious piece of sub g calculus that can be removed? If so then do so. This is not meant to be a 2 hour debridement session. Often 10-15 minutes of debridement be all that is needed.  
  
Do not rescale the entire mouth or even quadrants for that matter. Yes, you may look at the client and recognize a need for more intense, further debridement. If that is the case then reschedule the client back. The point here is that you **recognize the need for further debridement.**This is what re-evaluation is about. If this is a 4-6 week re-evaluation then chances are that your recommendation was for a 3 month re care appointment. Book the client for the 3 month recare. You do not need to book them back for the following week unless there are extenuating circumstances.   
  
Motivate your client...reinforce the positive behaviours and positive outcomes.

**Above all: ask your clinical faculty for advice and feedback.  Share your findings with them and tell them what you would recommend. You may now decide that a 2 month recare is better for the client...you may wish to extend the recare interval.   
  
Do not let the 4-6 re-evaluation appointment turn into a 2.5 hour clinic session. Use a time frame of 1 hour as your guideline.**

Sample entry: Record of Care:

June 22, 2014: Medical history updated: no changes. Authorization to proceed. (as per instructor). Reviewed intra/extra oral exam: petechiae no longer present on left side buccal mucosa; all else remains the same. Completed an updated 4-6 week periodontal assessment; client reports reduced bleeding while brushing. Both bleeding and plaque indices have been reduced by 10%. Tissue response has been good with tissues appearing pinker and firmer. There has been some minor reduction in probing depths. Reviewed oral self-care; Client reports difficulty with flossing, introduced a Proxa brush and I will check progress at next re care appointment. 3 month recare advised.

Completed 4-6 week post care evaluation.

What does an instructor have to check?

Please sign up to have an instructor evaluate your probing depths, and verify your CAL and review the post care findings that you have developed. This is an opportunity for you to discuss your findings with your instructor. The instructor will then sign your final post care evaluation. There is no official grade for this segment. Keep in mind that errors could result in a penalty being assigned.

\*\*\*\*\***Important: students who complete a 4-6 re care evaluation on their clients are eligible for one additional clinical credit.**

**Remember: when you complete the 4-6 week post care page you will also complete the final post care evaluation page. There will be 2 pages to complete in the client chart.**

Deciding on the continued care interval:

The most common intervals for continuing care are the 3, 4 and 6 month interval. Always keep in mind that care must be client specific. Use your critical thinking skills here: Use the following as a guideline:

**3MR:** Client presents with localized or generalized moderate – advanced periodontitis. A client with generalized early periodontitis could also fall into this recommendation.

**4MR**: Client presents with localized early periodontitis with CALS of 4 mm.

**6MR:** Healthy periodontium: no bone loss and CALS in the 1-3 range throughout the mouth.

Students must use their critical thinking skills here. Discuss your rationales for the continued care interval with your instructor.

Protocols for 3 & 4 month continued care clients:

* Prior to the appointment review the client’s chart to familiarize yourself with the status of the client. Review all previous assessment findings and be sure to review past goals that were partially met or not met and/or future needs of the client from the Evaluation section. Review the client’s record of care. You must be prepared to see this client and without a thorough review of all previous findings, you will not be prepared.
* Update medical/dental/cultural lifestyle history. **Have it checked by instructor. If it has been 12 months or more since the original medical history was taken it must be done again, not just updated.** Dental Hygiene. Please ask all 7 questions on the medical history update form of all your clients. They are a guideline provided by the CDHO which should be followed. Faculty will review your medical/dental/cultural lifestyle history, perform a quick intra oral scan and authorize you to proceed. Please note that any updates to the dental history or cultural assessment form are to be noted at the bottom of their respective pages. All changes must also be noted in the ROC.
* Please sign up to have the DDS perform an intra-oral scan to determine if radiographs are to be prescribed. Be sure to have your radiographic needs assessment form completed so that you can discuss the client’s radiographic needs with the DDS. **Remember only the DDS can provide the prescription for radiographs and they must not be taken without that prescription!!**
* **Review** your intra/oral extra/oral and note changes at the bottom of the form. This will not be graded. However, it will be reviewed by faculty. If you have failed to note a change of any type you will receive a penalty under documentation. If there are no changes to initial findings please simply check off “no changes”. If there are changes, check the appropriate box and note any changes in the client’s ROC. \***Important: a new IO/EO exam must be performed and documented every 6 months. Therefore, even if the client is in for a 3 month recall, the IO/EO exam must be completed from scratch at every other 3 month interval.**
* Review your hard tissue charting to determine if there are any changes. If there have been no changes, indicate on the odontogram “3 or 4 month recall –no changes--- sign it. If there are changes then you should complete a new odontogram. **You must sign up for the DDS to check your findings however no grade will be assigned. The DDS will perform a caries check, check the status of existing restorations and perform a pathology exam only and will not be reviewing occlusion etc. The DDS will make a note on your evaluation book---3month recall, and will sign off. However, if there are any changes which the student fails to note, a documentation penalty will be issued. Important: a new hard tissue exam, complete with new odontogram, must be performed and documented every 6 months. Therefore, even if the client is in for a 3 month recall, the hard tissue exam must be completed from scratch at every other 3 month interval or within the six month guideline.**
* The rest of the process is the same. You must proceed now with the remainder of the assessment as you normally would. **You will be graded on your periodontal assessment, (please perform a PSR to determine if a full screening is required) goals and treatment planning and of course implementation and post care evaluation.**

Protocols for the 6 month continued care client:

* Prior to the appointment review the client’s chart to familiarize yourself with the status of the client. Review all previous assessment findings and be sure to review past goals that were partially met or not met and/or future needs of the client from the Evaluation section. Review the client’s record of care. You must be prepared to see this client and without a thorough review of all previous findings, you will not be prepared.
* Update medical and dental history. Note any changes in the client ROC. **Have it checked by faculty and have them document authorization to proceed after a quick intra oral scan.**
* Review the cultural and lifestyle assessment. If there are no changes be sure to note that at the bottom of the page. Note any changes in the client ROC.
* Treat the client as if they were a new client. If it has been more than a year since the original medical history was taken, then please take a complete new medical history. Otherwise, updates are acceptable.
* During the periodontal assessment please perform a PSR to determine if a full screening is required.
* Follow through with all aspects of ADPIE.
* During the periodontal assessment please perform a PSR to determine if a full screening is required.
* Treat the client as if they were a new client. If it has been more than a year since the original medical history was taken, then please take a complete new medical history. Otherwise, updates are acceptable.
* Add additional pages for all sections, including a new odontogram.
* All sections will be graded by faculty.

Students can access a clinical check list which will help them as they proceed through client care. It is available on the website:

[www.toronto-college-dental.org/notes/images/clinicalchecklist.docx](http://www.toronto-college-dental.org/notes/images/clinicalchecklist.docx)

Continued Care

It is important that all clients are maintained on a regular continuing care and maintenance program. Therefore it is mandatory that you input your clients into the consult pro system. Faculty will verify that it has been done.

Process:

1. Upon completion of treatment all students will update the client’s continued care interval into the consult pro system.
2. Information will include the degree of difficulty, the continued care interval and the amount of time required for the appointment.
3. Students will only be able to access their own clients. Students will be unable to change the provider: only faculty has authorization to do so.
4. Each month the re care coordinator will print who is due for an appointment. The re care list will show the current provider. Based on the list, clients with no current provider will be assigned to students.
5. The coordinator will call the client to remind them that they are due and will send an email to the student to remind them to make an appointment (if they have not already done so)
6. Students are to keep the re- care coordinator advised of any contact with the client resulting in the client not wishing to return or not being compliant with showing up for appointments. Students are also responsible for noting in the record of care that a client was contacted.
7. If you are graduating then you are responsible to give the coordinator a list of all the clients you have seen and he/she will assign them to current students. You are not permitted to give your client list to another student. TCDHA wants to fairly distribute client names.

**Quality Assurance Program**

Quality Assurance Programs

Overview

An effective quality assurance program encompasses all aspects of client care. Quality assurance involves client safety, through proper protocols for radiographic safety and infection control. Documentation and client records also involve a large aspect of quality assurance.

Quality assurance aims for a high level of quality throughout of all aspects of the ADPIE process and the manner in which that process is delivered.

Radiographic Safety:

To ensure quality the following takes place:

* Setting clear guidelines/policies and procedures
* Educating all students/faculty on effective radiographic safety.
* Appointing of a Radiation Protection Officer
* Daily step wedge for all radiographic units.
* Accurate records showing the results of all step wedges.
* Daily tracking of all exposures.
* Annual Maintenance of radiographic units with appropriate evidence and documentation of all maintenance visits.
* Lead apron with cervical collar for all clients.

Infection Control:

* Setting clear guidelines/policies and procedures for infection control
* Educating all student/faculty on effective infection control procedures.
* Bi weekly spore testing to include tracking and documentation of all results.
* Chemical indicators to ensure proper functioning of sterilizers.
* Annual maintenance of all equipment.

Health and Safety:

* Setting clear guidelines for students/faculty and clients while in the TCDHA client care clinic.
* Development of a TCDHA health and safety committee.
* Training of all students and faculty on health and safety.
* Documenting all incidents which may impact the safety of any of the above.
* Reporting all safety concerns to the TCDHA health and safety committee.

Maintenance of All client records:

* Clear guidelines for documentation.
* Clear guidelines for maintenance of client privacy and confidentiality.
* Clear guidelines for storage of client records.
* Privacy policies and the appointment of a privacy officer.
* Auditing of all client charts.

Topics mentioned above are discussed in further detail throughout this manual. Please refer to the pages noted above.

This chapter of the manual will focus on the auditing of client charts.

Chart Audits:

The purpose of the client chart audit is to ensure quality of care for our clients and to ensure that our charts reflect the CDHO regulations on record keeping and are in accordance with the CDHO Standards of Practice. It is a method of quality assurance for both the client and the operator. It is our goal that the student is prepared for what is professionally expected of them by their governing body (CDHO), once they enter private practice. Auditing client charts is the most effective manner to assure quality and promote reflection.

Quality assurance programs are in place to ensure that the client has received the best care possible. It is a stepping stone to reflection for the Dental Hygiene Student; a chance for the student to determine if the care provided to the client was appropriate and indeed client specific. Chart audits are a responsibility of the Dental Hygiene student and also a responsibility of the Registered Dental Hygienist in private practice.

Throughout client care students will be auditing the care of the client by completing a chair side audit for each client. Students will ascertain if all the client’s needs were properly addressed and met, and that the Dental Hygiene Process of Care was followed. They will examine their documentation for clarity and accuracy. This is a learning experience. The goal here is to help you provide the best client care possible. Noting a deficiency in one client chart will enable you to make the appropriate changes for the next client.

As you work your way through the chair side audit, the dental hygiene faculty will be auditing you as well. Once you complete each section of client care, the faculty will review your care and your documentation and will note “No” if the criteria has not been met. This will provide the student with the opportunity to discuss the care of the client and ask any questions if needed. If there is a concern expressed by the faculty they will note it on the audit sheet. Once it has been addressed, the faculty member will note that it has been met. It must be noted that the client must be in the chair when the audit is taking place. This allows for open communication between the client, the student and the faculty. The only time when the client may not be present is during the post care evaluation.

Performing chart audits for the first time can be challenging. A well audited chart is a skill like any other. During third semester, students will have an opportunity to review a client chart to n their Ethics and Professional Role class to review their chart with other students and with the instructor. Open discussion will enhance future client care.

Chart Audit Policy

All students will participate in the chair side TCDHA chart audit to ensure comprehensive client care and adherence to CDHO regulations for recordkeeping. These are referred to as “in progress” audits.

Rationale

Auditing client charts enables the student and the faculty to provide the best client care possible. It allows us to review the client treatment and evaluate areas that may need improvement. Chart auditing contributes to the learning process of not only the student Dental Hygienist but also the Registered Dental Hygienist in private practice.

Process

1. Students will perform chart audits on **each and every** client. The chart audit form can be found under the chart audit tab in consult pro.
2. Auditing the client chart is a two part process for the student.
3. **In progress** auditing of client charts will be done when the client is in the chair and will be completed during each clinic session. Students will place a checkmark in the appropriate column, stating that the criteria has been met (yes), not met (no) or is not applicable (NA). \*\*The only portion of the chart audit which is not done while the client is in the chair is the post care evaluation unless there is sufficient time.
4. Faculty will also audit the client chart while the client is in the chair and will initial in the yes, no or NA column. This is an excellent opportunity to promote conversation between the client, the student and the faculty member. It is also an excellent opportunity for the instructor to provide guidance for the student. If there is a component of client care which has not been met, the faculty will check off “No”. The faculty will note the necessary correction by commenting at the bottom of the chart audit page. Students must then comply by making the correction and faculty will verify that the correction has been made. This verification may be noted on the chart audit or in client’s record of care.
5. When the dental hygiene faculty is auditing the client chart chairside, errors in client care or documentation may be noted. If this is the case it will be reflected in the student’s grade and noted on their clinical evaluation page, found in their e file. Errors may also be reflected through loss of marks in the chart audit component of student evaluation or through a professionalism penalty.
6. When client care has been **completed** be sure to sign the chart audit prior to handing in your post care evaluation. Auditing your chart PRIOR to handing in in for post care credit is the **second** part of the chart audit process. All students must take the time to review the chart in its entirety. The clinic setting is a busy one and items may have been missed. Are there signatures missing? If signatures are missing students can sign up in the signature required page of the chart audit binder at the front of the clinic. Review the ROC once again, and add an omitted entry if needed.
7. When the student completes a post care evaluation and submits their chart for evaluation and credit, faculty will complete and sign off on the post care portion of client care. They will then sign off on the final section of the chart audit. If there are deficiencies in the post care, faculty will note this in the post care evaluation binder. Students must check the binder to determine which charts need to be reviewed and which corrections must take place. Deficiencies in the client chart at this point will result in a minus mark being assigned for the chart audit. It may also result in a professionalism penalty for the student. Students will be tracked to determine if there have been ongoing issues with missing components of the chart audit. If a student has had deficiencies in more than 3 audits an appointment will be set up with the education coordinator to attend a remedial session on chart audits.
8. To clarify once again: the chart audit process is a two part process. **In progress** auditing of the chart will be ongoing as the client is in the chair. When the chart is handed in for post care evaluation, the student must audit the chart again. It is extremely important that the student review and audits the chart very carefully prior to submitting the chart for post care evaluation.

**Random Chart Audits:**

In addition to the chair side audit, the TCDHA chart audit team will randomly audit 2 client charts for each student during clinic practice II. If the audit is satisfactory then no further audits will take place. If they are not satisfactory then the student will be asked to submit a third audit. If it is not satisfactory the student will be referred to the educational coordinators for remedial assistance. During Clinic Practice III, each student will have 1 more chart audit reviewed by the team, following the same process as above.

CDHO Regulations:

**CDHO Regulations on Record Keeping: The client’s health record must contain:**

1. The client’s name, address and date of birth.
2. The date and particulars of each professional contact with the client, whether in person, telephone or electronically.
3. For each visit the actual time the registrant spends providing dental hygiene care.
4. The name and address of the client’s primary care physician or nurse practitioner if obtainable.
5. The name and address of the client’s primary care dentist, if obtainable, if the record is not shared with that dentist.
6. The name and address of any referring health professional.
7. An appropriate medical/dental history of the client.
8. Every written report received by the registrant in respect to examinations, test, consultations or treatments performed by any other person.
9. A copy of every written communication sent by the registrant relative to the client.
10. A notation of the type of each examination performed by the registrant and particulars of every clinical finding and assessment made by the registrant.
11. Particulars of any medication given to or taken by the client as a precondition to treatment or examination by the registrant.
12. A dental hygiene treatment plan.
13. The treatment or procedures performed on each of the client’s visits to the registrant, and the identity of the person applying the treatment.
14. Particulars of all advice given by the registrant and every pre-treatment or post treatment instruction given by the registrant.
15. Particulars of every controlled act within the meaning of Section 27(2) of the *Regulated Health Professions Act, 1991,* performed by the registrant, including the source of the authority to perform the controlled act.
16. Time spent (in minutes) on all dental hygiene interventions.
17. Particulars of every referral of the client by the registrant to any other person.
18. A record of every implied/verbal or written consent.
19. A record of every refusal of a treatment or procedure.

TCDHA has a list of acceptable abbreviations which may be used in the client chart. This list will be distributed to all students and will be posted on line.

Errors in client chart: if a student makes an error in the client chart and wishes to correct it, he/she must go back to the original form and make the changes. The computer system will note the date of the updated form and also archives the original so that a review of the client chart will reflect any changes that have been made.

CDHO Regulations on Standing versus Specific order and Self Initiation

It is important for the Dental Hygiene Student to be aware that they are always working under the authority of a member of the College of the Dental Hygienists of Ontario. This is stated in the “Regulated Health Professions Act 1991”: Section 29 (d).

In Ontario, the practice of Dental Hygiene is regulated under the Regulated Health Professions Act (1991) and the Dental Hygiene Act (1991). As professionals we are self-regulated. In dentistry we have what are known as 2 “controlled acts”. They are 1) scaling and root planing, and 2) restorative and orthodontic procedures.

**The following refers to the RHPA and the DHA Act regarding authorization and “controlled acts”. This was how it was recorded in the original document.**

“In accordance with the *Regulated Health Professions Act 1991, (RHPA),* a dental hygienist must have an “order” from a dentist to proceed with the authorized acts outlined in Section 4 and 5 (1) of the *Dental Hygiene Act, 1991 (DHA).*”

4. In the course of engaging in the practice of Dental Hygiene, a member is authorized, subject to the terms, conditions, and limitations imposed on his or her certificate of registration, to perform the following:

1. Scaling teeth and root planing including curetting surrounding tissue.
2. Orthodontic and restorative procedures.

5. “A member shall not perform a procedure under the authority of section 4 unless the procedure is ordered by a member of the Royal College of Dental Surgeons of Ontario”

**Self Initiation:** As of September 2007 the Dental Hygiene Act was amended to allow “self-initiation” by Registered Dental Hygienists. This means that an RDH can self-initiate treatment **without an order from a dentist**. However, Dental Hygiene Faculty who are self-initiating will not self-initiate under the conditions listed on pages 12-14 and will collaborate with another health care professional (family physician or DDS) before authorizing treatment.

CDHO statement on self initiation:

“On September 1, 2007 the Ontario legislature facilitated increased public access to dental hygiene services by proclaiming the amendment to the *Dental Hygiene Act, 1991*. This means that authorized dental hygienists are free to decide, based on a comprehensive assessment, to proceed with scaling and root planing, including curettage, without the order requirement. This legislation validates the belief of this College and the conclusion made by HPRAC in 1996, that removal of the order requirement from the *Dental Hygiene Act, 1991* would satisfy the public interest principles of access, equality, accountability and quality of care, without placing the public at an increased risk of harm. This is an example of good government. It places the needs of the public first”

What this means to Dental Hygienists

Dental hygienists now have the option to proceed with their authorized act of *“scaling teeth and root planing, including curetting surrounding tissue”* on their own initiative (if there are no contraindications as prescribed in the contraindications regulation) or under an order from a member of the RCDSO.

Those dental hygienists wishing to self-initiate must apply, and receive, authorization from the CDHO prior to practising without an order. All dental hygienists should have now received packages containing the application for self-initiation as well as other documents critical to self-initiation in Ontario. Dental hygienists who are authorized to self-initiate are identified on the public register and have received a seal to place on their wall certificates to ensure public confidence.

Dental hygienists who choose to continue working under the order may continue to do so. A client-specific order is still required for dental hygienists who provide orthodontic and restorative procedures and services. All dental hygienists who have **not** received authorization from the CDHO to self-initiate are required to: work under an order from a member of the RCDSO; have a hard, accessible copy of all standing orders; have documentation to support specific orders; and record a reference to the order in each client entry.

**CDHO statement complete.**

TCDHA Policy on Self Initiation.

What does this mean to the student of TCDHA?

The TCDHA supports their Dental Hygiene Faculty and currently all Dental Hygiene Faculty are authorized to self-initiate under the CDHO. This means that all of the Dental Hygiene Faculty is able to sign authorization for the student to proceed upon review of the client’s medical history. If there is a contraindication to treatment such as any of the 11 conditions listed on pgs. 12-14 of this manual, then the Dental Hygiene Faculty member may collaborate with the Dentist on the clinic floor at the time or with the family physician, before authorizing any type of controlled act. The Dental Hygienist will record the conditions under which the student may proceed.

Once the student is signed in, authorization to proceed will be documented in the client’s record of care for each and every appointment. This authorization confirms that the client’s medical/dental history has been reviewed by faculty and that the faculty has been apprised of the students plan for the clinic session. If authorization to proceed is received it is also the student’s formal authorization for the controlled act.

It is important that the student refer to the authorization when recording the controlled act. Since you are students you must state the authority that gave you the authority to proceed with debridement.

Documentation of Authorization for Controlled Acts

Date: Authorized to proceed as per: Lila McIndoe, RDH

(Student writes: Review MH/DH, no changes. Reviewed intra/extra oral exam and periodontal assessment; Reviewed oral self-care, modified bass technique (10 minutes), manual and ultrasonic debridement of quad one, (as per Lila McIndoe RDH)**,** 90 minutes. The computer will identify and note who provided the care and will note the name of the faculty member involved.

As you can see from the example above any time debridement is performed you must provide details of this controlled act (which teeth are involved, manual, ultrasonics or both, amount of time spent on the controlled act, and the authorization for the controlled act).Your authorization for the controlled act is the self-initiating registered dental hygienist who signed you in. You must note his/her name directly after the debridement notation. \*\*Please note that an RDH can withdraw his/her authorization for the controlled act at any time during a client’s care if it appears that the client may be at risk.

Documentation of Dental Hygiene Interventions

In addition to debridement, students must record the amount of time spent in minutes, on any dental hygiene intervention.

This would include:

* Debridement
* Oral self-care (client education)
* Polish (selective or full)
* Fluoride
* Sub gingival irrigation
* Tobacco cessation
* Nutritional counselling

Documentation for Clients who have contraindications for treatment:

There will be times due to a compromised medical history that there may be restrictions on how you are to proceed. The Dental Hygiene faculty will provide instructions both on the medical history assessment page 4 of 6.

Upon subsequent appointments the DH student will refer to the conditions noted under which they may occur to show that the instructions are being followed. It may be a matter of taking blood pressure at each appointment or ensuring that INR numbers are noted before starting care. It may be a matter of the client needing premedication prior to treatment. Regardless of what the instructions are, the dental hygiene student must always note at each and every appointment that they are following the instructions provided by the Dental Hygiene Faculty.

**Clinical Procedures**

#### Hand washing Protocol:

#### At the beginning and end of each and every client care clinical session please perform the following. This is referred to as the “long wash”.

Technique:

1. Remove watch and jewelry and roll up your sleeves.
2. Don protective eyewear and mask.
3. Turn on the water and adjust the temperature to a cool temperature. Be sure to keep the water running.
4. Using antimicrobial soap lather your arms and your hands.
5. Clean your fingernails.
6. Thoroughly wash your hands (both surfaces) and then wash each digit separately. Interlace the fingers to clean proximal surfaces.
7. Upon washing your hands work your way up to your elbows being sure to keep your hands above your elbows.
8. Begin to rinse starting at the fingers and up to the elbows. Please remember to keep your hands above your elbows.
9. Repeat the entire procedure again. The procedure should take 2-6 minutes.
10. Pat your hands and arms dry with paper towels.

In between clients or during client care: if the hands are not visibly soiled, an alcohol based hand rub will be adequate. Spend 15 seconds cleaning all surfaces of the hands and fingers. Don fresh gloves.

Vital Signs:

**Assessment** is the first step in the Dental Hygiene Process of Care. A proper assessment begins with a thorough medical history and determination of vital signs.

When completing a medical history form for a client there must be NO blank spaces. All sections must be completed and any “yes” answers will require an explanation.

Students **must** bring their drug reference textbook to all client based clinical sessions.

There are four vital signs:

1. body temperature
2. pulse
3. respiration
4. blood pressure

Body Temperature:

* Taken with a thermometer.
* Three types of thermometer; disposable, mercury-column or electronic. TCDHA utilizes an electronic thermometer with disposable ear pieces.
* Increase above normal may indicate a systemic infection.

Technique:

* Obtain the electronic thermometer from the dispensary.
* Inform the patient of the procedure.
* Hold the unit by the handle and place a disposable ear piece on the unit.
* Gently place the unit in the client’s ear.
* Press start.
* The unit will beep when the temperature has been read.
* Review and record the reading.
* Dispose of disposable ear piece.
* Wipe down the unit and return to dispensary.

NB: Patient Alert!

**If client’s temperature is over 41.0 (105.8F), treat as a medical emergency and transport to hospital.**

**If client’s temperature is 37.6-41.0 (99.6-104.8), check possible cause (such as hot drink), and check again. Review dental and medical history. Delay dental treatment if there are signs of respiratory infection or other possible communicable disease.**

Pulse:

The pulse is the intermittent throbbing sensation felt when the fingers are pressed against the artery. The pulse rate is the count of the heartbeats.

Technique:

* The most commonly used site is on the radial artery at the wrist and is called the radial pulse.
* Explain the procedure to the client.
* Hand the client in a comfortable position with are and hand supported, palm down.
* Locate the radial pulse on the thumb side of the wrist with the first three fingers. **Do not use your thumb as it contains a pulse.**
* When the pulse is found, exert light pressure and count for one minute. Check with a repeat count.
* As you count the pulse rate observe the following; is the rhythm regular, regularly irregular, or irregularly irregular? Is the volume and strength full and strong? or poor, weak and thready?
* Record all readings.

Respiration:

The function of respiration is to provide oxygen to the tissues and to eliminate carbon dioxide. Any variation of normal may be symptomatic of disease or emergency states.

Technique:

* Respiration check is usually done in conjunction with taking a pulse.
* Count the respirations immediately after counting the pulse.
* Maintain fingers over the radial pulse.
* Respirations must be counted so that client is **not** aware, as the rate may be voluntarily altered.
* Count the number of times the chest rises in one clocked minute.
* Observe the following: Depth: shallow or deep. Rhythm: regular (evenly spaced) or irregular. Quality: strong, easy, weak? Sounds: describe any sounds made during breathing. Client position: does the client have to move to breathe more comfortably?
* Record all findings

#### Blood Pressure

**Blood pressure** is the force exerted by the blood on the blood vessel walls.

**Systolic Pressure**: is the highest pressure. It is caused by ventricular contraction.

**Diastolic Pressure**: is the lowest pressure. It is caused by the effect of ventricular relaxation.

**Pulse Pressure**: is the difference between the systolic and the diastolic pressure.

**Technique:**

* Explain procedure to client
* Seat client comfortably, with arm slightly flexed, with palm up, and with the whole forearm supported on a level surface at the level of the heart.
* If you need to repeat the procedure, use the same arm as readings can vary between arms.
* Take blood pressure on bare arm, not over clothing.
* Apply the deflated cuff to the client’s arm supported at the level of the heart.
* Place the portion of the cuff that contains the inflatable bladder directly over the brachial artery. Some cuffs have an arrow to show how it should be placed. The lower edge of the cup is placed 1 inch above the antecubital fossa.
* Fasten the cup evenly and snugly.
* Adjust the position of the gauge for convenient reading but so that the client cannot see the mercury.
* Palpate 1 inch below the antecubital fossa to locate the brachial artery pulse. The stethoscope endpiece is placed over the spot where the brachial pulse is felt.
* Position the stethoscope earpieces in the ears, with the tips directed forward.
* Hold the fingers on the pulse.
* Close the needle valve attached to the hand control bulb firmly but so it may be released readily.
* Pump to inflate the cuff until the radial pulse stops. Note the mercury level at which the pulse disappears.
* Look at the dial, and pump to 20 or 30 mmHg beyond where the radial pulse was no longer felt.
* Place the endpiece over the palpated brachial artery, 1 inch below the antecubital fossa, and slightly toward the inner side of the arm.
* Release the air lock slowly (2-3mm per second) so that the dial drops very gradually and steadily.
* Listen for the first sound. Note the number; this is the systolic pressure.
* Continue to release pressure slowly, as you do the sound will become louder, then decrease, become muffled and disappear entirely. Note the number of the last sound heard as this is the diastolic pressure.
* Release further (about 10 mm) until all the sounds cease.
* Release the remaining air rapidly.
* Wait at least 30 seconds to repeat.

Ranges For Normal Vital Signs

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Blood Pressure | Pulse per minute | RespirationsPer minute | Temperature C |
| Infant | 74-100/50-70 | 80-160 | 30-60 | 37.4-37.6 |
| Preschool | 82-110/50-78 | 80-120 | 22-34 | 37-38.1 |
| School age | 84-120/54-80 | 75-110 | 8-30 | 36.6-37 |
| Adolescent | 94-140/62-88 | 60-90 | 12-20 | 36.1-37.2 |
| Adult | 90-140/60-90 | 60-100 | 12-20 | 36.1-37.2 |
| Geriatric | 90-140/60-90 | 60-100 | 12-20 | 35.5-37.2 |

A normal blood pressure is now considered to be **115/75.**

Points to remember:

1. A client’s blood pressure is usually lowest first thing in the morning. It will rise after meals or exercise.
2. Blood pressure is lower when reclined than when sitting or standing.
3. Always keep the client in a relaxed position before taking the blood pressure.
4. Always take a second reading to confirm the first.
5. If a client is hypertensive, a blood pressure reading should be taken and recorded at each appointment.
6. If a client is undergoing dialysis **DO NOT** take the blood pressure in the arm used for the dialysis procedure.
7. TCDHA follows all guidelines set by the CDHO. All protocols for blood pressure are posted in the clinic. They are also found in this manual on page: 176-177

**Intra Oral Photographs (Basic)**

There are 6 basic intraoral photographs that are a must for any comprehensive examination :

Thre are basic requirements to make aphotograph “diagnostic “

1. It has to be in focus
2. It has to have proper lighting
3. It must show the areas of interest
4. It must be as horizontaly accurate as possible



Right lateral Frontal in Occlusion Left Lateral

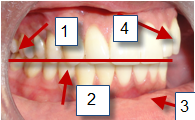


Upper Occlusal Frontal Slightly open Lower Occlusal

Crop the photos to show the maximum area without showing much of the cheek retractors and lips.

Left and right Lateral views

1. Make sure you retract the cheek as much as possible to see the molars
2. Make sure the occlusal plane is as horizontal as possible
3. Make sure the lower lip is retracted and not covering the teeth
4. Make sure you can see the opposing canine



Frontal Views

1. Make sure the occlusal plane is as horizontal as possible
2. Make sure you can see the two sides (molars ) evenly. Note here we see a bit more of the patient’s left
3. Make sure that the open view is only slightly open and that the teeth are not overlapping with the bottom



Occlusal views

1. Try to get as far back as possible . preferably the second molar .
2. Keep the tongue as low as possible . Ask the patient to keep it down .
3. Make sure the lower lip does not cover the lower teeth in the Mandibular view .Use a mirror to retract the lip if needed.
4. Try to be as horizontally correct as possible.



All of the above can be achieved with just cheek retractors. For more in depth intra oral photos we can use mouth mirrors to get more comprehensive diagnostic photos.

Coronal Polishing Procedure:

Coronal polishing is only performed on an “as needed” basis. Most often, a selective polish is all that is required. Information should be provided for each patient concerning individual needs.

1. Check client’s medical history for any contraindications for the polishing process.
2. Use the modified pen grasp.
3. Establish a fulcrum (you may tend to use a cross arch or opposite arch to allow for manipulation of the hand piece.
4. Apply steady even pressure on the rheostat to produce an even, low speed.
5. Fill rubber cup with polishing paste and apply the revolving cup lightly to the tooth surface for 1-2 seconds. Use a light pressure so that the edges of the cup flare slightly.
6. Turn hand piece to allow for proper adaptation into the proximal areas.
7. Start at the distal surface of the most posterior tooth and work forward. Always work in a sequence.
8. Replenish prophy paste as required.
9. Maintain a constant low speed. If you operate the rubber cup is moving too fast, it will generate heat and harm the client.
10. Perform a limited mouth rinse as you move from quadrant to quadrant, to provide a better field of vision, and to allow for client comfort.
11. Floss all areas for client, and allow them to rinse their mouths.

## Please refer to page 62 to view criteria on coronal polish.

Fluoride Application:

Tray Method

1. Explain technique to the client.
2. Client is to be seated upright.
3. Be sure that tray selection is correct.
4. Fill tray 2/3 full. You need to be sure that when inserted, the fluoride will flow upwards or downwards as needed, to cover the surface of the teeth. You don’t want to over fill however, make sure that you have sufficient fluoride in the tray.
5. Air dry dentition. If client is sensitive use 2x2 gauze to dry teeth.
6. Insert the trays, one at a time, with the mandible first and then the maxilla.
7. Insert the saliva ejector.
8. Have client close their teeth together and “chew” for a second or two.
9. Have the client tilt their head down slightly. Observe client at all times!!
10. After four minutes, remove both trays and the saliva ejector.
11. Remove excess fluoride with the High volume evacuator.
12. Instruct client NOT to swallow, but to spit several times to remove all excess.
13. Do not allow the client to rinse.
14. Give client post procedure instructions.

## Please refer to page 64 to view criteria on fluoride treatments.

## Fluoride Treatment

Varnish

1. Explain the procedure to the client.
2. Thoroughly remove all plaque & calculus.
3. Wipe teeth dry with 2 x 2 gauze: (teeth may be too sensitive for the a/w syringe)
4. Isolate the teeth with cotton rolls.
5. Apply a thin layer of varnish to the tooth with a cotton swab.
6. Wait for 10 seconds allowing the product to dry.
7. After ten seconds, you can allow the treated area to become moistened. This material will harden immediately on contact with saliva or moisture.
8. Give constant supervision.
9. Give client post procedure instructions.

Client Instructions:

* + Do not brush teeth for 4 hours
  + Avoid hard foods for 4 hours (it may remove some of the fluoride film)
  + After 4 hours remove film by brushing
  + NB: always check manufacturer’s instructions before using the product. In our clinic we currently use Duraflor.
  + **If a client is receiving a fluoride varnish, a conventional fluoride treatment may not be administered on the same day.**

## Alginate Impressions

## Procedure:

1. Explain procedure to the client.
2. Examine the client’s oral cavity noting crowding, missing teeth, arch size or tori.
3. Have client remove any appliances or prosthetics.
4. Apply Vaseline to lips.
5. Drape the client.
6. Select a tray size and try it in.
7. Add utility wax to the borders of the tray.

Criteria for Tray Selection:

1. Width: tray must be wide enough for ¼ inch of alginate allowance on the facial and lingual, without causing discomfort in the buccal fold or impinging on the lingual aspects.
2. Length: Long enough to cover the mandibular retromolar pads and the maxillary tuberosity. There should be a ¼ inch clearance anterior to the centrals.
3. Beading wax may be added to the entire rim or just in areas where needed. Beading wax helps to extend the length of the tray, give it more depth when needed, and may reduce pressure on the soft tissues.

Procedure:

1. Have all material ready chair side. Do not forget to have a kidney bowl close by if required.
2. Seat patient upright.
3. Instruct patient to swallow just before insertion.
4. Maxilla:
   * Stand in the 11:00 position (RH) 1:00 (LH)
   * Hold the tray in your dominant hand; retract the clients cheek and lips of opposite side while at the same time, retracting the same side with the edge of the tray. “Rotate” the tray into the mouth.
   * Line up the tray using the nose as a guide. Remember to ensure that there is at least ¼ inch clearance labial to the most anterior tooth.
   * Seat tray in the posterior region first, gradually seating into the anterior region.
   * Lift out the cheeks and lips to allow for flow of the material. Client is to remain relaxed.
   * Hold tray using gentle pressure, keeping fingers about midway back.
   * A saliva ejector may be used if required.

Mandible:

* Stand in the 9:00 position. (RH) 3:00 (LH).
* Same insertion as per maxilla, instead use chin as a guide.
* Allow for ¼ inch clearance on the lower centrals
* Seat the posterior of the tray slightly before the anterior and instruct the client to lift their tongue as tray is being seated.
* Once tray is seated, tongue can be relaxed.
* Pull lips and cheeks out to allow for material flow.
* Maintain light even pressure on the midsection of the tray.

Tray Removal:

1. Lift the soft tissue of the cheeks away from the tray in an attempt to break the seal. If necessary, place the side of your finger in the buccal vestibule and apply pressure on side of the tray.
2. Hold the handle and raise the posterior section slightly, then raise anterior section, once both are relieved, lift entire tray up, and with a rotary motion remove one end of the tray, followed by the other.
3. Rinse the impression under slow running water to remove saliva, blood, and debris.
4. Immerse impression in disinfectant. Wrap trays in damp paper towels, put them in a sealed container and have a clinic monitor pour it up. If a night guard or whitening tray is to be made it will be the responsibility of the operator to make the trays.

Glaze Technique:

Once the alginate is in the tray, dampen your fingers. Wipe the surface of the impression material to create a smooth or glazed surface.

Smear Technique:

Leave a little impression material in the bowl after loading the tray. Scoop this material up with your fingers and smear it into a high vaulted palate and or over occlusal surfaces prior to seating the tray.

**\*Please note: taking alginates for study models, fabrication of whitening trays or sports gaurds must be in the treatment plan for the client. All alginates must be poured and study models created for the client.**

Pit and Fissure Sealants

The following instructions are guidelines only. Please refer to the manufacturers guidelines for specific instructions.

1. Have all materials ready at your unit.
2. Using a pumice paste (non-fluoridated) polish the tooth surface.
3. Place Dri Angles over parotid Duct.
4. Isolate area using cotton rolls and dry tooth thoroughly or rubber dam (no Dri Angle required if using rubber dam).
5. Place Saliva ejector in mouth.
6. Apply etch for 15-20 seconds.
7. Remove cotton rolls and thoroughly rinse for 30 seconds.
8. Dry the area & evaluate to ensure that the area is adequately etched and has a white chalky appearance. Re-etch if necessary.
9. Place new cotton rolls, and dry area again for 15-20 seconds.
10. Apply a primer if sealant system has one & let dry.
11. Apply the sealant material over pits, fissures and inclined planes. BE CAREFUL NOT TO OVERFILL.
12. Allow material to flow ahead of applicator tip.
13. Remove any excess using an explorer or fine tipped applicator. Try to avoid creating bubbles.
14. With photo polymerized sealants apply light to each portion of the sealant for 20-30 seconds as per manufacturer’s instruction before advancing the light to another area.
15. With Autopolymerized sealants prepare a separate mix for every two teeth.
16. Evaluate the sealant with an explorer. Use the explorer in a zigzag motion over the cavosurface margins of the sealant to determine if they have any excessive discrepancies, voids & bubbles. Try to dislodge the sealant.
17. Check proximal contacts with dental floss.
18. Re-etch and repeat procedure if imperfections are noted.
19. Remove isolation.
20. Remove any thin sticky film present on the surface of the hardened sealant using a dampened cotton roll or gauze.
21. Check occlusion with articulating paper.
22. Insert articulating paper along the occlusal surface and have the client tap teeth together and slightly from side to side.
23. Observe all marking to determine if they have the same intensity and can reproduce the same contacts as determined prior to placement. Teeth should “feel” as they did when assessed before placement.
24. Premature contacts are areas where there is too much sealant and these will register as darker areas when checked with articulating paper.
25. Finished sealant should reproduce the same contacts as determined prior to placing the sealant.
26. Client can often tell by the “feel” if sealant is too high.
27. Reduce premature contacts with slow speed hand piece, round or flame shaped finishing burs or polishing stones that will fit the area being reduced.
28. Adapt the side of the bur or stone along the margin, contacting both tooth and sealant.
29. Rotate the bur or stone from the sealant to the tooth following the outline of the cusps. Always begin at the center of the restoration and work towards the cavosurface margin.
30. Recheck the occlusion and ask client how it feels.

Sub-Gingival Irrigation

“Sub gingival irrigation is the intentional irrigation of a gingival crevice or periodontal pocket when the point of delivery is directed under the gingival margin.” (Wilkins)

Chemotherapeutic agents are used to flush out the pocket and this serves to reduce the number of bacteria in the pocket and may promote healing. Irrigation disrupts microbial colonization. Irrigators may be either manual or power driven. Chlorhexidine 0.12% is usually the medicament of choice.

Procedure:

1. Inform the client as to why you would like to irrigate. Obtain their consent if you have not already done so.
2. Upon completion of the debridement session, allow the client to rinse with water.
3. Fill the irrigating syringe with 0.12% Chlorhexidine solution.
4. “Walk” the irrigating syringe subgingivally around the sulcus, as you would when using your periodontal probe. Activate flow of the antimicrobial for at least 5-6 seconds per tooth.
5. Be careful to use the saliva ejector to remove any excess solution. Do not permit the client to swallow the solution and be sure to inform them not to rinse after the procedure.
6. Upon completion, advise the client not to eat or drink for at least 30 minutes.

Sub gingival irrigation must be treatment planned for the appropriate clients and student must provide rationale for its use. Students will be briefly observed during their first application only.

\*\*As students will learn in their periodontics courses, evidenced based research now shows that sub gingival irrigation can be of limited value. Please discuss your thoughts with your instructor.

Application of Topical Anaesthetic

Topical anaesthetic is defined as a “solution applied to the mucous membrane before the initial needle penetration or scaling to anaesthetize terminal nerve endings to promote client comfort” (Darby & Walsh, 2014, p.1242).

In our clinic the Dental Hygiene Student may be asked to place the topical anaesthetic in preparation for a local anaesthetic injection by the DDS. Or topical anaesthetic may be used as a pain management strategy for clients experiencing sensitivity during debridement procedures.

Absorption of the topical anaesthetic agent is through the mucous membrane and only small amounts should be used to avoid toxicity (Darby & Walsh, 2014).

Application of topical anaesthetic must be included in the treatment plan and authorized by the Dental Hygiene Faculty.

Procedure (Gel)

1. Review the client’s medical history to ensure that there are no contra indications to using topical anaesthetic.
2. Explain the procedure to the client before you begin and obtain their consent if you have not already done so.
3. With a piece of 2x2 gauze wipe the application site to remove any debris or saliva from the area.
4. For use as a pain control management technique: Using a cotton tip applicator place a small amount of topical gel on the gingiva around the teeth where you are planning to debride. Please place the gel for only a small area at a time. As a guide place it on the tissues of no more than 2-3 teeth. **NB: do not slather it on! If too much is applied the result can be toxic for the client**.
5. For use prior to injection of local anaesthetic: Using a cotton tip applicator place a small amount of the topical gel at the injection site.
6. Allow the cotton tip applicator to stay in contact with the tissues for 1-2 minutes.
7. Constantly observe the client for possible allergic reactions.

NB: Recently new products have come onto the market. Currently TCDHA is using “Cetacaine” in the dental hygiene clinic. Cetacaine is an intra sulcular type of topical anaesthetic applied subgingivally using a syringe. Its use has proven very effective. During the first application of Cetacaine, faculty will demonstrate the technique and then permit the student to apply it under their guidance. Once the student has been observed during one application they will not be observed again unless they require assistance.

Polishing of Restorations

“Polished amalgam retains less oral biofilm and resists tarnish and corrosion better than unpolished amalgam” (Darby & Walsh, 2014, p. 697). Amalgam restorations are less popular than they used to be.

This skill will be demonstrated in Clinic Practice I.

Procedure for Polishing Amalgams

1. Explain the procedure to the client. Obtain their consent if you have not already done so.
2. Using a slow handpiece and a selection of rubber cups and points, polish the restoration, starting with the most abrasive to the least abrasive, keeping the operating field moist at all times.
3. Do not alter tooth structure.
4. Rinse the mouth of debris.

\*\*Current evidence based research shows that there is controversy regarding any potential benefit to this procedure. Although all students will have the skill demonstrated to them and will be evaluated on this skill, it is unlikely they will perform this skill in the client care clinic.

**Dispensary & Supplies**

Clinic Supplies

Dispensary:

The dispensary will operate during all clinical hours. All requests for supplies must be made through the dispensary staff. Students must be prepared for each client in advance of their appointment.

It is important that you are not wasteful! Use your discretion in determining the quantity of goods required.

The following will be supplied to the student upon request to the dispensary. Please bring receipt to dispensary to confirm payment of procedures if it is a material that represents an additional fee for the client. All receipts will be scanned into the client chart.

* Sealant material (receipt required)
* Phosphorous plates (receipt required)
* Impression trays and alginate
* Desensitization material
* Cavitron units and sleeves
* Rubber dam armamentarium
* Local and topical anesthetic
* Fluoride

All students will be provided with tags. Once an item is requested from the dispensary a tag will be placed on the peg board to identify which student has taken out a supply. Once the student returns the equipment or supply to the dispensary the student will have their tag returned to them.

It is the student’s responsibility to return all supplies and equipment clean and ready for sterilization and in good working order.

Dental equipment and supplies are very expensive. Please follow all manufacturers’ instructions for their care. A binder containing all manufacturers’ instructions will be available to the student. This binder will be kept in the dispensary.

Instrument Care:

All instruments are to be put through the re-circulation process, dried thoroughly and wrapped. All cassettes must be brought to the dispensary within 15 minutes of clinic completion. Student’s name and unit number must be clearly marked. Dispensary staff will sterilize all cassettes and have them available for the next clinical session. (N.B. please refer to procedures for re-circulation in the Health, Safety and Asepsis section of this manual). Student’s instruments must be signed in and out of clinic.

Any broken instruments or equipment failure must be reported to the dispensary staff immediately. There is sheet in the dispensary for this purpose.

Consumable Supplies:

All consumable supplies will be kept in the recirculation area. It is important that you not be wasteful. Use your discretion in determining the quantity of goods needed. Any item not found in the cupboards in the re-circulation area will be available from the dispensary.

The dispensary staff and monitors will replenish consumable supplies. It is the responsibility of the monitors to inform the dispensary staff when items need to be restocked. Monitors will also take responsibility for restocking.

The dispensary staff and monitors will prepare tray set-ups with disposable supplies in advance.

The following items are issued to each student for the unit. Supplies which have been issued to the dental hygiene units **are not** to be removed.

|  |  |  |
| --- | --- | --- |
| **Under sink**: | **In drawers:** | **Assigned items**: |
| * disinfectant (spray) * kidney basin * sink cleanser * small scrub pad | * hand mirror * safety glasses for clients (adults & paedo) * kleenex | * Dental unit * Fletcher manikin * typodont |

Client Self-Care Aids (available in the dispensary)

The following will be available for the student to dispense to their clients on an as needed basis. Again, we must stress that students use their discretion when dispensing these items.

1. Toothbrushes (paedo, youth, and adult sizes).
2. Floss Threaders.
3. Floss (waxed and unwaxed).
4. Sensodyne toothpaste

Also available for demonstration purposes is the Oral B rotary brush. There are 2 large teeth models, and two rings of various types of manual brushes and aids. All of these must be signed in and out and cannot leave the clinic.

Prevention of

Disease Transmission

(Infection Control)

Infection in the Dental Clinic

Infection is the spread of disease-producing organisms – pathogens. Infection also refers to the presence of pathogens in the body.

1. Pathogens live almost anywhere in the environment: air, dust, surfaces, and within the body in body fluids.
2. Although most pathogens can be easily killed by the use of disinfection and sterilization, many, including Hepatitis B, can live on dry surfaces for a week or longer.
3. The body has barriers that keep many pathogens out: skin is the primary barrier. Mucous membranes in the mouth, nose and other body openings also form a protective shield against pathogens.
4. Pathogens easily pass into the body through cuts or scrapes in the skin or mucous membranes. Once inside the body, most pathogens live in blood and saliva.
5. When pathogens invade, the body tries to fight them with special cells and fever. Under certain circumstances – if the body is weak or lacks immunity to the invading pathogen, or if the pathogens are too strong or too numerous – infection and disease can occur.
6. AIDS, Herpes simplex virus 1, Hepatitis B, Measles, Chicken pox, Staphylococcal and Streptococcal infections, Influenza, Mumps, Pneumonia and Tuberculosis are only a few of pathogens and infectious diseases that are transmissible in the dental healthcare environment.

Disease transmission: (Reference: RCDSO Infection control guidelines).

There are three modes of transmission:

Direct: Direct contact with blood, oral fluids or other materials.

Indirect: Contact with an intermediate contaminated object such as a dental instrument or surface.

Droplet**:** contact of oral, nasal or conjunctival mucosa with droplets, spatter or spray containing micro-organisms generated from an infected

person, such as by coughing, sneezing or talking

TCDHA: Pandemic Protocol:

In 2009: The H1N1 was declared a global pandemic by the world health organization. TCDHA has established a protocol that all clients entering the building must be screened. All students have been provided with the screening procedures and relevant questions to be completed.

NB: Should a provincial alert be sent to health care professionals regarding a possible pandemic, students will be notified and the TCDHA will follow all provincial guidelines and recommendations. Notification of protocols will be posted in the clinic, emailed to students and posted on the website.

Please refer to the following website: <http://www.ccohs.ca/pandemic/type/checklist.html>

**Pandemic Defined**: ‘A pandemic is a worldwide outbreak of a specific disease that spreads easily and rapidly through many countries. It is usually a serious illness that causes a large percentage of the population to become ill because they have little or no immunity to it. ([www.ccohs.ca](http://www.ccohs.ca))

1. Once TCDHA has been notified regarding a possible pandemic all students, faculty and support staff will be notified through email, in class discussion and the TCDHA website. Signs and symptoms will be posted.

2. All incoming clients to TCDHA will be screened.

3. All faculty, staff, and students are advised to stay home if they are ill. Only with a physician’s approval may they return to the school.

4. TCDHA will continue to monitor the situation and provide everyone with daily updates regarding the pandemic.

5. TCDHA will follow all provincial guidelines for pandemics.

All students, faculty and support staff are advised to do the following;

* Frequent and thorough handwashing
* Regular touch point cleaning
* Keep hands away from face
* Cough into elbow or tissue
* Maintain healthy diet & sleep
* STAY HOME IF ILL

Prevention of Disease Transmission

It is the responsibility of the dental hygiene student to maintain the chain of asepsis. This college follows standard precautions. Currently we follow the RCDSO Guidelines for Infection Control. These guidelines are based on Centres for Disease Control guidelines. A copy of these guidelines may be found in the dispensary. They have also been reviewed in your microbiology class. They are also available on line:

<http://www.rcdso.org/pdf/guidelines/2918-Infection-ControlUpdateV2.pdf>

The RCDSO also provides updated health notices regarding health issues affecting the health of the public.

<http://www.rcdso.org/import_health_notice.html>

\*\*Students will be evaluated on setting up and tearing down their units. Please refer to checklist and evaluation criteria on pages: 167-168 which provides the proper sequencing of the clean and disinfect procedure.

Toronto College of Dental Hygiene and Auxiliaries: Infection Control Policy

TCDHA takes a 3 prong approach to infection control:

* + 1. Cleaning and Disinfecting the Unit. Including set up and take down of unit; preparation of all armamentarium for sterilization.
    2. Personal Protective Equipment for the student, and student responsibilities.
    3. Protection of the client.

TCDHA Infection Control Protocols:

Operatory and Equipment Care

Introduction

To prevent the transfer of microorganisms, proper aseptic techniques must be performed prior to, throughout and following each clinical period. To safeguard against cross contamination and/or injury, the student ensures that the unit and equipment are maintained and functioning properly at all times.

Personal protection equipment must be worn during all phases of cleaning and disinfecting the dental unit.

Dental Hygiene Operatory Asepsis Procedures (Set-up):

1. Perform a long hand wash. Place on lab coat as protective barrier.

2. With clean hands fill the empty water bottle with water.

3. Don PPE and flush each type of dental water line (air/water) for 2 minutes.

4. Hold and run handpiece lines over the cuspidor for 2 minutes by stepping on the rheostat.

The cavitron water lines must also be bled for the same amount of time if using the cavitron. If the dental unit has not been used for several days, then the lines should be bled for longer (4-7 mins.)

1. Obtain 1 litre of prepared evacuator solution and run solution through the high volume, saliva ejector and cuspidor.
2. Clean the following with Optim and 4x4 gauze including:

* + 1. Dental Station: clean field, countertops, faucet, faucet handles, top of soap dispenser, rim of sink, doors of unit and drawer handles.
    2. Dental light: control arm, switch and handles; clean light cover with damp cloth.
    3. Dental unit components: bracket table (top and bottom, controls and switches. Be sure to clean the supports for the handpieces and air/water syringe. Continue by cleaning the air/water syringe, couplings and toggles and complete length of the hosing.
    4. Dental Chair control switches, headrests and arms of chair. Use Optim on the upholstery. Clean the foot pedals, chrome base, base of chair and junction box.
    5. Oral evacuation system: the High Volume evacuator, saliva ejector, couplings and length of hosing.
    6. Operator stool (seat, back and adjuster pull underneath chair)
    7. Cuspidor and client water dispensing area. Clean suction trap.

\*\* Don new exam gloves to disinfect the high risk areas.

Disinfect all high-risk surfaces. This is done by soaking a 4" x 4” gauze with Optim; swab the surfaces and leaving it to dry. (Minimum: 10 minutes). Please see # 7 for all high risk areas.

\*\* Dispose of mask and gloves; perform hand hygiene with antiseptic hand wash for 15 seconds.

7. Apply Barriers and prepare needed supplies once unit has been cleaned and disinfected:

Wrap with plastic wrap or barriers:

* 1. Saliva and high volume suction couplings
  2. Chair controls
  3. Light handles and switch.
  4. Air and water syringe
  5. Operator stool height adjustor.
  6. Attach over gloves to the unit so that you may use your over gloves when writing in the client chart, using the computer, or retrieving items needed in client care or in self-care education.

1. Retrieve and place: headrest cover, bibs, gauze, trash bag, paper tray liner, Dixie cup, saliva ejectors, cotton rolls, fluoride trays, etc.

Clean disposable materials to be used with each client.

Include: a) headrest covers

b) Bibs, 2" x 2” gauze, trash bags

c) Paper tray liners for clean field area

d) Instrument wraps for cassettes/tray cover

e) Dixie cups, saliva ejectors, cotton rolls

f) barriers and sleeves

g) Fluoride trays

h) Prophy cup & brush

9. Bring instrument cassette to your unit and unwrap in front of the client. You can use the inside of the blue wrap as part of your tray cover.

Dental Hygiene Operatory Asepsis Procedure (Tear Down)

1. Once client is dismissed, perform hand hygiene and put on new PPE
2. Place utility gloves over new exam gloves and proceed to sterilization center with your instruments and any sharps that need to be discarded. (\* All PPE must be worn in the sterilization area.)
3. Obtain 1 litre of prepared evacuator solution from sterilization center and return to unit.
4. Return to unit and remove utility gloves and with exam gloves remove barriers and discard all waste. (Please see TCDHA Policy on Hazardous waste on page 170 of this manual).
5. Run evacuator solution through the high volume, saliva ejector and cuspidor.
6. Flush air/water lines for 20-30 seconds.
7. Clean all surfaces of the dental unit, stools, trays, carts, light, arm, ultrasonic unit, etc.
8. Clean and disinfect HVE and saliva ejector evacuator couplings and hoses. Evacuator brushes may be used. Saliva ejector traps must be clean.
9. Sink and cuspidor are to be cleaned thoroughly with a liquid/powder cleaner (Ajax, Vim). Trap is to be removed, cleaned and scrubbed (or placed in ultrasonic) then returned to bowl.
10. Remove PPE and perform hand hygiene.
11. Unit chairs are to be raised to their high position, rheostats placed on paper towel and then placed on seat of the chair, lights are to be turned upwards and bracket trays placed over the seat of the chair.
12. Lights are turned upwards and bracket trays placed over the seat of the chair
13. Empty water bottle and assemble to unit empty.
14. Turn off power to unit and to your computer.

Once your units are cleaned and disinfected you may prepare your instruments for sterilization.

\* For infection control protocols in the radiography rooms please refer to your Radiology lab manual.

Instrument Care Prior to Sterilization

Guidelines:

Avoid scrubbing instruments prior to sterilization as this puts you at risk of a puncture wound and potential exposure to HIV, hepatitis C and syphilis. It is not necessary to scrub instruments if they have no organic debris on them. Since instruments are wiped with gauze as the student debrides there is usually no need to scrub the instruments. Bring your cassette to the recirculation section of the clinic to be placed in the ultrasonic.

Always wear your heavy rubberized gloves when handling your instrument cassette.

Re-Circulation and Sterilization

Take your cassettes to the recirculation area where they will be placed in the ultrasonic for 10 minutes. After ultrasonic cleaning, the cassette must be rinsed under running water, left to drain for a few minutes, dried, wrapped with a BLUE WRAP, numbered and handed in to the dispensary staff for sterilization.

Wrap and properly tape cassettes to be sterilized. Write appropriate identification on the cassette. Disposable bags are available for handpieces, impression trays etc. Place items for sterilization in the metal baskets found in the recirculation area. Dispensary staff will sterilize all instruments and equipment.

Return all items to be sterilized to the dispensary 15 minutes prior to the end of clinic. If you run late, do not leave your kit on the counter. The college is not responsible for any lost cassettes.

Rules for the Re-Circulation Room

When in the re-circulation room:

1. UTILITY GLOVES (heavy rubberized gloves) are to worn when bringing instruments to the room and when placing and removing the cassettes from the ultrasonic cleaners.
2. Students who are wrapping and taping cassettes in the re circulation room may wear a new pair of examination gloves.
3. Please wear safety glasses and masks at all times.
4. No more than 6 cassettes should be placed in the ultrasonic cleaner at one time. Be sure that the ultrasonic solution covers all the instrument cassettes. The ultrasonic should be run for a minimum of 10 minutes with the lid on. Utility gloves must still be used to handle the cassettes when they are removed from the ultrasonic unit.
5. RINSE with hot water and place to drain and partially DRY.
6. Using the towels provided, pat dry all instruments and external surface of cassette prior to wrapping.
7. WRAP cassettes and write your name and UNIT number CLEARLY on top.
8. Place cassettes on dispensary counter to be STERILIZED.
9. Clean all countertops and sinks with cleanser and Optime33.
10. Clinic monitors are responsible for ensuring that all clinical units are shut down properly and that all clinical and recirculation areas are neat and tidy.

Equipment Maintenance

1. Follow protocol for Infection Control Procedure for daily clinic start-up and shutdown.
2. Keep your cabinets stocked with soap, paper towels and Kleenex. Keep soap dispenser clean.
3. Clean and lubricate your handpiece after each use. Refer to instructions included with your handpiece.
4. Following client dismissal, place the reflecting surface of the light face up, approximately 18” away from the headrest. Position the chair upright, in a slightly raised position.
5. Clean the cuspidor traps and change as needed. Clean your suction traps at the beginning of each day.
6. Spore testing will be completed by dispensary staff to ensure that our sterilizers are running effectively. Documentation of spore testing will be kept in the dispensary. The importance of spore testing is taught in the microbiology course during semester 1 and demonstrated during the partner care clinics in Clinic Practice I.

Handpiece Care

You are responsible for ensuring the correct maintenance of all hand-pieces.

1. High speed Handpiece Motor:

* Clean by spraying HANDPIECE CLEANER liberally to the following areas:
  + drive air tube (2nd largest hole)
  + chuck
* Wipe exterior with wet gauze and dry thoroughly
* Lubricate using a single spray of LUBRICANT into the drive air tube
* Place in autoclave pouch and hand in to the dispensary for sterilization.

2. Slowspeed Handpiece Motor

* Clean exterior only using HANDPIECE CLEANER

\*\*Never use the cleaner on the interior of the slow speed motor

* Using LUBRICANT apply:
  + A single spray internally
  + Clean out excess
* Wrap in pouch and hand in to dispensary for sterilization.

1. Contra Angle Attachment/U-Style Adapter

* Clean by spraying HANDPIECE CLEANER liberally into:
  + back end of the attachment
* Wipe exterior with wet gauze and dry
* Lubricate with a single spray of HANDPIECE LUBRICANT into backend
* Wrap in pouch and hand in to dispensary for sterilization.

For all handpieces you do NOT need to lubricate again before use.

**2.Personal Protective Equipment & Student Responsibilities:**

1. All students must have current vaccinations updated, including inoculation to Hepatitis B.
2. Students must have on file, a record of their current health history. Any student testing positive for any type of Hepatitis, HIV or tuberculosis, or any type of contagious situation must notify the Dean of the college. Please see policy on blood borne pathogens in the Policies and Procedures manual.
3. It is the responsibility of the student NOT to come to client care sessions while ill. However, if ill, a doctor’s note must be provided.
4. Upon arrival in the clinic perform a long hand wash (please refer to procedures section in this manual). During client treatment an alcohol based hand rub is suitable unless the hands are visibly soiled.
5. Masks, gloves and safety glasses are to be worn at all times.
6. Gloves are to be changed for each and every client or if they have been damaged in any manner. Gloves may need to be changed during client treatment if they appear heavily soiled. When in doubt…don a new pair.
7. Masks are to be changed for every client. Avoid touching your mask during client treatment. If your mask is damp then you must change it.
8. Protective eyewear is to be cleaned and wiped with a disinfectant due to possible splatter from client care.

**3. Protecting our client!**

1. The student must take a thorough medical history on each client. A new full medical history must be taken once per year. In between an update is completed. Ask questions and be alert to any clinical symptoms the client may exhibit (such as sweating, clammy skin, glazed eyes etc). A thorough intra/extra oral exam may also provide clues to the general health of the client. This is what is referred to as performing a “risk assessment”.
2. Safety glasses are to be worn by each client (unless prescription glasses are worn).
3. Clients will pre-rinse with Oral B for 30 seconds before all intra-oral procedures.

Effective dental treatment can be rendered in the dental clinic to most patients with infectious diseases by following established infection control practices. Medically compromised patients in advanced stage of infectious diseases may require specialized facilities for proper treatment and management. Please refer to chapter on Medically Compromised clients.

To summarize infection control and to provide optimum safe care for both the operator and the client:

Risk Assessment>>>> Hand Hygiene>>>>>Use of PPE>>>>Safe Disposal of all sharps and handling of instruments.



Dental Hygiene Operatory Asepsis Checklist (Set-up)

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Criteria | Satisfactory | Unsatisfactory | Comments |
| 1. Perform a long hand wash. Place on lab coat as a protective barrier. |  |  |  |
| 2. With clean hands fill the empty water bottle with water |  |  |  |
| 3. Don PPE remembering to put on your exam gloves last. |  |  |  |
| 4. Flush each type of dental unit water line (air/water) for 2 minutes. |  |  |  |
| 5. Hold and run handpiece lines over the cuspidor for 2 minutes, by stepping on the rheostat. |  |  |  |
| 6. Obtain 1 litre of prepared evacuator solution from sterilization center and return to unit. Run evacuator solution through the high volume, saliva ejector and cuspidor |  |  |  |
| 7. Using fresh exam gloves begin cleaning base of the unit and the rheostat. Starting at the base of the unit: clean foot pedals, chrome base, and junction box using soap and water/paper towels. For the remainder of set up, Optim33 TB is to be used with 4 x 4 gauze. |  |  |  |
| 8. Using the Optim, clean dental unit components (bracket tray and support arm, supports for hand pieces and complete length of hosing, air/water syringes, couplings and toggles) |  |  |  |
| 9. Clean dental light handles, and support arm/switches. |  |  |  |
| 10. Clean the dental chair (head and footrests), seat and arms. \*\*Clean light cover carefully. Do not remove the cover. |  |  |  |
| 11. Clean Station countertops, door knobs, sinks, soap dispenser. If sink is visibly soiled, clean with soap and water prior to using Optim. |  |  |  |
| 12. Clean operator stool (top to bottom). |  |  |  |
| 13. Clean oral evacuation system (i.e. cuspidor, HVE, water dispenser, coupling and length of hosing. Clean suction trap |  |  |  |
| 14. Don new exam gloves to disinfect **all high risk** **areas**: using 4 x 4 gauze soaked in Optim33TB; swab on and leave on for a minimum of 10 minutes. (Refer to pg. 161 for high risk areas) |  |  |  |
| 15. Dispose of mask and gloves. Perform hand hygiene with antiseptic hand wash for 15 seconds. |  |  |  |
| 16. Place barriers to **high risk areas**: saliva and high volume suction couplings, chair controls, light handles and switch. Operator stool height control. \*\*AW syringe is also high risk but barrier is to be applied while client in chair. |  |  |  |
| 17. Attach over gloves to the unit |  |  |  |
| 18. Retrieve and place: headrest cover, bibs, gauze, trash bag, paper tray liner, dixie cup, barrier sleeves, saliva ejectors. Bring instruments to unit in blue wrap and open while client is in the chair: Apply AW syringe sleeve while client is in the chair. Don gloves when opening instrument cassette and applying AW barrier. |  |  |  |

To obtain a mark of SAT for this competency: a student must have no more than 3 unsat errors.

SAT \_\_\_\_\_\_\_\_ UNSAT \_\_\_\_\_\_\_\_\_



Dental Hygiene Operatory Asepsis Checklist (Tear down)

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Criteria | Satisfactory | Unsatisfactory | Comments |
| 1.Once client is dismissed , perform hand hygiene and put on new PPE |  |  |  |
| 2. Place utility gloves over new exam gloves and proceed to the sterilization center with your instrument cassettes and any sharps that need to be discarded. (All PPE must be worn) Place instrument cassette in ultrasonic for 10 minutes. |  |  |  |
| 3. Obtain 1 litre of prepared evacuator solution from sterilization center and return to unit. |  |  |  |
| 4. Return to unit and remove utility gloves and with exam gloves remove barriers and discard all waste. (Disinfect utility gloves) |  |  |  |
| 5. Run evacuator solution through the high volume, saliva ejector and cuspidor |  |  |  |
| 6. Flush air/water lines for 20-30 seconds. |  |  |  |
| 7. Using Optim33 TB and 4 x 4 gauze. Clean dental unit components (bracket tray and support arm, supports for hand pieces and complete length of hosing, air/water syringes, couplings and toggles) Clean HVE and saliva ejector couplings and hoses |  |  |  |
| 8. Clean any additional carts or ultrasonic units used during clinical session. |  |  |  |
| 9. Clean the dental chair (head and footrests), seat and arms. \*\*Clean light cover carefully. Do not remove the cover. |  |  |  |
| 10. Clean operator stool (top to bottom). |  |  |  |
| 11. Clean sink and cuspidor with liquid/powder cleaner(Ajax/Vim) |  |  |  |
| 12. Remove PPE and perform hand hygiene |  |  |  |
| 13. Don new exam gloves and disinfect the high risk areas: using 4 x 4 gauze soaked in Optim33TB; swab on and leave on for a minimum of 10 minutes. **If ultrasonics were used: please disinfect as well. Cavitron tips will be sterilized**. |  |  |  |
| 14. Raise unit chairs to highest position, place rheostats on paper towel on the seat of the chair. Lights are turned upwards and bracket trays placed over the seat of the chair. |  |  |  |
| 16. Empty water bottle and assemble to unit empty. Remove your exam gloves and perform hand hygiene. |  |  |  |
| 17. Return to re circulation area to dry and wrap instruments in preparation for sterilization. PPE to be worn in recirculation. |  |  |  |

To obtain a mark of SAT for this competency: a student must have no more than 3 unsat errors. Please note for evaluation purposes, students will only be asked to state the steps that they would take in this process. SAT \_\_\_\_\_\_\_\_ UNSAT \_\_\_\_\_\_\_\_\_

# TCDHA Policy on Hazardous (Biomedical) Waste Material

TCDHA has adopted the Biomedical Waste Management Protocol of the RCDSO.

“Biomedical waste is classified as hazardous waste and must not be disposed with regular garbage. It must be handled safely to protect human health and the environment” (RCDSO, 2009).

There are two types of biomedical waste: Anatomical waste (human tissue) and non-anatomical (sharps and blood spattered materials).

Anatomical is limited to oral surgeons and periodontists and as such is not applicable in the TCDHA clinic setting.

Non Anatomical:

Sharps: needles, syringes with needles must be separated and collected in a yellow puncture resistant, link proof container and labelled with a biohazard sticker on it. This container can be found in the recirculation area. When full, it must only be released to an approved biomedical waste carrier for disposal.

Blood Soaked Materials: This refers to materials that when compressed release liquid or semi liquid blood. These materials must be placed into a yellow liner bag that is clearly marked with a biohazard label. Once filled it must it must only be released to an approved biomedical waste carrier for disposal. \*\*\*It is important to note that in most instances, items that have come in contact with blood, saliva or other bodily fluids are NOT classified as biomedical waste. Provided that that the item does not release blood or semi liquid blood if compressed, it should be considered general office waste.

General Waste:

* All garbage containers should be waterproof and out of reach of small children.
* Use plastic bags to line the garbage containers.
* Do not overfill them or place sharp or heavy items in the bags.

# Infectious Disease and the Dental Hygiene Student

It is important for the dental hygiene student to realize they will be required to take part in the care of clients with various infectious diseases which may include Hepatitis and HIV during their course of study.

* Training will be provided on how to prevent the spread of disease.
* There is a risk, albeit, it slight, that students may accidentally contract a communicable disease during the course of their program.
* All students are responsible for preventing the spread of infectious diseases to others.
* Each student is expected to complete a medical form detailing health history including all immunizations.
* All students must have their immunizations updated
* All students must have the hepatitis B vaccine
* Any student who tests positive for HIV, Hepatitis B or C or has active Tuberculosis is requested to inform the College before commencing the program.
* If the student is ill they should remain at home until they are safe to return.

Puncture Wound Protocol: Post Exposure Management Program

* Please stay calm. Excuse yourself from the client and speak to a faculty member immediately. Immediate first aid will take place.
* Thoroughly wash the wound with an anti-microbial hand wash solution. There is no evidence that “bleeding” of the wound reduces the risk of transmission.
* If the eyes, nose or mouth are involved, flush the area well with large amounts of water.
* Primary closure of the wound should be performed (if necessary). Apply a band aid or dressing.
* The faculty member will complete an “Exposure to body fluids” form.
* After reviewing the report, you and the faculty member will sign it and submit to the Safety Officer for review. It will then be forwarded to the program coordinator.
* A faculty member will take the responsibility for explaining to the client that an exposure incident has occurred to a student/faculty member and will ask the client if they will provide consent for blood testing. Please be aware that we cannot force the client to be tested. This form is called client risk assessment form “A” and it will be submitted with the Exposure to Body Fluids” documentation. Faculty will then provide the client with “Form B” to take with them to their family physician.
* If appropriate seek post exposure assessment at a medical health facility. Faculty will guide you in this process if required.
* If you decide to be tested, confidential testing should be done as soon as possible after exposure and then again at 6 weeks, 12 weeks, 6 months, and at 12 months after exposure for HIV blood testing. For exposure to Hepatitis C: as soon as possible after exposure and then again at 4-6 months after exposure. This is a guideline only. Please follow the advice of your own family physician. If the client is a known carrier of HIV it is advisable to go to the emergency room immediately since post exposure prophylactic therapy should be administered ideally within the first 1-2 hours. However PEP can be administered up to 72 hours after the exposure.

Post Exposure Prophylaxis for HIV Exposure:

The student must be careful to practice **Standard Precautions** for all clients. It is important to work methodically and not rush. Working carelessly may lead to a possible exposure to HIV or Hepatitis A, B or C.

Most exposures occur during the handling of the instruments extra orally and **not** during intra oral procedures.

**HIV:**

To determine whether a prophylactic medication regime is required, one must first assess the level of risk. If the client is not a high risk client for HIV then PEP will not likely be recommended. Physicians will also look at the type of transmission and the amount of fluids involved. Rest assured they will be thorough.

It is ideal to start the medication regime within one-two hours of exposure, although it can be administered up to 72 hours after the exposure. The types of drugs administered will vary and can depend on the source client. Usually the length of treatment on PEP is for duration of 4 weeks.

Please do not panic. The chances of the HIV being transmitted from the client to the student are extremely low.

Reference for information provided below is from the CDC. Please refer to their website; <http://www.cdc.gov/hepatitis/HCV/HCVfaq.htm>**).**

Darby and Walsh (2014, 4TH Edition) is also referenced.

**Hepatitis A:**

Hepatitis A is an acute liver disease caused by the hepatitis A virus (HAV), lasting from a few weeks to several months. It does not lead to chronic infection.

Hepatitis A is spread through oral-fecal contamination and as such with standard precautions the risk to the Dental Hygiene student is very low. If students are planning to travel, then often this vaccination is recommended by their family physician. If a student tests positive for Hepatitis A then they will be restricted from client contact and the contact environment with other students/faculty until 7 days after the onset of jaundice.

**Hepatitis B: (HBV)**

Hepatitis B is a liver disease caused by the Hepatitis B virus (HBV). It ranges in severity from a mild illness, lasting a few weeks (acute), to a serious long-term (chronic) illness that can lead to liver disease or liver cancer.

All students have been immunized against Hepatitis B. It is advisable that your level of antigens is checked during regular physical exams to ensure proper protection. Adults who have been immunized against Hepatitis B are not at risk for contracting HBV. If for religious reasons, a student has NOT been immunized for HBV then they must see their doctor within 24 hours and in less than 1 week. It is likely that the physician would initiate the vaccination protocol.

If a student is HBV positive there is no restriction to clients. Standard precautions should always be followed.

**Hepatitis C:**

**Hepatitis C carriers may be either acute or chronic. 75%-85% of the cases go on to become chronic. In 15-25% of the cases patients clear the virus from their system without treatment and do not develop chronic hepatitis. With the use of “Standard Precautions” in Dentistry the risk of contracting Hepatitis C is extremely low.**

**Should an exposure occur; and to be thorough, you should test the source client; follow the protocols for puncture wound. Please follow up with your family physician. You should be tested for the anti HCV and there are several tests which will be performed. HCV does not show up on a blood test immediately and could take several weeks for it to be evident. False positives are possible so an alternate test is advisable. Repeated testings are recommended at 4-6 months to determine status. Once again consult your family physician and they will assess you properly. Please note there is NO pre exposure vaccination or post exposure prophylaxis for Hepatitis C.**

If a student is HCV positive there is no restriction to clients. Standard precautions should always be followed.

**Air Borne Pathogens:**

**Students are also at risk for air borne or droplet infection. It is important for the student to take the necessary precautions. Eat properly and get plenty of rest and exercise.**

**Colds and Flu: there are many strains of the flu. Flu shots are highly recommended to increase your immunity. If a pandemic has been recognized then it is highly recommended that students follow all recommended protocols.**

**Tuberculosis:**

**Tuberculosis falls into 2 categories; primary and active. Clients with active tuberculosis can be highly contagious and cannot be seen in our clinic. If a client reports having tuberculosis or even testing positive but not having it, then clearance must be provided by the family physician. We need to verify which category the client falls into. Please refer to the medical consultation request form on page 177 of this manual.**

**If a student develops ACTIVE tuberculosis then they will be restricted from client care and student/faculty contact until proven non-infectious. If they have primary TB (a positive skin test and/or positive chest x-ray), then there is no restriction. It is ONLY if the student has active tuberculosis would they be removed from contact with clients/students and faculty.**

**Other:**

**Conjunctivitis: Viral and bacterial conjunctivitis is easily spread. If the cause of the conjunctivitis is bacterial then the client should be asked if they have begun antibiotic eye drops. If not, they should not be seen. Hand hygiene following all Standard precautions is essential to prevent the spread.**

**Herpes 1 (HPV 1): Students are expected to use standard precautions if they develop herpes 1. Students will not be permitted to see clients if they present with an active lesion(s). Clients will also be refused treatment if they present with an active lesion. Once lesions are healed treatment may be provided or received.**

**Measles: If active then students will be excluded from contact with clients/students/faculty until 7 days after the rash appears. The same applies to clients who report a medical history involving active measles.**

**Measles: (post exposure of susceptible student, faculty or personnel); excluded from contact from the fifth day after first exposure through the 21st day after last exposure or 4 days after rash appears. The same applies to clients who report a medical history involving active measles.**

**Mumps: If active then students will be excluded from contact with clients/students/faculty until 9 days after the onset of parotitis. The same applies to clients who report a medical history involving active mumps.**

**Mumps: (post exposure of susceptible student, faculty or personnel); excluded from contact from the twelfth day after first exposure through the 26th day after last exposure or until 9 days after the onset of parotitis. The same applies to clients who report a medical history involving active mumps.**

**Rubella: If active then no contact with clients/students/faculty until 5 days after the rash appears.**

**Rubella: (post exposure of susceptible student, faculty or personnel); excluded from contact from the 7th day after first exposure through the 21st day after last exposure. The same applies to clients who report a medical history involving active rubella.**

**Meningococcal infection: Excluded from contact with clients until 24 hours after effective therapy has been implemented.**

**Above information was referenced from Darby and Walsh, (2014) 4th edition pages 105-107.**

**\*\*Please remember that when we follow Standard Precautions our risks are negligible. Always assess the risk (through a proper medical history), wash your hands, wear your PPE and handle all sharps carefully. If an exposure does occur then please contact your family physician and follow their advice. All students are advised to have their vaccinations up to date: including Hepatitis B, DPT and MMR. Students who have not been vaccinated may not be permitted access to community placements. Please refer to student policy and procedure manual.**

**Care of Compromised Clients**

**In the Dental Hygiene Clinic**

TCDHA Policy On Compromised Clients:

It is our ethical responsibility to provide care to the public of Ontario. However there are times when we may not be able to do so if the client’s health is compromised in any way.

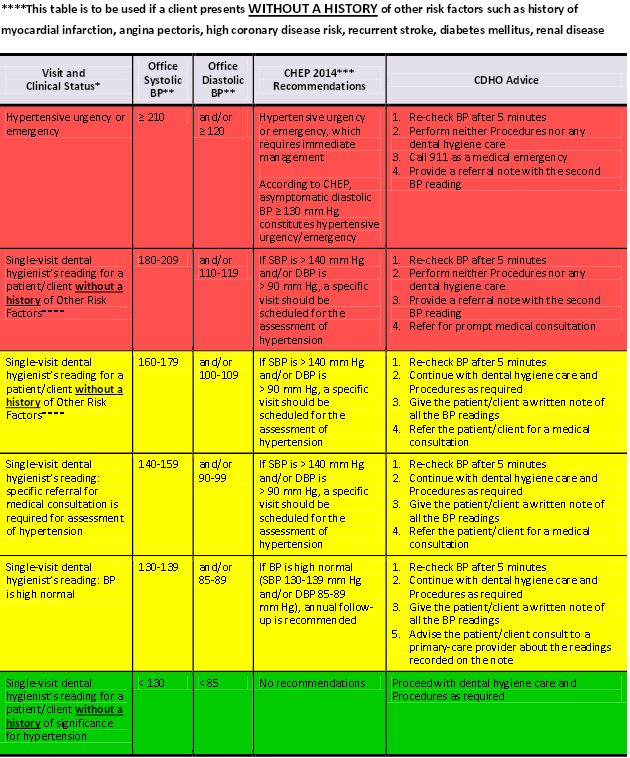
Clients who present with the following will need further information provided to us from their family physicians, and **may** need to be treated elsewhere. TCDHA will do its utmost to provide care to all clients, ensuring their safety in our clinical setting. If a client presents with any of the following the Registered Dental Hygienist will collaborate with the DDS on the clinic floor and if needed, the client’s family physician or specialist. A medical consultation request form will be completed and sent to the necessary professionals for clearance. Once it has been returned it will be reviewed by the Dental Hygiene Faculty, scanned into the client record, and instructions for the care of the client will be documented on the medical history assessment page 4 of 6.

Clients presenting with:

1. Uncontrolled diabetes.
2. Uncontrolled epilepsy.
3. Untreated Hepatitis.
4. Any conditions (cardiac or otherwise) for which antibiotic prophylaxis is required.
5. Any unstable medical or oral health conditions where the condition may affect the safety of the client.
6. Active Chemotherapy or radiation therapy.
7. Clients who present with significant immunosuppression.
8. Respiratory infections to include but not limited to Active Tuberculosis.
9. Clients with blood disorders.
10. Clients under the influence of drugs or alcohol which may impair their decision making process in the Dental Hygiene Process of Care.
11. Elevated blood pressure. \*blood pressure may be elevated due to client nervousness. See chart on the next page: Chart follows CDHO guidelines.
12. Clients with a previous history of bacterial endocarditis.
13. Any clients presenting with a medical or oral health condition with which we are not familiar.

As mentioned previously in this document. The CDHO knowledge network is a wonderful resource for students and faculty. It can be accessed through the CDHO website at: cdho.org. TCDHA will follow guidelines recommended by the CDHO.

Please refer to the next four pages to review 1) the CDHO guidelines for blood pressure, 2) Medical consultation referral form for elevated blood pressure and 3) the medical consultation referral form for clearance on general health issues.



**\*\*Students take vitals on clients during their first appointment. If the reading(s) fall in the yellow or red zone then a medical consult with the family physician is indicated. Provide your client with a copy of their readings. Should the readings fall in the yellow or red zone, the student will be instructed to take blood pressure readings at all subsequent appointments. Readings are to be documented in the client record. Students must also follow up with the client at subsequent appointments to remind them to see their physician. Students must document this conversation with the client in the ROC.**



**300 Steeprock Drive, Toronto, Ontario, M3J 2W9**

**PHONE: 416-423-3099 FAX: 416-423-3092**

**MEDICAL CONSULTATION REFERRAL FORM: BLOOD PRESSURE**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_:

The above client presented in our dental hygiene clinic for his/her care:

Current Medications/Conditions:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The client’s BP readings were as follows.

:

Date: \_\_\_\_\_\_\_\_\_\_\_ BP Reading: \_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ BP Reading: \_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_ BP Reading: \_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ BP Reading: \_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_ BP Reading: \_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ BP Reading: \_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_ BP Reading: \_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ BP Reading: \_\_\_\_\_\_\_\_\_

According to our regulatory guidelines, clients who present with blood pressure readings in the above range(s) must be provided with a copy of their BP readings and a referral to their family physician for follow up.

TCDHA Dentist/RDH Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**300 Steeprock Drive, Toronto, Ontario M3J 2W9**

**PHONE: 416-423-3099 FAX: 416-423-3092**

**MEDICAL CONSULTATION REQUEST FORM: CONFIDENTIAL**

Patient’s signature indicating permission to contact physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_:

We are planning to proceed with dental hygiene treatment on our mutual patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. He/she has given permission for us to contact you and has indicated a history of medical problems and current medications as follows:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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He/She presented to our dental hygiene clinic today with the following health concern. We need your authorization before we can proceed with dental hygiene care.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does any of this client’s medications need to be modified? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_

If (**YES)**, please indicate what modifications are required. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is Antibiotic Prophylaxis recommended? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_

If (**YES)**, please indicate the diagnosis for which the antibiotics are recommended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can the patient proceed with dental cleaning which includes multiple appointments of debridement of the teeth below the gingivae which results in a transient bacteremia? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_

If (**NO)**, please provide reasons: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICIAN SIGNATURE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for your prompt reply.

TCDHA Dentist/RDH Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>**

***Date received by TCDHA\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reviewed by DDS/RDH\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_***

# Clients Requiring Pre-Medication

The Toronto College of Dental Hygiene follows all required protocols of the American Heart Association.

Any client refusing the required antibiotic will not be seen in our clinic.

NB: For clients requiring premedication, there must be a minimum of two weeks between appointments. Should a student wish a student to remain for a morning and afternoon clinic a single dose is not sufficient for client protection. Meds will be taken one hour prior to commencement of treatment and then once again prior to the next appointment. Please see following pages for further details as per the CDHO.

Cardiac Conditions Requiring Pre Medication

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 bacterial endocarditis (BE). The client’s oral health and oral self-care practices are very important.

**\*\*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.*

**Dental procedures for which prophylaxis is recommended in patients with cardiac conditions listed above:**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 no infected 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.

\*\*Please be aware that this is a large paradigm shift for our clients. Many of our clients have been instructed to take premedication for many years because of mitral valve prolapse. Many physicians still want their patients to continue taking antibiotic prophylactic coverage. However, that is the decision that the client must make and it must be an informed decision. Dentists on the clinic floor cannot be expected to write prescriptions for conditions that do not require antibiotic coverage. If the client and the physician insist on antibiotic coverage for cardiac conditions NOT recognized by the AHA as needing antibiotic coverage, then it will be up to the client to obtain the necessary script from their own physician.

Other Clients that may require pre medication

NB: Certain medical conditions may require premedication such as: uncontrolled diabetes, organ transplantation, advanced HIV infection, neutropenia, indwelling catheters, systemic lupus erythematous or clients undergoing significant immunosuppressive therapy. Clients who have taken the appetite suppressant fenfluramine/phenteremine (fen/phen) or dexfenfluramine (Redux) can develop valvular abnormalities and should be evaluated for premedication. Other conditions to include (but not limited to):

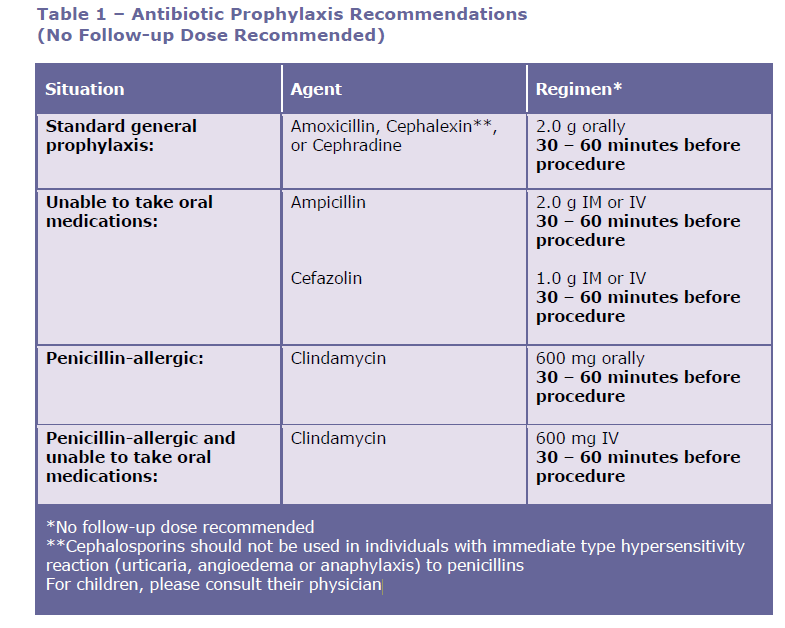
* **First two years following joint replacement. \* The American Academy of Orthopaedic Surgeons has released a new guideline:** PREVENTION OF ORTHOPAEDIC IMPLANT INFECTION IN PATIENTS UNDERGOING DENTAL PROCEDURES: This report offers evidence of when premedication should be considered. TCDHA will refer to this document. Currently the ODA feels that according to recent evidence based research, premedication is NOT indicated. Decisions will be made on a case to case basis.
* Previous prosthetic joint infections.
* Malnourishment.
* Hemophilia.
* Inflammatory arthropathies; rheumatoid arthritis, systemic lupus erythematosus.
* Radiation compromised clients
* Clients who have had a splenectomy

The CDHO has issued the following statement on joint replacement: Permission has been received from the CDHO to use this information in the TCDHA manual.

“The need for antibiotic prophylaxis for the prevention of infective endocarditis and hematogenous joint infection should be considered on an individual basis in conjunction with the health care provider most familiar with the client’s specific condition. Treatment decisions should be made in light of all circumstances presented by the client. Treatments and procedures applicable to the individual client rely on mutual communication between client, dental hygienist, physician, dentist, and other health care practitioners. The dental hygienist is ultimately responsible for making the decision whether or not to proceed with dental hygiene services.

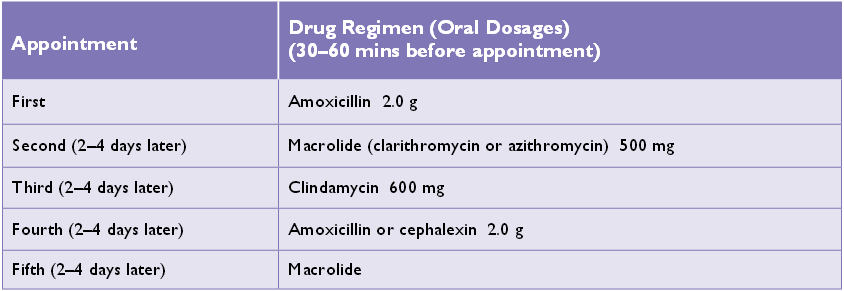
The following recommendations are based on the current guidelines of the American Heart Association (AHA) and the American Academy of Orthopaedic Surgeons (AAOS). These guidelines are provided to aid dental hygienists in their clinical judgment regarding antibiotic prophylaxis for clients who have had medications prescribed for antibiotic prophylaxis prior to dental hygiene procedures. This guideline no longer contains

recommendations for specific medical conditions. For considerations on whether prophylactic antibiotic coverage is required for a specific medical condition, please consult the CDHO Knowledge network.” (CDHO)



Please Note: Prior antibiotic use should be considered before prophylactic antibiotics are prescribed as resistant organisms may develop. If the need for prophylaxis closely follows prior antibiotic exposure (i.e., within 9 to 14 days), an antibiotic from a different antibiotic class should be considered

Table 2



Antibiotic Prophylaxis Recommendations for Adult Clients at Risk for Infective Endocarditis Who Require Multiple Dental Hygiene appointments within a 9-Day Period (No penicillin allergy)

These recommendations are for clients returning for multiple appointments within the 9 -day period, but on different days. One of the best ways to eliminate this need for a “rotational schedule” of the antibiotics is to

schedule the client’s multiple appointments at least 10 –14 days apart. Using the same antibiotic between dental hygiene appointments that are scheduled within a 9 -day period increases the risk for resistance and may

reduce the efficacy of the drug. If you need to follow a rotational schedule for a client who is allergic to penicillin, eliminate amoxicillin

in the rotation. Depending on the allergy, you may also determine that cephalosporins are contraindicated. One of the macrolide antibiotics

or clindamycin should be considered instead.

Clients on Blood Thinners: International Normalized Ratio

Many clients today will present with reports of diagnosed cardiovascular disease, or a history of pulmonary embolism, and because of such have been placed on blood thinners by their doctor. The student must determine the client’s INR numbers. INR refers to the clotting time. Many of your clients will be aware of their INR numbers but some may not. In any case, the INR numbers need to be determined and confirmed by the family physician before treatment begins. At TCDHA we have set a guideline of 2-3 as an acceptable range. However, always verify with the family physician if unsure. Most recent studies have shown that it is safe to keep the clients on their blood thinners since the risk of taking them off the thinners is greater than the risk of treating them while on the medication. As always check with the family physician.

Protocols for Clients with Diabetes

As per the CDHO, a Registered Dental Hygienist would not proceed with dental hygiene care on a client with uncontrolled diabetes. Please refer to the CDHO Knowledge network for their advisory on Clients with Type I, II or gestational diabetes.

Background:

1. Persons taking hypoglycemic drugs with or without insulin are at risk of hypoglycemia if they exceed the prescribed dose(s) or if they disrupt their normal intake of food.

2. Prior to dental treatment, persons with diabetes should have eaten and taken their medication as directed.

3. Diabetics treated with insulin may require an increase in dose if an acute oral infection develops; those treated with hypoglycemic agents may require adjunctive, short-term insulin. The physician manages the insulin needs; the oral healthcare provider treats the infection with local and systemic therapies, in liaison with the physician.

4. Persons with diabetes are at increased risk of serious oral

diseases such as gingivitis and periodontitis because they are generally more susceptible to bacterial infection and they have decreased ability to fight bacteria that invade the gums.

5. Children and teenagers who have diabetes are at greater risk

of oral disease than those without diabetes.

6. If blood glucose levels are poorly controlled, diabetics are more likely to develop serious gum disease and lose more teeth than non

diabetics.

7. As with other infections, serious gum disease may be a factor in causing blood glucose to rise and in making diabetes harder to control.

8. Other oral problems associated with diabetes include thrush and dry mouth, which can cause soreness, ulcers, infections and cavities.

The medical and medications history -taking should

1. Focus on screening the patient/client prior to treatment decision relative to:

a. key symptoms

b. medications considerations

c. contraindications

d. complications

e. co morbidities.

2. Explore the need for advice from the appropriate primary or specialized care provider(s).

3. Inquire about:

a. patient/client’s having eaten and taken their medication as directed prior to the Procedures and oral healthcare treatment generally

b. history of trouble keeping blood glucose levels under control

c .diabetes-related problems with previous dental/dental hygiene care

d. symptoms indicative of inadequate control of blood sugar

e. the patient/client’s understanding and acceptance of the need for oral healthcare

f. medications considerations, including over-the counter medications, herbals and supplements

g. problems with previous dental/dental hygiene care

h. problems with infections generally and specifically associated with

dental/dental hygiene care

i. the patient/client’s current state of health. how the patient/client’s current symptoms relate to

i. oral health

ii. health generally

iii. recent changes in the patient/client’s condition

Protocols for clients with diabetes:

1. The best time for scaling of teeth and root planing including curetting surrounding tissue, orthodontic and restorative practices, and other invasive interventions is when the blood glucose level is in the target

range and the diabetes medication action is low.

2. If the patient/client takes insulin, a morning visit after a normal breakfast is best.

3. The patient/client should have taken the usual medications unless the physician/primary care provider has recommended that the patient/client should change the dose or medication prior to the dental care.

4.The oral healthcare provider should consult with the Physician/primary care provider to decide about adjustments in diabetes medications, or to decide if antibiotic prophylaxis is needed before invasive procedures to prevent infection.

\*\*All of the above has been referenced from the CDHO Knowledge network:

In addition to the above information:

1. Determine the client’s blood glucose level. If the client has not taken or does not know their glucose level for that day, then provide them with the glucose meter and have them take their own reading. NB: only in an emergency can an RDH take the client’s blood glucose.

\*\*The CDHO does not provide an ideal number for blood glucose. Numbers can vary for each client and what may be normal for some might not be “normal” for others. When working with a client who has diabetes, one must look at the overall picture with which the client presents. Do not be afraid to ask questions, find out everything you can. Also be sure to educate the client on the important link between periodontal disease and oral health.

Health and Safety in the Dental Hygiene Clinic

Clinic Safety for Clients and Students:

1. Instruct the client to wear prescribed or safety glasses during the examination and treatment phase. Clean the client’s safety glasses with soap and water after each use.
2. Handle all dental materials in a safe manner.
3. Do not transfer instruments across the client’s eyes.
4. Pretest handpieces and rotary instruments prior to their use.
5. Do not sharpen instruments in the vicinity of the client’s eyes or ears.
6. Maintain correct and safe posture when sitting in the operator or dental assistant chair.
7. Handle all dental instruments with care. Report any cuts immediately to the Supervisor on clinic duty.
8. Be aware of the location of the emergency drug kit and the oxygen unit found on the clinic floor. Please report accidents or emergencies to the instructor(s) on duty in the clinic. For any accident or emergency, complete an accident and emergency report in duplicate. (Available from the dispensary or from the faculty).
9. Students must wear masks and gloves during all phases of client management. Gloves must be changed if they become ripped during treatment.
10. Students must wear prescribed or safety glasses when in the clinical, radiography, sterilization and laboratory areas.
11. Each student must have over gloves available to them at their unit. Over gloves must be worn whenever working outside the oral cavity.
12. All students must have a clear health history and a current update of all vaccinations and immunizations. It is mandatory for the student to be immunized for Hepatitis B. All clients must be provided with an oral b pre rinse prior to treatment. If there is a contraindication to oral b then a 0.12% chlorhexidine pre rinse will be used.
13. TCDHA clinic follows all WHMIS protocols. In this facility: Mr. Harry Xu is the WHMIS officer. All products have material safety data sheets located in the dispensary. Faculty has been WHMIS trained. TCDHA also follows all Ministry of Labour guidelines for health and safety. TCDHA has a health and safety committee in place and faculty has been formally trained in health and safety.

**Toronto College of Dental Hygiene & Auxiliaries: Policy on Radiation Safety**

**Radiation Safety Requirements for the Dental Clinic:**

The exposing of al radiographs in Ontario falls under the Healing Arts Radiation Protection (HARP) Act.

In this facility Dr. Boris Pulec, DDS is the Radiation Protection Officer.

A person enrolled in a recognized x-ray safety course (such as the one provided in the Dental Hygiene Program at the Toronto College of Dental Hygiene and Auxiliaries) may be permitted to operate an x-ray machine while under the supervision of a qualified individual.

Dental Hygienists and Dentists are deemed to have met the required qualifications by virtue of their training.

All clients will be provided with the proper shielding, using a gonadal and thyroid shielding.

A quality assurance program is in place in this facility and the facility participates in a daily testing (step wedge) as well as annual testing of the x-ray equipment. Students must track the number of radiographs exposed and must take a step wedge at the beginning of radiography lab sessions and prior to client care clinics. All tracking information is available in the dispensary and in the Dental Radiography Lab.

All radiographs must be prescribed by the DDS on the floor of the clinic.

All students must present their signed prescription for radiographs to the dispensary before the radiographs will be dispensed.

All students must have informed consent from the client before exposing radiographs on the client.

All radiographic interpretation must take place while the client is in the chair.

All radiographs must be client specific, resulting in the lowest possible radiation exposure, cost and inconvenience to the client, consistent with the diagnostic information requirements.

Repeat films and exposure will be kept to a minimum.

All students will record and track all exposures taken during a clinical session.

Accurate functioning of all radiographic equipment will be monitored

Radiation Protection Officer

Responsibilities

1. Ensuring that the installation complies with all applicable regulatory requirements, including equipment registration with the appropriate regulatory agency.
2. Establishing safe working conditions in accordance with recommendations of “Safety Code 30” of the HARP Act.
3. Ensuring that all equipment functions properly, is operated properly and is maintained by competent personnel only.
4. Ensuring that operators are properly trained in the operation of the equipment being used.
5. Ensuring that students (operators-in-training) operate dental x-ray units only under the direct supervision of an experienced operator.
6. Implementing and maintaining a quality assurance program for the Dental Clinic.
7. Maintaining and keeping all records of the Quality Assurance program and records pertaining to the performance of the dental radiographic units.
8. Promoting the rules of radiation safety.
9. Ensuring that all operators have read and are familiar with the Safety Code of the HARP Act.

Equipment Care in the Radiography Rooms

1. Handle the phosphorous plates with extreme caution. When inserting them into the scanner please hold them with the cardboard and then release them. Dispose of the disposable covers.

2. If you suspect equipment malfunction, consult a faculty member or the clinic coordinator.

3. Radiography rooms and processing area must be kept neat at all times.

Dental Materials Lab Safety Requirements

* Students may utilize the dental labs between the hours of 8-7 however; all safety measures must be adhered to when working within the dental lab as indirect supervision will be enforced by our dental faculty member. If you need to go into the materials lab you must sign in at the dispensary. Students are responsible to leave the lab neat and tidy.
* Safety glasses must be worn when mixing materials or using laboratory equipment.
* No jewelry is to be worn in the laboratory area.
* Lab coats are to be worn. Be sure that hair is pinned back from the face, and is off the neck. If long enough, hair should be in a bun.
* Be careful when handling knives or other sharp instruments.
* Handle hot instruments with care.
* Model trimmers and dental lathes can cut and damage fingers. Follow instructions for their use and handle with care. Make sure they are turned off after use. Instructions have been posted in the materials lab.
* Handle all dental materials with care and follow manufacturer’s instructions for mixing. Be particularly careful when handling hot waxes and base plate material.
* If an accidental burn or cut or eye injury is received, the student will report it to the instructor on duty. If injury is to the eye please flush out the eye at the eyewash station located in the clinic and in the laboratory areas. Any type or incident or accident will need to be reported on an incident report form, which should be completed in duplicate and handed in to the faculty on duty.
* It is important not to leave impression stone on equipment, counters or floors. All vibrators are to be bagged prior to use, to prevent gypsum products from adhering to their outer surfaces. As well, all counter top space should be covered prior to starting.
* All alginate impressions must be sprayed with disinfectant prior to bringing them to the materials lab for pouring. Students MUST wear PPE when working in the lab to complete assigned competencies from client care.

Class Time: Class monitors will be assigned for each session to ensure complete cleanliness. Independent Study Overtime: Students are responsible for cleaning their individual working areas. Abuse of the privilege of overtime sessions will result in the withdrawal of the opportunity!

Protocols for working in the dental materials lab outside of class time:

1. The materials lab will be kept locked outside of the scheduled lab time.
2. During all clinical sessions the lab will be available to all students. However, students can only request entrance to the lab after the first 30 minutes of clinic and up to final 30 minutes of clinic. \*\*students are not permitted in the materials lab when there is a dental materials lab session taking place. \*\*note: new clinic will have a materials lab in the clinic itself.
3. To access the lab you must go to the clinic and request a dental materials lab kit. You will be assigned a kit and asked to sign in. If required, you will be assigned a burner.
4. The materials lab will be opened for you to use. Once you are finished you must return the kit to the clinic and sign it back in.
5. The monitor will check the lab for cleanliness.
6. You are responsible for all the contents of the materials lab kit when it is in your possession. If anything is missing when you return it then you will be responsible for replacing it. Please check your kit carefully.
7. There are to be no more than 3 students working in the materials lab at the same time.
8. Failure to keep the lab clean will result in disciplinary action.

Monitor Duties

Monitor assignment dates are posted on the bulletin board on the student information board in the main clinic. Monitors will be responsible for assisting in the opening and closing of the clinic. This will necessitate coming in before and leaving after the rest of the class. It will be the monitor’s responsibility to arrange for a substitute should they be unable to attend for their assignment. The clinic coordinator will have a checklist for each student to review

1. Upon opening the clinic, turn on all switches and lights. Check in with dispensary staff.
2. Clean and disinfect the shared counters at the front of the clinic and post the “sign-in” sheets.
3. Request from dispensary any supplies that need to be replenished, e.g. paper towels, mouth wash, tray covers etc. Assist in dispensing tray set ups to the students.
4. Ensuring and assisting each student to prepare his/her own instruments and equipment for sterilization. No more than 15 minutes before a clinical session is over, each student must ensure their instruments and equipment are brought to the dispensary ready for sterilization.
5. Monitors will complete a decorum check on their classmates.
6. All equipment, counter tops and sinks in the clean-up area must be cleaned and disinfected daily. Weekly scrubbings of all equipment and surfaces in these areas must be also done by the monitors. This also applies in the laboratory areas.
7. Monitors will be available to assist other students with charting, or developing radiographs.
8. Monitors will sign students in and out of the dental materials lab.
9. Monitors will participate in any screenings that are necessary.
10. When participating as a monitor, the student will not have any clients of their own in the clinic. All time is to be spent assisting other students and ensuring that the clinic runs smoothly.
11. Upon closing the clinic, turn off switches in electrical panels and suction and close all doors.
12. Monitors will have a checklist provided for them at the beginning of the clinical session. Once the monitors have completed all of their responsibilities, at the end of the clinic, the dispensary staff will sign their monitor sheets. Please see checklist on the next page.
13. Failure to complete any of the monitor responsibilities will result in a professional penalty.

If a monitor notices that a student has left their unit in a manner that is not appropriate, please report it to the clinical coordinator. It is not the responsibility of the monitor to “clean up” after every student. Each student is still responsible for the proper care and maintenance of their own units.

Monitors are expected to complete the decorum check in a professional manner. If a student is not following decorum protocols then the monitor must bring it to the attention of the faculty. The faculty will then address the issue. As a monitor DO NOT get into any type of confrontation with another student.

If a faculty member notes that a student is not in proper attire and following all guidelines, they will check the decorum binder to ensure that it has been formally documented as such. If it has not been noted by the monitor then both the monitor and the student will receive a penalty.

**M O N I T O R D U T I E S**

**Monitor: 1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Monitor: 2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date / Time: \_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **TO DO** | **Monitor #1** | **Monitor #2** |
| Expose a step wedge in the RAD room and ensure that the results have been documented. |  |  |
| Clean and disinfect the shared counters at the front of the clinic and post the “sign-in” sheets. |  |  |
| Assist with distribution of instrument cassettes. |  |  |
| Prepare and set up trays and disposable supplies |  |  |
| Prepare the ultrasonic bath (s) |  |  |
| Report under stocked items to dispensary / Restock supply cupboards. |  |  |
| Complete a decorum check on fellow students. |  |  |
| Prepare Alginate pouches  **Monitor Lab Usage: report to dispensary** |  |  |
| Assist students when needed for documentation of probing depths. If students require other help please verify that it is ok to do so with the faculty first. |  |  |
| Drain and clean the ultrasonic after all instruments are done. |  |  |
| Spray and disinfect all counters in the re circulation room. Be sure all sinks are clean. |  |  |
| Make sure ALL counters are free of any instruments or garbage at the end of clinic. |  |  |
| Make sure ALL garbage bins are empty at the end of each clinic |  |  |
| Empty out garbage bin in RAD ROOM, and turn off control switches. |  |  |
| Upon closing the clinic, turn off switches of  x-ray processors, RAD room and ensure that all units are OFF |  |  |
| Remain in the clinic until all students have left, check in with dispensary staff to verify that you may leave and to have your form signed. |  |  |

**Dispensary Signature:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency

Protocol

To ensure the safety of our clients, student and faculty TCDHA has protocols in place to be followed in the case of an emergency.

TCDHA Emergency Protocol:

1. TCDHA has appointed a safety officer to ensure that all safety and emergency protocols in the Dental Hygiene Clinic are being met, reviewed and updated as needed. In this facility Mr. Harry Xu is the safety officer. TCDHA follows all Ministry Of Labour guidelines.
2. Staff and students must maintain “C” level of C.P.R. Yearly recertification is recommended for all students and faculty. According to the CDHO, if there is an expiry date noted on the CPR certificate then CDHO will accept that. TCDHA will honour the date on the certificate. This will be recorded and verified by the education coordinator. **Students and Faculty are not permitted in clinical sessions without a valid CPR.**
3. There is a first aid kit and a medical emergencies drug kit located in the clinical setting. The contents of which are reviewed and updated if required at the beginning of each clinical semester and more often if required. The locations are clearly marked.
4. There are two emergency eyewash stations located in the clinical setting and in the dental materials laboratory.
5. Health Rooms: There is one health room located at each campus. At the Steeprock campus the health room is located in the clinic and at the Lodestar campus the health room is located in the radiography lab. They are both clearly marked. If you are not well, please notify a faculty member. \*\*in new building, health room is located in client care clinic.
6. There is a defibrillator located in the client reception area and its location is clearly marked. All DDS’s and Dental Hygiene Faculty have been trained in its use. The defibrillator will be checked bi weekly by faculty to ensure that it is running properly.
7. There are 2 emergency oxygen carts and the oxygen cylinder will be checked weekly by dental staff. Only the DDS can administer oxygen, unless it is an emergency.
8. Emergency practice drills will be conducted.
9. During the client’s initial appointment, a complete and thorough health history must be obtained by the student, to be reviewed by the self-initiating dental hygienist. Dentists on the clinic floor will also want to review the medical history prior to completing a hard tissue examination. This record must be updated on each subsequent appointment. As mentioned previously in this document we are assessing the risk of a possible emergency.
10. It is important that the student continuously monitor the client for signs of impending problems, e.g. changes in colour, respiration, speech and perspiration. If these signs appear, the student must immediately inform the dental hygiene or dental faculty.

Emergency Management Procedure

1. Student A recognizes a potential medical emergency.
2. Student A informs a fellow student (Student B) in the next unit, of the medical emergency. Student A is able to keep an eye on their client.
3. Student A returns to client, loosens clients clothing, places client in appropriate position, establishes airway, evaluates clients’ condition and begins to take vital signs. Student B informs the dentist and dental hygiene faculty of the medical emergency.
4. Student B retrieves the oxygen and blood pressure equipment, the defibrillator and also the emergency drug kit.
5. Primary client care is initiated by Dental Hygiene Faculty and/or D.D.S.
6. If an ambulance is required, student B informs dispensary to call 911. Student B goes to the front entrance to wait for and escort the ambulance attendants to the dental clinic.
7. Student B instructs fellow students to dismiss their clients from the clinic.
8. Student A, the D.D.S. and Dental Hygiene Faculty continue to render emergency care, ie. CPR, and monitor vital signs until the ambulance arrives.

Safety Procedures For Medical Emergencies and or Fire

It is imperative that all students:

1. Know the location of the Emergency Equipment, Oxygen and First Aid Kit.
2. Review emergency procedures and participate in practice drills.
3. Be aware of our address and our phone number. It is posted by the phone in the dispensary.
4. Follow all safety precautions noted in this manual
5. Report any and all accidents, regardless of how minor, to a faculty member. An accident report must be completed and kept on file. \*NB this applies to our clients as well. Any accidents or injuries on campus must be reported and a report filed.
6. If a fellow student is not well, please provide assistance and notify a faculty member.
7. If you smell smoke or suspect that there is a possible danger in the clinic; find assistance immediately.
8. In case of fire, please sound the alarm and then proceed in an orderly fashion to assist clients who may need special help.
9. Evacuation route is posted in the clinic and is very clear. Please review these protocols with your client.
10. Leave the college immediately…**DO NOT RETURN FOR PERSONAL BELONGINGS!** Close all doors behind you.
11. Remain outside until you are informed it is safe to return.

**\*Documentation of any accidents, emergencies or incidents must be documented. Any incident, emergency or accident must be noted in the client’s record of care and an official report filled out. Faculty will provide you with the appropriate form dependent upon the type of incident that occurred. If a student is involved in any type of accident or emergency situation faculty will document the situation and place the document in the student file.**

**\*\*all documentation will be referred to the Program Coordinator and the Dean of Students for review and follow up if required.**

**\*\*All protocols for fire and or medical emergencies have been posted in both campuses. Fire emergency protocols can be found in the client care clinic at the Steeprock campus in every classroom, and beside every fire extinguisher in both campuses.**

**\*\*Protocols for medical emergencies are found in the Client Care Clinic and in all classrooms. They are also found in the Health Room, the Pre clinic and Radiography Lab, the classroom and the front reception area**

**Remember, the most important thing is for everyone to stay calm.**