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INFECTION CONTROL PROCEDURES

Hand Washing

Hand washing is considered the single most important procedure for the prevention of disease transmission. Faculty and students must perform a complete hand washing procedure at the beginning of each clinical or laboratory session, and as needed through the day. Hand washing is followed by an alcohol based hand sanitizer.

Clinical workstation preparation and breakdown

All equipment and working surfaces are properly cleaned and disinfected prior to patient arrival and upon completion of treatment. Protective coverings are used to cover equipment and are changed after each appointment. Surfaces that are in contact with saliva and/or blood are properly disinfected following each appointment.

Treatment Phase

A thorough medical history is taken on new patients and updated on each reappointment. Patients with transmissible oral lesions or diseases in their acute phase (i.e. herpes) are not treated at this time. The student operator consults with the supervising dentist and patient’s physician when a serious systemic infection is suspected and/or identified.

Protective eyewear is provided to each patient before treatment begins and is worn throughout treatment phase to protect from splatter, debris, or from injury.

Before treatment, the patient rinses with a mouthwash to reduce the microbial flora in the mouth.

During treatment, sterile instruments and supplies are utilized at all times. Instrument packages are opened in the presence of the patient. Sharpening kit, including test stick, is also opened in the presence of the patient when sharpening chair-side. If sharpening prior to patient arrival, then instruments and sharpening kit are re-sterilized. When packaging, receiving, or passing sharp instruments, care is taken at all times to avoid cross-contamination or injury.

During the data collection phase of the appointment, students may use laminated reference materials that can be disinfected after each use. Meticulous care is taken to prevent contamination of all records, including student grade sheets.

The student operator must wear a face shield when using equipment that generates an aerosol (i.e. ultrasonic, etc.).

The student operator must remove gloves before leaving their respective work area, or accessing any storage area/compartment, including file cabinets. When student operator has called for a graded check, the gloves are removed and hands re-sanitized.
Needles are not bent, broken or otherwise manipulated by hand. Appropriate method are used to recap needles. Uncapped needles do not remain on the instrument tray. The capped needle are removed from the syringe and placed in the red puncture-resistant SHARPS container in the sterilization area.

Radiology treatment rooms are treated in the same manner as clinic treatment rooms. All radiology equipment and devices used in obtaining radiographs are prepped and disinfected according to procedure.

Proper disinfection techniques are performed when doing adjunct procedures in the clinic such as, laboratory procedures, phase microscope usage, intra-oral photography or any other treatment that might introduce a blood borne pathogen.

**Front Desk/Sterilization Rotation**

No gloves are worn out of the students’ work area to eliminate introducing blood-borne pathogens into the reception, front desk area and sterilization area.

**Bio-hazard materials and sharps disposal**

Each MSSU dental hygiene clinic site has an identified mechanism for disposal of bio-hazardous waste and sharps containers. These items are appropriately disposed of in timely manner to eliminate risk of exposure.

**At-risk individuals**

Each MSSU dental hygiene clinic site has a current list of any individual, student or employee that may be exposed to blood-borne pathogens at any time during a clinical or lab session.

**OPERATORY SETUP/Breakdown**

This procedure outlines the steps to be taken in order to assure control over transmission of infection and cross-contamination of patients treated in the Missouri Southern State University Dental Hygiene Clinics in Joplin, Rolla and Sikeston. Before treatment and after treatment of any patient, this procedure is followed using aseptic technique to maintain proper infection control.

**Supplies Needed for Unit Preparation:**

1. PPE (gloves, masks, operator & patient safety glasses, lab coat & scrubs)
2. Working dental unit
3. ICX Dental Line Cleaner Tablet
4. Disinfectant wipes (Sani-Wipes, CaviCide wipes, etc)
SETUP

1. Obtain proper PPE. Using aseptic technique throughout procedure put on operator mask and clean glasses/goggles before beginning procedures.
2. Perform short hand washing scrub.
3. Fill unit water bottle with tap water. Drop one ICX tablet into the water bottle, taking care to not touch tablet with ungloved fingers. Attach the water bottle. Water line treatment is performed once a day. During the course of treatment, if the water bottle needs to be refilled, NO additional ICX tablet will be necessary. Allow at least 60 seconds for ICX tablet to fully dissolve before performing water line maintenance in Step 11.
4. Obtain Utility Gloves
5. Disinfect the following, with Disinfectant wipe, working from top to bottom and from outside in.
   a. Pens and clipboard
   b. Countertops and sink
   c. Keyboard and mouse
   d. Light arm and attachment pole
   e. X-ray view box (if present in cubicle)
   f. Bracket tray
   g. Delivery system arm and assistant arm
   h. Back of chair, headrest side of chair and chair base
   i. Rheostat
   j. Operator & Assistant stools back, and seat height adjuster
6. Cavi Wipe Utility gloves
7. Dampen corner of cloth towel with warm water. Clean the following and then dry with cloth towel:
   a. Light cover and glass back
   b. Metal rolling cabinet
7. Clean upholstered areas of patient chair and operator’s stools with cloth towel and soapy water.
8. Spray Windex on alternate corner of cloth towel to clean the following:
a. Bracket tray  
b. Paper towel holder  
c. Faucet  
d. Clear plastic front of light cover only  
e. Metal pieces on operator stool  
f. Rheostat

10. Remove utility gloves and perform short hand washing scrub.

11. Water line Maintenance  
   a. Turn on master switch  
   b. Press the flush button located on the side of the bracket tray  
   c. Run water through tri-syringe and purge hand piece for two minutes.  
   d. Leave the rest of the water in the bottle to use during patient treatment.

12. Obtain the appropriate barrier wraps and drapes and cover the following:  
   a. Dry Cleaning Bag  
      i. Patient Chair  
      ii. Main bracket tray, unit arm, & hoses  
   b. Sticky Wrap  
      i. Light switch  
      ii. View box switch  
      iii. Assistant arm control panel  
      iv. Computer Mouse  
      v. Cabinet Drawer Handles  
      vi. Power button to computer screen  
   c. Saran Wrap/Foil wrap  
      i. Operator stool adjustments (both chairs)  
      ii. Lever and lock on patient chair  
   d. Sleeve covers  
      i. Saliva ejector (slow & high speed suction)  
      ii. Air/water syringe (tri syringe)  
      iii. Handpiece (slow speed handpiece is to be covered when used)  
      iv. Light handles (foil can be used)  
      v. Pens  
   e. Shower cap  
      i. Keyboard  
   f. Assistant arm  
      i. Biohazard bag (secure with sticky wrap on control panel)

13. Obtain assessment tray from central & place over covered unit bracket tray.  
   a. Tray with tray cover  
   b. 1 cotton tip; 2 gauze  
   c. Cup with mouth-rinse  
   d. Patient bib  
   e. Bibez

14. Put sterile cassettes onto tray maintaining aseptic technique. After opening barrier wrap,  
    allow cassette to slide onto tray without touching with bare fingers.
15. Orientate the cubicle so it is ready for the patient to enter and sit down. Light and main unit arms are out of way, the arm of the chair is dropped down; operator stools are out of the patient’s way, etc.

**SUPPLIES NEEDED FOR UNIT MAINTENANCE:**

1. PPE, including Utility Gloves
2. Vacuum line cleaner for suction lines
3. Enzymatic cleaner for bull frogs
4. Glutaraldehyde solution for tubing

**BREAKDOWN**

After dismissing patient and completing any necessary paperwork, begin the process of cleaning your operatory by following these steps.

1. After dismissing the patient and completing all paperwork, begin the process of cleaning your operatory by following these steps.
2. Perform hand washing technique and put on clean pair of utility gloves.
3. Flip rheostat switch over to blue dot, obtain tri-syringe and all handpiece tubing and purge until all water is out of lines. Make sure to purge air through lines for one minute.
4. Remove tri-syringe tip. Wipe metal tri-syringe tip clean with gauze, then autoclave.
5. Run ¼ gallon evacuation cleaner through the following both the high speed and slow speed suction if used during the patient appointment
6. **Do not proceed any further until the suction is turned off.**
7. **Continue – still wearing utility gloves**
8. Remove bullfrog and clean with bottle brush dipped in glutaraldehyde to remove debris. Leave separated and remove valve barrel. Swab barrel and end of tubing.
9. Remove bullfrog from high speed suction and clean with bottle brush dipped in glutaraldehyde to remove debris and stain. Leave separated and remove valve barrel. Brush barrel and end of tubing.
10. Place all parts of bullfrog in baggie filled with diluted enzymatic cleaner and run in ultrasonic for 7 minutes (between every patient). Central will rinse, dry and place in the Statim. Central will return to unit.
11. Remove trap (bucket) and clean hole with bottle brush and 2 x 2 dipped in glutaraldehyde. Place in bleach water for 10 minutes. (Use a 1-10 parts of bleach to water ratio) Central will rinse, dry and return to unit.
12. CAREFULLY close cassette containing instruments from tray set up and place in central to be disinfected and sterilized. When taking cassette to central, place cassette on tray and transport to central while wearing gloves.
13. Remove all plastic drapes and tie off trash bags.
14. Place any blood or saliva soaked gauze or other materials in the biohazard bags. Lay biohazard bag on floor for central to retrieve.
15. Keeping the utility gloves on, wash gloved hands with antimicrobial soap for 30 seconds, dry and sani-wipe the utility gloves, then proceed.
16. Sanitize all items as described in the cubicle set-up instructions including base of chair, sink and cabinets.
17. Clean out sink with appropriate cleaner and wipe off soap dispenser.
18. Clean plastic light cover with water dampened white towel.
19. Polish all stainless steel on chrome sink faucet, unit operators stool and rheostat.
20. Remove gloves and wash with antimicrobial soap for 30 seconds, use hand sanitizer.
21. Turn unit off.
22. Adjust cubicle as follows:
   a. Straighten the patient chair backrest to full upright position
   b. Raise chair 15 inches off floor
   c. Place operators stool in the adjacent area on the opposite side of the sink.
   d. Place bracket tray directly in front of patient headrest.
   e. Position the light over the bracket tray in front of headrest with the light facing down.
   f. Place assistant’s arm pushed in and resting next to chair.
   g. Place rheostat on base behind chair back.
   h. Verify that all hoses and cords are untangled and freely hanging.
23. Verify that no debris remains on floor around unit.
24. Central will bring sterilized bullfrogs and baskets back to the cubicle. Wearing clinic gloves, replace the components of the bullfrog and suction basket.

CENTRAL STERILIZATION PROCEDURES
Each student is assigned Central Sterilization Rotation duties during each semester. This procedure outlines the steps taken when the student is assigned to the Central Sterilization Rotation. The student maintains asepsis at all times in order to maintain proper infection control protocol. These duties may vary slightly at each MSSU dental hygiene location.

1. Arrive 30 minutes prior to the beginning of the clinical session and remains in central area to prepare for the clinical session.
2. Disinfect all counter tops and cabinet doors, drawers and handles in the central sterilization area with Sani-Wipes.
3. Check that towels and appropriate cleaning agents are full and available for each student clinician to use for cubicle preparation.
4. Obtain an instrument tray for each operator and disinfects all surfaces on each with Sani-Wipe.
   a. On each tray place:
      i. Plastic cup with mouthwash for patient
      ii. FOUR 2X2 gauze
      iii. Cotton tipped applicator
      iv. Bib and Bibeze
      v. Single floss packet
      vi. ICX tablet (morning only)
   b. Have baggie filled with appropriate barriers and supplies available for each clinician (see #10 below)
5. Inventory supplies in the central sterilization area, prepare list of needed supplies and presents to an instructor by 8:30 a.m.
6. Launder items from previous clinical period.
7. Clean external surfaces of autoclave with a soft dry cloth. A damp cloth with soapy water may be necessary if autoclave is soiled.
8. Wipe internal surfaces of autoclave.
9. Fill Ziploc baggies with expendable supplies for next clinical session:
   a. Shower cap cover(s)
   b. 1 Biohazard bag
   c. 5 syringe/handpiece sleeves
   d. 2 light handle covers
   e. 8 foil or blue sticky barriers
   f. 2 Large barriers (dry cleaning bags)
   g. Saliva ejector, high speed suction
10. Obtain supplies for students as requested.
11. Sterilize student instruments and expendable supplies (such as 2x2’s, tongue blades, etc.) prior to the next clinic session. (It is the responsibility of the individual student clinician to prepare his/her instruments for sterilization pick-up)
12. Prepare enzymatic cleaner per manufacturer’s directions
13. Prepare Evacuation system cleaner in gallon jugs for student use (1/4 gallon per student clinician – refer to lines on jugs)
14. Prepare (wraps, labels & initials) radiology packets and assists in radiology prep throughout the day.
15. Prepare bleach water in gallon size Zip-lock bag for trap disinfection.
16. Pickup Biohazard waste from each cubicle and place in appropriate Biohazard Container at the end of each session.
17. Water in ultrasonic units should be disposed of after use.
18. Disinfect instruments trays with Sani-Wipe.
19. Replenish all containers on countertop and in the cabinets.
20. Check all supplies to ensure sterile supplies are present in quantities necessary for next clinic session. If they are not, then sterilize necessary supplies.
21. Disinfect all countertops with Sani-Wipe and checks each of the following at the end of the day.

**Tuesdays**

- Clean the Tuttnaure autoclave once weekly per manufacturer’s instructions located on page 48 of the manufacturer’s operating manual. The operating manual is located in the drawer below the Tuttnaure.
- Clean the MidMark autoclave once weekly per manufacturer’s instructions.
- Perform biological testing on all autoclaves and Statim(s)
• Clean the Statim by following these steps:
  a. Use soapy water and scrub the inside of the cassette with a cleaning pad.
  b. Rinse thoroughly to remove any traces of soap.
  c. Clean exterior surfaces with soapy water and towel.
  d. Lubricate seal by applying liquid soap to exposed parts of the seal on the inside of
     the cassette lid and the engagement holes at the back of the lid beside the hinge.

**Thursdays**

• Remove all supplies from central sterilization cabinets and wipes disinfectable items with
  Sani-Wipe.
• Wipe out inside cabinet surface with warm soapy water. Replaces all items in cabinets in
  a neat and orderly manner.
• Windex any glass in central sterilization area.

**Monthly**

• Clean all autoclaves and Statim per manufacturer’s instructions labels with date and
  initials on masking tape.
• Dispose of and replenish Glutaraldehyde, label container with date and initials

**FRONT DESK PROCEDURES**

Each student is assigned Front Desk Rotations during each semester. This procedure outlines the
steps taken when the student is assigned to the Front Desk Rotation. The student must wear
appropriate clinical attire and maintain professional conduct at all times. **These duties may vary
slightly at each MSSU dental hygiene location.**

1. Arrive 30 minutes prior to clinical session.
2. The student is responsible for making sure they have the correct amount of starting cash
   and that the total equals receipts at the end of the clinic day.
3. Greet all patients. Distribute parking permits to patients at this time.
4. Collect clinic fees; enter payment into the patient account in EagleSoft.
5. Give patient the “Patient Information Sheet” and HIPAA information
6. Enter/edit patient information on patient edit screen in EagleSoft (see Appendix II).
   a. Verify that patient is NEW or RETURNING to eliminate duplication of patients
      in EagleSoft
   b. Verify patient was provided and signed HIPAA in edit screen (see Appendix II).
8. After all AM or PM patients are checked in, print receipts and distribute to patients.
9. Answer the CLINIC phone and take messages. Document all calls, and give messages to
   the appropriate individual. Use following script to answer the phone:
   a. “Dental Hygiene Clinic, this is (first name only), how may I help you?”
   b. Document ALL communication with patients in the patient notes with specifics
c. Answer questions for the person if you can, if you cannot, tell them the secretary or an instructor will return the call, pass any message and phone number to the appropriate individual.

10. Assist radiology and central sterilization as time permits.
12. At the end of the day:
   a. Print a schedule for the next clinical day. Note which patients have been confirmed.
13. Verify that all patients have been “walked out” by the student clinician
15. After accounts are balanced, run an End of Day Report. All computers must be logged out of EagleSoft before beginning this procedure.
16. Turn monies and Deposit Report into the Secretary. If any corrections need to be made, let the secretary know before end of day report is run
17. EagleSoft Check-in Procedures (see Appendix II).

**Existing Patients**
1. Review patient account for any discrepancies.
2. Review that previous services have been walked out.
3. Check account alerts, update as needed. Ex. Referrals, MSSU Student, etc.
4. Collect and post payments as necessary in the accounts tab.

**New Patient**
1. Obtain needed personal information as stated above.
2. Collect and post payment in account screen.
3. Sign required documents. Ex. HIPAA
4. All minors – place responsible party information in the patient edit screen
PROCESS OF CARE PROCEDURES
PATIENT POOL
There are two main sources for dental hygiene clinic patients: Patients previously seen in the clinic (re-care patients) and those new to the clinic. New patient screening appointments are performed by screener rotation assignments. All patients are eligible for screenings, however, a new screening must occur on patients who have not had a dental cleaning in the MSSU Dental Hygiene Clinic in 2 or more years. All screening patients must receive necessary radiographs on the day of the screening per the Doctor’s prescription. Following the screening, the patient’s name goes into a pool where they are scheduled for treatment based upon patient’s needs and student learning needs. The screener does not have priority to schedule this patient back with them unless it is their family member. The EagleSoft screening code is ASCRN. There is no charge for a screening, however, the patient is charged as usual, upon return for follow-up treatment.

PATIENT CATEGORIES

AGES
- Pediatric patient: ages 5 – 12 years (children under 5 years of age are not seen in the MSSU dental hygiene clinics)
- Adolescent patients: ages 13 – 17 years
- Adult patients: 18 years of age and over
- Geriatric patients: ages 60 and above

PLAQUE LEVELS
- Light: 1 – 25%
- Moderate: 26 – 50%
- Heavy: 51 % and above

CALCULUS FORMATION; REFERENCE GUIDE

Granular   Nodule   Spicule   Band   Finger-Like   Proximal Ledge
Projection
Calculus Deposits

<table>
<thead>
<tr>
<th>Class</th>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No Calculus</td>
<td>Slight Calculus – requires little or no scaling</td>
</tr>
<tr>
<td>I</td>
<td>Simple</td>
<td>Supragingival calculus extending only slightly below the free gingival margin</td>
</tr>
<tr>
<td>II</td>
<td>Light/Moderate</td>
<td>Moderate amount of supragingival and subgingival calculus, or subgingival calculus only</td>
</tr>
<tr>
<td>III</td>
<td>Moderate</td>
<td>Abundance of supragingival and subgingival calculus, or subgingival calculus only</td>
</tr>
<tr>
<td>IV</td>
<td>Heavy</td>
<td>Generalized supragingival and subgingival ledges around cervical thirds of crowns and bands on most root surfaces</td>
</tr>
</tbody>
</table>

Periodontal Skill Level (ADA)

<table>
<thead>
<tr>
<th>Type</th>
<th>Probing Depths</th>
<th>Bleeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>I Gingivitis</td>
<td>&gt;3 mm</td>
<td>Localized Points</td>
</tr>
<tr>
<td>II Early Perio</td>
<td>3-4 mm</td>
<td>Generalized Points</td>
</tr>
<tr>
<td>III Moderate Perio</td>
<td>4-6 mm</td>
<td>Moderate - Heavy</td>
</tr>
<tr>
<td>IV Advanced Perio</td>
<td>&gt;6mm</td>
<td>Heavy</td>
</tr>
</tbody>
</table>

EDENTULOUS
This category of patient has patient no more than 8 permanent teeth.

SEXTANT = 4 teeth minimum        QUADRANT = 5 teeth minimum
ASA CLASSIFICATION

I. A normal healthy patient

II. A patient with a mild systemic disease may be well controlled, (example: healthy pregnancy, asthma, allergies etc.)

III. A patient with severe systemic disease that limits activity but is not incapacitated (example: stable angina, post MI, etc.)

IV. A patient with an incapacitating systemic disease that is a constant threat to life (example: unstable angina, MI, Cerebrovascular accident w/in 6 mos., uncontrolled epilepsy, uncontrolled diabetes)

V. A moribund patient not expected to survive 24 hrs.

AAP/ADA CLASSIFICATIONS

<table>
<thead>
<tr>
<th>AAP Class</th>
<th>Description</th>
<th>ADA Class</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class I Gingival Diseases</td>
<td>Dental plaque-induced gingival diseases&lt;br&gt;Non-plaque-induced gingival lesions</td>
<td>Type I Gingivitis</td>
<td>No loss of attachment&lt;br&gt;BOP may be present</td>
</tr>
<tr>
<td>Class II Chronic Periodontitis</td>
<td>Localized Generalized (&gt;30% of sites are involved)&lt;br&gt;(slight: 1-2 mm CAL;&lt;br&gt;moderate: 3-4 mm CAL;&lt;br&gt;severe: &gt; 5 mm CAL)</td>
<td>Type II Early Periodontitis</td>
<td>Pocket depth or attachment loss: 3-4mm&lt;br&gt;BOP may be present&lt;br&gt;Localized area of gingival recession; Possible class I furcation involvement</td>
</tr>
<tr>
<td>Class III Aggressive Periodontitis</td>
<td>Localized Generalized (&gt;30% of sites are involved)&lt;br&gt;(slight: 1-2 mm CAL;&lt;br&gt;moderate: 3-4 mm CAL;&lt;br&gt;severe: &gt; 5 mm CAL)</td>
<td>Type III Moderate Periodontitis</td>
<td>Pocket depths or attachment loss 4-6 mm&lt;br&gt;BOP; Class I or II furcation involvement; Class I mobility</td>
</tr>
<tr>
<td>Class IV Periodontitis as a Manifestation of Systemic Diseases</td>
<td>Associated with hematological disorders&lt;br&gt;Associated with genetic disorders&lt;br&gt;Not otherwise specified</td>
<td>Type IV Advanced Periodontitis</td>
<td>Pocket depths or attachment loss over 6 mm&lt;br&gt;BOP; Class II or III furcation involvement; Class II or III mobility</td>
</tr>
<tr>
<td>Class V Necrotizing Periodontal Diseases</td>
<td>A. Necrotizing ulcerative gingivitis&lt;br&gt;B. Necrotizing ulcerative periodontitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Class VI Abscesses of the Periodontium</td>
<td>A. Gingival abscess&lt;br&gt;B. Periodontal abscess&lt;br&gt;C. Pericoronal abscess</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Class VII
Periodontitis
Associated
With
Endodontic
Lesions
A. Combined periodontic-endodontic lesions

Class VIII
Developmental or Acquired
Deformities and
Conditions
A. Localized tooth-related factors
B. Mucogingival deformities and conditions around teeth
C. Mucogingival deformities and conditions on edentulous ridges
D. Occlusal trauma

SOAP NOTES
S= SUBJECTIVE (what the patient tells you)
S: _____ year old, (Ethnicity: Caucasian, African American, Hispanic, etc.), male/female presents for (assessment, radiographs, study models, treatment, etc.). No chief complaints (or state the chief complaint). Medical history reveals (no significant findings or list significant finding). Most previous dental treatment and radiographs at (name of dental office, type of treatment, date of treatment, or dental care has been as needed only for pain).

O= OBJECTIVE (what you see in exam, including radiographs)
O: Temp: ___ F, temporal; Pulse: ___bpm, right/left wrist, describe; Resp: ___rpm, describe; BP: ___ right/left arm, MIL: _____; Smoking Status/Tobacco Use: non tobacco-user or describe use

A= ASSESSMENT (ASA, AAP, DOD)
A: ASA: ____ due to (reason); AAP: ____; DOD: (degree of difficulty); Plaque index: (score and goal)

P=PLAN (treatment completed, treatment planned, radiographs, process of care plan, OHI, next visit)
P: obtained consent; obtained (new or updated) medical history; obtained vitals; checked in with (Dr. or faculty); Pre-rinsed with _____ mouthwash (don’t forget the brand & flavor); (new or updated) EOIO; perio assessment; calculus detection; PI with red disclosing solution; OHI: (give specifics of OHI) recommended ____________ ; (type of radiographs) prescribed by Dr.
_______; (type of radiographs) digital radiographs exposed; ____retakes; used lead apron; process of care developed and reviewed with patient and (faculty); (type of treatment: full mouth or selected area for SRP) blended approach or hand scaled; selective polishing with (type and flavor of prophy paste); Flossed; Checked by instructor; dental charting with Dr. _______; fluoride varnish with (brand and flavor), (specific) post-op instructions given; tissue check by ____________; referred to general dentist; (type of recare: 3 months, 4 months, 6 months, 12 months) recare appointment to be scheduled at a later date or pt to return on _______________ to complete treatment (list treatment to be completed);

** IF any of the above information in the SOAP notes is covered in EagleSoft tabs excluding vitals, students can note to refer to that tab.  (i e. Significant finding refer to Med HX tab)

**SCHEDULING PATIENTS**

It is the responsibility of the student to schedule new, continuing and re-care appointments for their patients. It is the responsibility of the student to secure clinic patients needed to fulfill course requirements. If a student is ill, it is his/her responsibility to reschedule his/her patient. Please refer to Section 4: Eagle Soft Procedures to find out how to properly schedule patients. Each student’s schedule is found in the Eagle Soft dental management system.

It is the student’s responsibility to confirm all of his/her patients. Front desk will confirm patients when possible. All phone calls to patients should be made from the clinical phones. **Do not** call patients from your personal phones. When calling to confirm patients, always maintain your professional demeanor. Identify yourself first and that you are a student in the Missouri Southern Dental Hygiene Program. You should record in writing, **all** phone conversations in the clinical Treatment Record (T&P Notes). Also record that the appointment was confirmed on the “On Schedule” screen in EagleSoft (see Appendix II).

Patients are asked to give a 24-hour notice if they must cancel an appointment. **All cancellations and broken appointments are noted in the Treatment Record. Upon notation, discuss this with your assigned faculty member.**

When calling your patient, it is important to maintain a professional demeanor. Please refer to the following script as an example of professional conduct.

**If the patient calls into the clinic:**

Good morning/afternoon, MSSU dental hygiene clinic this is (your name), how may I help you? We have an appointment available on (date and time), would that work for you?

At this appointment, a student clinician will be assessing your oral health needs and taking x-rays. This appointment will take approximately 2-2.5 hours. You will then be scheduled for an
appointment at the next available opening for your treatment. There will be a $20 charge for services, payable at the time of the appointment. The $20 fee covers the assessment, cleaning, x-rays and any other services necessary for your treatment at our clinic.

**If you return a call to the patient for an appointment:**

Hello, this is (your name) from the MSSU dental hygiene clinic. We have an appointment available on (date and time), would that work for you?

At this appointment, a student clinician will be assessing your oral health needs and taking x-rays. This appointment will take approximately 2-2.5 hours. You will then be scheduled for an appointment at the next available opening for your treatment. There will be a $20 charge for services, payable at the time of the appointment. The $20 fee covers the assessment, cleaning, x-rays and any other services necessary for your treatment at our clinic.

*If the patient has already had a screening and needs to be appointed, please try to appoint them with students equally, based on the patient status.

*If the patient is a recare appointment, they may be scheduled as well, just make sure these appointments are also divided equally, based on patient status.

**The Day Before You See the Patient**

Many good habits that you can develop early in your career will lessen the chance of you being without a patient or losing professionalism points.

**Two days before clinic:**

1. Check the appointment book to see who you have scheduled.
2. **Returning patients:** Review the patient's record to see if he/she needs premedication, anesthesia, etc. If a new physician’s clearance is required, make sure the patient is aware of the need and secures a new clearance prior to the patient’s next scheduled appointment (see Appendix III).
3. Call to confirm the appointment, if front desk has not already completed this for you. Ask if the patient is currently taking any medication, if so, compile a list. Be sure to instruct the patient to bring medications which may need to be taken during the appointment, such as inhaler, nitro, etc. Get the name, address and phone number of their MD. Make sure to inform the patient of the fees, length of appointment, parking, and the need to take all premedication as recommended.
4. NEW patients: gather medical history to determine if a physician’s clearance or premedication is needed. Make sure the patient is aware of the need and secures a physician’s clearance prior to the patient’s scheduled appointment.

5. Provide the patient with your first name & the clinic’s phone number. Refer to each specific site and location for correct phone numbers.

6. Check with the lead clinic instructor (at each site) concerning special situations that might alter your plan to treat the patient.

CONDITIONS REQUIRING PHYSICIAN’S CLEARANCE PRIOR TO TREATMENT
Clearance is Valid for 1 year unless changes in patient’s medical condition

1. Heart Conditions
   a. Prosthetic Cardiac Valve
   b. Previous Endocarditis
   c. Congenital Heart Disease
      i. Unrepaired cyanotic congenital heart disease, including those with palliative shunts and conduits.
      ii. 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.
      iii. Repaired congenital heart disease with residual defects at the site or adjacent to the site of a prosthetic patch or prosthetic device.

2. Heart Attack within previous six months (either stent or by-pass treated)

3. Congestive Heart Failure

4. HIV positive

5. Hepatitis B, C, D

6. Cancer Treatment- Currently receiving radiation or chemotherapy treatments or treatments have been completed within past 6 months

7. End Stage Renal Disease involving Dialysis

8. Prosthetic Joint Replacement Surgery

9. Organ Transplant Recipient or Awaiting Transplant

10. Extensively & unmanaged Immuno-compromised Patient

11. Positive TB skin test requiring chest radiographs and medical treatment

12. Any major cardiac, pulmonary, gastrointestinal, kidney, liver, orthopedic surgery within previous six months.

13. ASA Class III or IV patients
   a. Uncontrolled Blood Pressure
   b. Uncontrolled Diabetes
   c. Unstable Angina
   d. Uncontrolled epilepsy
   e. Stroke within previous six months
NO TREATMENT

1. Active TB
2. Temperature ≥100
3. Blood Pressure ≥160/100

PROCEDURES BEFORE SEATING PATIENT
Before your patient is seated, many procedures must be followed. Remember that at 8:00 a.m. there are many patients to be checked in, phones ringing, money being collected, etc. If all students help with patient flow, more time can be utilized on actual patient care. Remain in your cubicle until you are notified your patient has arrived and is ready to be seated.

1. Set up your operatory. Refer to the Operatory Setup/breakdown Procedures (pages 5-9).
2. Find your patient's record in EagleSoft and review patient file.
3. Obtain a new grade sheet for a new patient or obtain your ongoing grade sheet from your instructor.
4. You are notified by the Front Desk when your patient has arrived. You must keep your OnSchedule visible on your desktop to see when patient has arrived. A yellow light will appear next to your patient’s name, signaling that the patient is waiting in the patient waiting area.
5. Under no circumstances are patients to be in your chair until they have been checked in properly. Even if they are your family or friends, they must remain in the patient reception area and are not to be seated in the clinic until after the doctor or an instructor is in the clinic and proper procedures are completed. Failure to follow proper check in procedures results in errors in the evaluation area of TalEval.
6. Student clinicians may not leave the clinic floor without permission from an instructor.

SEATING THE PATIENT – BEFORE DOCTOR CHECK-IN
Once your patient has paid, and received and signed the HIPAA form, the front desk student changes the status of the patient on the OnSchedule to green. Under no circumstance are you to escort your patient into the clinic until the patient has been completely checked-in.

1. Go to the reception area and greet your patient. Hang coats on coat racks, not in your cubicle.
2. Escort the patient to your cubicle. Make sure purses and valuables are left in sight of the patient and taken by patient upon leaving the chair. The University cannot be responsible for personal property of patients.
4. Have patient rinse for 30 seconds with mouth rinse and spit. Immediately dispose of used mouthwash in the sink to avoid spillage.
5. What the patient sees and hears on his/her first appointment makes a lasting impression on him/her. Create a good impression in appearance, poise, and speech. Be cheerful, kind, and confident no matter how you feel. Make your surroundings neat and nonthreatening.
6. Words have psychological influence. Do not use such words as "hurt, scrape, dig, needle, cry, afraid, blood, oops" etc. as these words tend to produce the sensation they suggest or concern in the patient. Instead, try phrases such as "this will not bother you" or "let me know if this is uncomfortable".
7. Complete or review the Medical History. This form is signed by the patient at each appointment. You are responsible for all information on the medical history. By following up on information on the medical history form, you can gain valuable information. Use reference books such as the PDR and Drug Information Handbook for Dentistry to learn about drugs or diseases. For example, find out why a patient is on penicillin, how much are they taking and for how long, have they had any reactions to the medication. It is your responsibility to be able to answer any questions the Doctor or an instructor has concerning your patient’s medical history.
8. If a patient needs pre-med, make sure that the patient has taken the medication and document the medication, dosage and time taken in SOAP notes.
9. Take all vital signs of each patient at every appointment. It is not permissible to treat a patient with systolic pressure of 160 or greater and/or a diastolic of 100 or greater. Consult your clinical instructor as questions arise.
10. Patients with temperatures of 100° or higher are dismissed. Consult your clinical instructor as questions arise.
11. If a patient presents with questionable blood glucose readings consult your clinical instructor as questions arise. A Physician’s Clearance may be required.
12. Make sure your patient has signed the medical history. IF the patient is a minor, less than 18 years of age, a parent or legal guardian must sign the Medical History or treatment will not be rendered. **Once the Medical History is signed, ask the parent or guardian to be seated in the reception area.**

**PROTOCOL FOR PATIENT CARE**

**NEW PATIENT SCREENING**

New patient screening appointments are performed on designated screening days. Patients above the age of 18 years, who have not had a dental cleaning in more than 2 years are eligible for screenings. Following the screening, the patient will be scheduled for treatment based upon needs and student requirements (See Appendix IV).
**Screening procedure**

1. Place patient napkin.
2. Open instrument cassette and assemble mirror.
3. Obtain medical history.
4. Perform a **short** extra/intraoral examination. You are screening for oral pathologies that are present. Describe lesions in EagleSoft in the Clinical Exam. Use the Radiology Exam Type option. Complete only the Occlusion and Head tabs. All findings will be recorded in these tabs. If no significant findings are noted, then record in the comments sections, “findings within normal limits”.
5. Follow directions on screening form. (See E on form-Dr. Will do a screening exam and prescribe radiographs.)

**Instructor Classification:**

1. Have your tray set-up neat for instructor arrival. Have mirror, explorer and gauze ready for the instructor’s use.
2. Once the Instructor arrives: brief the instructor on the Health History, Extra/Intraoral inspection, Calculus Charting and Periodontal Charting
3. Always introduce the instructor to the patient. In general, the patient’s name precedes that of a faculty member. For example, “Mrs. Smith, I’d like you to meet my instructor, Mrs. Jones.”
4. As the instructor checks forms, you are expected to click on the appropriate tabs being checked so that the instructor can read the information or dictate information to the instructor as asked. Have a pen ready to make notations on the grade sheet as the instructor directs.
5. The instructor who checks this information will agree or disagree with your findings. The instructor will discuss with you the patient classification.
6. Refer to the Screening form.

**PRESCREENED OR RETURNING PATIENTS**

1. Obtain Medical/Dental History and Vitals from patient.

**Steps in completing Medical/Dental History and Vitals:**

a. Begin by completing or updating medical history. Ask follow up questions to any “Yes” answers on medical history. Ask: date of diagnosis or incident; treatment received; Dr. providing treatment; Medications for treatment; Type and date of surgeries; Any complications to surgery; Was general anesthetic used; Any allergies or reactions need to be listed and treatment for allergies; Has patient taken prescribed medication before treatment; Did patient eat; Does patient take, have they taken in the past or have they been prescribed premedication for dental treatment. Look up any diagnosed diseases and record dental considerations or
treatment modifications in comments and record reference. Record all documentation in comments Section.

b. If this is an update then need to ask if there are any changes to medical history since last visit. Document changes in comments section or state in comments section “No changes to medical history since last visit”.

c. List all medications patient is currently taking along with dosage, dental contraindications; reason for taking medication; and references.

d. Obtain patients’ Chief Complaint. Ask patient if they have any dental concerns or if they are having any dental pain or problems. This is documented in the treatment record under “S”.

e. Obtain dental history and complete the general tab and history tab.

f. Obtain vitals (temp; bp; pulse; respirations) and record in treatment notes under “O”.

2. Prior to beginning treatment, an instructor or the doctor reviews and grades the medical history. When the faculty member gets to you, introduce patient and faculty member.

3. Clinical Examination: The first step is to have the patient rinse with mouth rinse. Record in the treatment notes that patient rinsed with mouth rinse.

Steps in completing Clinical Examination (EOIO):

a. Begin clinical exam by completing the head and neck exam. Remember to complete the extraoral exam before the intraoral exam (see Appendix I).

b. Record TMJ findings under the TMJ tab.

c. Proceed to palpating the lymph nodes and thyroid. Remember to have patient seated in an upright position to palpate these structures. Record any findings on the head tab in the comments box. Be descriptive when documenting; for example, “Bilateral upper anterior cervical lymph nodes mobile, non-tender.”

d. Complete the intraoral exam by palpating and assessing all structures. Mark ONLY those lesions or structures that are abnormal under the head tab. Describe these structures in the comments box.

e. Assess the occlusion. Document the dental classification, cuspid and molar relationships, overbite, overjet, division, midline, crossbite, and profile.
   - Class I – Mesognathic
   - Class II – Retrognathic
   - Class III - Prognathic

f. Next, move to the cosmetic tab and assess the morphology, alignment, discoloration, and the presence of diastema. Record the specific tooth numbers affected in the comments box.

g. Assess the habits of the patient and record under the habits tab. This information may be gathered anytime during the assessment phase. Document any specific findings or recommendations to the patient in the comments box. For example: Patient is a smoker. In the comments box you would document “how many packs a day patient smokes, patient is interested in ceasing smoking, recommended ceasing smoking, educated patient on benefits or quitting and
h. Complete dental charting of what is present visually. Not necessarily graded at this time.

i. X-rays should be available when the assessment and dental charting are evaluated by faculty. Students are to determine the patient’s need for radiographic images and complete the radiology treatment plan. Faculty review the radiology treatment plan before having the doctor approve any necessary radiographic surveys.

**Floor Clinicians:** Students sign up with central to go to the radiology area to expose the prescribed radiographic surveys at any time during the assessment phase.

**Screeners:** Students inform central when the screening patients are ready to have the radiographic surveys exposed. The scheduled radiology operators complete the radiographic surveys on all screening patients.

j. CONTACT YOUR INSTRUCTOR – you are ready for EOIO check.

**NOTE: ONLY during DH 190 does the student stop for EOIO check. IN DH 290 and DH 390 students proceed with complete assessment before asking instructor for a check.**

k. Open the perio chart and complete perio charting. IF the patient is a light classification, then the full mouth will be evaluated. If, while assessing the first quadrant, it is determined the patient may be a class II or higher, then the student confers with the faculty to determine if a quadrant approach or full mouth approach is taken. These steps may vary, dependent upon the clinical session DH 190, 290 or 390. Record pocket depth, gingival margin, mobility, furcation grade, and bleeding.

l. Assess the periodontium. Document the consistency, inflammation, margins, exudates, attached gingival and papilla. Record the gingival statement in the comments box.

m. Complete calculus charting.

n. Complete the Plaque Index. Record the plaque score in the comments box under the Perio tab. Also record where the disclosing agent accumulated. For example, localized plaque accumulation at the gingival margin of posterior teeth. Record plaque score, goal and hygiene.

o. Complete patient education. Have the patient brush for you and watch patient brush. Remember to hold a mirror for the patient so they can see. Then give recommendations to patient and demonstrate for patient. Then have patient demonstrate new technique for you. Record your oral hygiene recommendations in the comments box under the general tab. At this time, talk to your patient about their current oral hygiene care. Document and make further recommendations.

p. The patient is to be as plaque free as possible for the instructor to perform assessment check. After the PI and OHI is completed, the patient is required to brush all remaining plaque index off his/her teeth prior to proceeding with patient care.
4. **Contact your instructor - you are ready for an Assessment check.**
   - Have Perio charting and radiographs available for the instructor to check.
   - Have calculus charting/grade sheet readily available for instructor. Refer to the legend on the bottom of the gradesheet for properly noting calculus. Document any corrections that instructor indicated on the grade sheet. After completing exam with instructor, make corrections in EagleSoft and change status to complete and save.
   - Have TalEval open (patient information should already be posted)

5. You may give your patient a break or dismiss your patient at this point while you are completing the care plan with the instructor. Fill in care plan for anticipated number of visits with planned treatment at each appointment. *(In DH 190, an instructor assists the student in developing the process of care plan; DH 290 and 390 the student is responsible for completing the plan).*

6. Present care plan to patient and obtain consent. Educate patient on expected outcomes, etc. Post proposed treatment in Eaglesoft.

7. Begin scaling and/or scaling and root planing according to care plan.

8. Following completion of scaling and root planing, sign up for scale check with your assigned instructor. **Make sure instrument tray is free of debris and that instruments, including mirror, are clean and in place.** When the instructor arrives to perform a scale check, hand the mirror and explorer to the instructor and have gauze available. Also, have the patient’s mouth free of debris and blood before the check.

9. Any remaining deposits are noted according to the legend on the grade sheet. When possible, your instructor provides you with feedback and guidance to remove remaining deposits.

10. Following removal of residual deposits, sign up for 2nd scale check. If the treatment area has been anesthetized but the student is unable to complete treatment due to time constraints, the instructor completes the patient treatment. The student does not receive credit for the area.

11. When the instructor considers scaling complete, the student proceeds to the polishing procedures.

12. When preparing to polish, it is beneficial to first disclose the patient to check for any residual plaque or sheet calculus. Rubber cup or prophy-jet polishes, selectively, with proper armamentarium and agent. Proceed to flossing patient to remove any residual debris and rinse.

13. Have disclosing agent available for instructor. Instructor may re-apply disclosing agent if needed. Assist with water syringe and saliva ejector.

14. Once a grade for supragingival deposit removal is rendered, the student removes any residual plaque, sheet calculus or stain as noted.

15. If there are any residual supragingival deposits, the student needs to obtain a second polish check.
16. Any corrections to the dental charting must be changed in EagleSoft and the student is responsible for making the changes and marking errors on their grade sheet. Dental charting may be completed at any time during the patient care.

17. If at any time during the treatment procedures you would like faculty assistance or feedback on how you are doing in a specific area, you may ask for assistance and faculty will help you.

18. Complete any adjunctive treatments per the care plan (i.e. sealants, desensitizing agent, etc.) All adjunctive treatments must be checked by faculty prior to fluoride treatment.

19. Instruct patient as to benefits and application procedures of fluoride. Administer fluoride. Fluoride is administered to all patients based upon their assessed needs. Give post treatment instructions.

20. Discuss with clinical instructor permission to release patient.


22. Document all procedures in the treatment notes (SOAP). Walkout your patient in Eaglesoft, changing proposed treatment to completed. Upon completion, faculty checks your treatment notes and a final grade is calculated.

**PATIENT CHECK-OUT & DISMISSAL**

**Check-out:**

1. Check out times vary per semester. You must abide by the posted check-out times.
2. The student is responsible for documenting all procedures, recommendations, interactions, etc. in the treatment and progress notes. It is also the student’s responsibility to make the record available to the assigned faculty to check the documentation of treatment and progress notes (See SOAP notes on page 17).
3. Before the patient is dismissed, the student processes the patient in EagleSoft. This is referred to as a “Walk Out”.
4. Walk Out your patient by opening the Clinical Chart.
5. Click on the “Fast Walkout” button.
6. The screening service that you provided show up in the statement. Confirm you are the provider on the form; if not, change as appropriate. Press “Process”.
7. Message front desk to request a check-out by an instructor. The instructor does a final check of the paperwork at this time. Make sure to have all paperwork completed. Failure to complete all necessary paperwork results in a deduction of daily points.
8. Have a mirror free of debris and ready for the instructor to perform a final tissue check.
**Dismissal of Patient:**

1. At the final treatment appointment: the student provides the Nonsurgical Post Periodontal Therapy Instructions to the patient, when applicable (See Appendix V). ALL patients receive a referral letter for further care (See Appendix VI). Any patient agreeing to participate as the student’s clinical board patient is informed of the clinical board process and provided with the Board Patient Post-Operative Care Agreement form to be read and signed (See Appendix IX).

2. Prior to escorting the patient from the cubicle, ask the patient to complete the Patient Satisfaction Survey. Then place completed survey in the appropriate location. Escort the patient to their personal belongings and help them to become orientated. Do not rush the patient out of the clinic.

3. Proceed to the front desk with the patient.

4. The student is responsible for his/her assigned area at the end of the clinical session. Refer to the Operatory Break-down for specific instructions.

5. Students are not dismissed from the clinical area until all of the clinical/radiology operatories have been check by the faculty. You must remain by your operatory area for a check to be completed. Make sure to have your daily grade sheet out during the check-out process. Your instructor assesses your daily grade at this time.

**RE-EVALUATION PROTOCOL**

Re-evaluation is required within 4 – 6 weeks for all Class III & IV patients who have received scaling and root planning.

1. Update medical history (dentist signs and approves)
2. Oral Inspection updated
3. Re-probe entire mouth, detect and chart calculus
4. Plaque index and OHI
5. Check-in with instructor
6. Process of Care plan
7. Ultrasonic full mouth to de-plaque and disrupt the Biofilm (unless contraindicated)
8. Hand scale as needed and Polish
9. Instructor check
10. Recommend recare appointment.
   a. Standard of care for periodontal maintenance is 3-month interval.

**DENTAL SEALANT PROTOCOL**

As with other MSSU dental hygiene clinic policies, the placement of dental sealants is based on the individual patient needs and preferences.
Dental Sealants are placed on fully-erupted permanent posterior teeth of children, adolescents and adult patients, dependent upon the patient needs and as prescribed by the supervising dentist. (No operculum present)

**IF the patient has been referred to our clinic for dental sealants; a prescription from the referring dentist is necessary.**

*Adopted by DH faculty council January 2011
Updated January 2016*

**TALEVAL – STUDENT INSTRUCTIONS**

**Student Profile:**

Complete ALL student personal information **EXCEPT Graduation date.** Make sure to include emergency contact and phone.

**Entering Patient Information:**

All students (screeners & clinicians) shall open the Patient Profile/List in the Patient Data tab. Locate existing patient. Verify correct name and birth date. Enter the patient EagleSoft ID# as the patient number. Joplin add a J after the patient number, Rolla an R and Sikeston an S (i.e. 6117J). For all new patients, students must enter the patient information. Patient data includes the patient’s legal name (may also add nickname), Eaglesoft ID#, and date of birth.

**Student Evaluation by Instructor (Daily – AM & PM):**

Faculty completes the patient header for each patient experience for the a.m. and p.m. appointments. After each patient is dismissed, faculty discuss TalEval assessment and SOAP note entries. Instructors post comments and feedback in the comments box – **Students do not post patient headers or notes in the comments area.**

**Student External Rotations:**

Students need to take several copies of the paper TalEval evaluation forms to the rotation site. The student is in charge of filling out the header information and self-grade as they would be graded in Taleval in the clinic. The dental hygiene student supervisor verifies and signs the form for each patient experience. The student submits the completed/signed forms to the MSSU clinical faculty at each site in the sealed envelope from the dental hygiene student supervisor.
MANAGEMENT OF MEDICAL EMERGENCIES
MEDICAL EMERGENCY PROTOCOL

If you are with a patient that exhibits signs of distress or is in an emergency situation, adhere to the following protocol.

1. Calmly, but firmly tell the student in the cubicle next to you (identified as rescuer #2) to immediately secure the supervising dentist, your assigned instructor and central sterilization assistant (identified as rescuer #3).

2. Rescuer #1 (operator) remains with your patient, making her/him comfortable, opening her/his airway. Start CPR, if indicated and monitoring her/his vital signs until the supervising dentists arrives.

3. Rescuer #2 obtains appropriate personnel, assists with CPR, and watches the clock, as directed by the supervising dentist.

4. Rescuer #3 returns to the cubicle with the supervising dentist and the instructor. The instructor notifies the Dental Hygiene Department Chair. The supervising dentist and Department Chair are in charge, determine if an ambulance is needed, and which emergency supplies or equipment is needed.

5. The instructor is responsible for obtaining emergency equipment and supplies.

6. Rescuer #3 is responsible for contacting the ambulance, if needed, as follows:
   a. Proceed to the nearest telephone and call Safety and Security, as appropriate for your campus; then dial 911.
   b. Advise security or emergency personnel that an ambulance is needed immediately at your location. Give operator specifics to your location, such as, Building name and room number.
   c. The student assigned to front desk monitors the building entrance and directs ambulance personnel to the needed area.

7. Rescuer #1 monitors the patient's vital signs and provide assistance as directed by the supervising dentist. Rescuer #1 documents vitals and prepares the incident report form.

8. All students and faculty should be prepared to provide basic life support under the direction of the supervising dentist.

9. All other students are to remain calm and at their cubicles unless called upon to assist.

10. See Appendix VII for the Medical Emergency Incident Report form.
ACCIDENT AND INJURIES
On occasion, students may incur minor injuries or accidents during any preclinical and clinical courses. Injuries are reported immediately to the course instructor. An Incident Report Form is completed and referral for care recommended as needed (See Appendix VIII).
1. Consistency through Exudate must be assessed and filled out.
2. Attached gingival and Papillae must be assessed and filled out.
3. Periodontal diagnosis must be marked with the appropriate diagnosis
4. Comments: A concise and accurate gingival statement must be noted and include the plaque index score.
5. Once periodontal charting is completed come back to this tab and hit the calculate button.
1. Must assess pain, popping, crepitus and deviation.

2. If a YES answer to history of trauma is indicated, further question the patient and explain in the comments section: what kind of trauma, when did it occur, what was diagnosis and treatment.
1. Note the dental classification: Class I, Class II or Class III
2. Note the skeletal classification
3. Both cuspid (Canine) and molar relationships should be assessed; Adult molar relationship is to be noted in the comments area.
4. Overbite through profile conditions are to be assessed and filled out.
1. If there is a yes response to any item or any area, further explanation is required in the comments area. Any tooth abnormalities are to be noted in the comments area.
1. Any abnormalities should be recorded and explained (size, shape, color, location, texture) in the comments area. Only document abnormalities.
1. This tab can be completed as part of collecting the patients’ dental history
2. History = the patient states in the past they did the stated habit, but you do not see any evidence of habit.
3. Manifestation = the clinician sees evidence of the habit; i.e. – erosion of maxillary anteriors indicating bulimia/anorexia.
4. Potential = the patient states that they may commit habit from time to time but is not aware of it and the clinician sees no signs of habit
1. The clinician may collect part of this data with the patients’ dental history.

2. Other = additional aids that patient may use; i.e. – proxy brush

3. Emotional Motivators – You should be collecting this information as you are talking with the patient. What motivates the patient to take care of his/her oral health? You do not ask the patient what motivates him/her; this is for you so you can educate the patient.

4. Emotional Concerns – You also collect this data as you are talking with patient. You do not ask the patient what his/her emotional concerns are.

5. Only fill out the pain section if the patient states they are having pain and further explain the pain in the comments section.

6. After the clinician has completed the plaque index with his/her patient, then proceed to OHI. Document complete instructions in the comments area in the general tab.
1. History section can be completed as part of patient dental history.
2. Sensitivity Section – any positive answers should be further questioned and explained in comments area. What teeth are sensitive? Are they sensitive to hot and cold; all the time, etc.
3. Any positive answers to last box should include further questioning. Place pertinent information in the comments box, including but not limited to:
   a. The date of treatment?
   b. Any complications?
   c. DDS that completed treatment?
APPENDIX II – EAGLESOFT PROCEDURES

When entering procedures for patients, it is important to access the different areas of Eaglesoft through the patient’s chart. The chart is accessed by clicking on the schedule, then the patient or through the dental chart screen. Categories such as: clinical tabs, SOAP notes, account management information, scheduling, walkouts, appointment cancellations, etc. These categories are access by utilizing the toolbar at the top of the screen in the schedule or the bottom of the screen in the dental chart.

HOW TO SCHEDULE AN APPOINTMENT:
1. Go to schedule
2. Click on Go To (calendar at the top)
3. Pick the date
4. Click ok
5. Click on time
6. Right click
7. Go to schedule appointment, click
8. Go to new, put in first and last name and phone#, click ok
9. Then find patient
10. Click use
11. Click confirmed if you want or you can leave it like it is
12. Click ok (If patient has been there before just find patient, you don’t have to click new)

HOW TO DELETE A PATIENT OFF SCHEDULE:
1. Find date and time
2. Right click, delete, ok (you can find patient in person and delete. Since they have not been seen in the clinic as of yet and if they don’t reschedule)

HOW TO MOVE APPOINTMENT:
1. Go to schedule
2. Find appointment
3. Right click/click move appointment/block
4. Go to new appointment
5. Right click/paste from move or copy/patients name will appear on side, click it
6. (If all day appointment drag anchor down to lunch, then right click and copy paste to after lunch hours)

HOW TO PUT PATIENT IN COMPUTER:
1. Go to person
2. Click new
3. Put in first and last name, address, phone number, sex, date of birth, click ok

HOW TO APPLY PAYMENT TO PATIENT:
1. Work within the patient chart
2. Click on the account link within the toolbar
3. Click on account payment
4. Click use
5. In payment type click check or cash, if paying with check put in check number
6. Put in amount
7. Make sure print payment receipt box is NOT checked
8. Then click ok, it will ask are you ready to apply this payment, click yes

HOW TO SEE WHAT DATE A RETURNING PATIENT PAYED:
1. Go to account
2. Click patient
3. Find patient
4. Click use (it will show first visit and how much they paid and what date it was)

HOW TO DO AN END OF DAY REPORT:
1. Click report
2. Click my favorites or all
3. Click on payment reconciliation
4. Click on process
5. Click preview report (all cash should be listed on top section and checks on bottom and the total for the day)

HOW TO OBTAIN PATIENT SIGNATURE FOR CONSENT AND HIPAA:
1. In the “on schedule screen” single click on the patient with whom you are working
2. Go to the tool bar and select the activities link; then select Smart Docs
3. Under the letters tab (left side of screen) open HIPAA treatment and consent document
4. Ask patient if they have any questions about HIPAA policy. If none, mark indicated areas with an X and SAVE the document.
5. Place cursor on signature line, click on stylus in the toolbar, have patient sign the HIPAA form with the signature gem or on a computer with a touch screen. SAVE and repeat for additional required signature. SAVE and close document.

HOW TO VERIFY HIPAA IN PATIENT ACCOUNT:
1. Remain on highlighted patient in the “on schedule screen”.
2. In the tool bar, click on the edit patient tab (little guy with pen).
3. Open patient information page.
4. Check 3 HIPAA boxes; update if patient is returning.
# APPENDIX III - PHYSICIAN CONSULTATION REQUEST FORM

Missouri Southern State University  
Dental Hygiene Clinic  
Physician Consultation Request

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>________________________________</td>
<td>________________________________</td>
</tr>
</tbody>
</table>

The above named patient has presented with the following medical problem(s):

<table>
<thead>
<tr>
<th>Adrenal insufficiency or steroid therapy</th>
<th>Bleeding disorder</th>
<th>Mitral valve prolapse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart murmur</td>
<td>Hypertension</td>
<td>Rheumatic heart disease</td>
</tr>
<tr>
<td>Prosthetic heart valve</td>
<td>Radiation therapy to head/neck</td>
<td>Drug allergies</td>
</tr>
<tr>
<td>Anemia</td>
<td>Cardiovascular disease</td>
<td>Pacemaker</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>Liver disease</td>
<td>Systemic lupus erythematosus</td>
</tr>
<tr>
<td>Prosthetic joint</td>
<td>Renal dialysis with shunts</td>
<td>Endocarditis</td>
</tr>
<tr>
<td>Anticoagulant therapy</td>
<td>Chemotherapy</td>
<td>Prescription diet drugs</td>
</tr>
<tr>
<td>HIV</td>
<td>Leukemia</td>
<td>Systemic-pulmonary artery shunt</td>
</tr>
<tr>
<td>Pulmonary disease</td>
<td>Renal disease</td>
<td>Other:</td>
</tr>
<tr>
<td></td>
<td>Diabetes</td>
<td></td>
</tr>
</tbody>
</table>

*Treatment to be performed on this patient includes:

- Deep scaling (with some removal of epithelial tissue)
- Dental radiographs (x-rays)
- Use of magnetostrictive ultrasonic devices
- Local anesthesia obtained with 2% Lidocaine, 1:100,000 epinephrine
- Local anesthesia epinephrine concentration may be increased to 1:50,000 for hemostasis, but will not exceed 0.2mg total

*Most patients experience the following with the above planned procedures:

- Minimal bleeding with transient bacteria
- Appointment length: ________________________________
- Prolonged bleeding
- Number and frequency of appointments: ___________
- Stress and anxiety:  _____Low  _____Moderate  _____High
- Other: ________________________________

**PHYSICIAN’S RESPONSE**

Please provide any information regarding the above patient:

*Need for antibiotic prophylaxis
*Current cardiovascular condition
*Coagulation therapy
*History and status of infectious disease- active __________ Completed treatment and no longer infectious __________

**CHECK ALL THAT APPLY:**

- OK to PROCEED with dental treatment with NO special precautions and NO prophylaxis antibiotics.
- Antibiotic prophylaxis IS required for dental treatment according to the American Heart Association and/or the American Academy of Orthopedic Surgeons guidelines.
- OTHER PRECAUTIONS are required (please list):
- DO NOT PROCEED with dental treatment (reason):
- DELAY treatment until this date: ________ (reason):

<table>
<thead>
<tr>
<th>Physician’s Signature</th>
<th>Date</th>
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<td>__________________________</td>
<td>__________________________</td>
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</table>
APPENDIX IV – SCREENING FORM

DH Program Screening Form
Dental Health Programs Screening Form

Patient’s Name: ___________________________ Student Requested _____________________
Student Screener: ___________________________ Date Screened: _________________________

Directions:
A. Conduct a medical history and take patient vital signs.
B. Get instructor’s or dentist’s permission to proceed.
C. Do a cursory screening for obvious lesions and pathologies.
D. Classify the patient for these characteristic:
   1. Calculus Deposits – visual (use air), explore all surfaces and document
   2. Periodontal Evaluation – condition of gingiva, probe one tooth in each sextant, mobility
   3. Count # of Teeth Present
   4. Existing Conditions
   5. Treatment Considerations
E. Dentist prescribes radiographs and transfers patient to student in Radiology Rotation

CALCULUS FORMATION; REFERENCE GUIDE

Granular  Nodule  Spicule  Band  Finger-Like Projection  Proximal Ledge

1. Calculus Deposits: Circle the calculus classification

<table>
<thead>
<tr>
<th>Class</th>
<th>Description</th>
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<tbody>
<tr>
<td>Class 0</td>
<td>No Calculus</td>
</tr>
<tr>
<td>Class I</td>
<td>Simple</td>
</tr>
<tr>
<td>Class II</td>
<td>Light/Moderate</td>
</tr>
<tr>
<td>Class III</td>
<td>Moderate</td>
</tr>
<tr>
<td>Class IV</td>
<td>Heavy</td>
</tr>
</tbody>
</table>

Slight Calculus – requires little or no scaling
Supragingival calculus extending only slightly below the free gingival margin
Moderate amount of supragingival and subgingival calculus, or subgingival calculus only
Abundance of supragingival and subgingival calculus, or subgingival calculus only
Generalized supragingival and subgingival ledges around cervical thirds of crowns and bands on most root surfaces
2. Periodontal Evaluation: Circle Periodontal Estimation

Probing Depths  Bleeding  Mobility
<4 mm  None  No
4 mm  Localized Points  No/Slight
5 mm  Generalized Points  Slight +1
6 mm  Moderate - Heavy  Moderate +2
7 mm  Heavy  Severe +3

3. Teeth Present: Count and record the molars, premolars or anterior teeth present in each sextant. Count all teeth present, primary or permanent dentitions (do not indicate primary and permanent as separate count tallies).

<table>
<thead>
<tr>
<th>Quadrant</th>
<th>Premolars</th>
<th>Anterior</th>
<th>Premolars</th>
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<th>Quadrant</th>
<th>Molars</th>
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4. Existing Restorations: Indicate the (amount in number) of each type of restoration present.

Amalgams  _____  Composites  _____  Crowns  _____  Fixed Bridges  _____  Removable Partial Dentures  _____  Full dentures  _____  Dental Implants  _____  Total: <4  >4

Indicate by circling Yes or No for Orthodontic Bands

5. Treatment Considerations: Indicate treatment needed by placing X after each consideration:

Immediate referral to a physician for a medical concern____
Immediate referral to an oral surgeon for a suspicious lesion____
Immediate referral to general dentist____
Possible periodontal case study____
Possible boards patient____
Sealants #____
Radiographs (Check Type): FMX____ Panorex ____ BWX____

Student’s Signature ________________________________  Instructor’s or Dentist’s Signature ________________________________

Patient Compliance Agreement

I have been informed of the findings from this screening appointment and the approximate cost of treatment here at Missouri Southern State University Dental Hygiene Clinic. I understand that since this is a teaching institute I will be assigned to a student whose level of education requires the learning experience my dental condition provides. I am aware that the student who will be treating me expects me to arrive on time for my appointments and that being late or missing any appointments could result in discontinuation of my treatment since the student must have a patient in every clinic session in order to receive a passing grade for the clinical course. I understand that each appointment will be up to three hours long and that multiple appointments may be required to complete my treatment. My signature indicates my commitment to the student’s learning experience and my intent to attend all appointments or call at least 48 hours in advance to cancel my appointment so that the student can find a patient to replace me.

______________________________________________  ______________________________________________________
Patient’s Signature
APPENDIX V – NON SURGICAL POST PERIODONTAL THERAPY INSTRUCTIONS

Missouri Southern State University
Dental Hygiene Clinic
Non Surgical Post Periodontal Therapy Instructions

Periodontal disease, unlike other diseases, cannot be cured by your doctor or medication alone. Overcoming this disease will largely rest on your efforts. Our part of the treatment is only the beginning. It is critical that you follow the oral hygiene and medication regimens provided by your healthcare provider. Without your commitment to a healthy mouth, your efforts and ours will have been in vain.

Please read and follow these procedures. They will make you more comfortable and will help to prevent any possible complications.

Care of your mouth. Start brushing, flossing, and continuing your prescribed oral hygiene regimen immediately. You have to go easy at first, but make every effort to keep your mouth plaque free. We recommend rinsing your mouth several times on the day of treatment with warm salt water to soothe the tissue (use ¼ tsp salt to 8 oz. warm water). A chlorhexidine or other mouth rinse may also be prescribed.

Discomfort. Some discomfort is expected when the anesthesia wears off. It is recommended that you take the over-the-counter pain medication that you normally use for pain or headaches to eliminate any discomfort. Sensitivity to cold or touch may temporarily occur. Removing all plaque from the tooth surfaces and brushing with desensitizing toothpaste will usually reduce or eliminate sensitivity.

Eating. Your next meal should be soft. Avoid any hard, gritty foods such as peanuts, popcorn, chips, and hard bread for the next 3-4 days. Also, it is best to avoid hot, spicy foods and alcohol for at least 24 hours. Avoid eating while numb.

Bleeding. Slight bleeding may continue for a few hours following the procedure. This is not unusual and should stop. If excessive bleeding continues, please call the clinic.

Swelling. Very seldom does swelling occur. If it does, rinse your mouth every couple of hours with warm salt water.

Smoking. Please refrain from smoking for 24 hours or longer after periodontal debridement procedures. Tobacco use interferes with the healing. (This would be an excellent time to quit using all tobacco products.)

Exercise. Avoid any aerobic activity for the rest of the day; e.g., jogging, tennis, racquetball, or anything strenuous. Take it easy.

Other. Expect tissue to shrink due to the inflammation and infection getting better. Teeth may appear longer and teeth may be slightly sensitive to temperature.

Follow up. You will need a follow up 4-6 week evaluation appointment for fine scaling and polishing after all periodontal therapy is complete.

Recare. It is critical that you see a Registered Dental Hygienist every 3-4 months for a thorough cleaning to avoid bacterial recontamination and to evaluate your progress.
Date: February 5, 2016

Dear (Patient’s Name):

Thank you for choosing Missouri Southern State University’s Dental Hygiene Clinic to meet your oral hygiene needs. As a teaching facility, we appreciate you giving the students the additional time needed to learn the profession.

During your visit(s), we have been able to provide you with quality dental hygiene services but in order to complete your care a comprehensive dental examination still needs to be performed to determine if any further treatment is required. It is our recommendation that you follow through by scheduling this appointment with your regular dental professional.

To assist you in your efforts to maintain optimal oral health, your dental hygiene recall interval has been set at _____ months.

Best Regards,

Missouri Southern State University
Dental Hygiene Department
# APPENDIX VII – MEDICAL EMERGENCY INCIDENT REPORT

**Missouri Southern State University**  
**Dental Hygiene**  
**Medical Emergency Incident Report Form**

<table>
<thead>
<tr>
<th>Finding</th>
<th>Time</th>
<th>Finding</th>
<th>Time</th>
<th>Finding</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulse:</td>
<td></td>
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<tr>
<td>Respiration:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Oxygen Delivery:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Medications administered:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Time:**
  - Onset:
  - Cessation of Breathing:
  - Cessation of Pulse:
  - CPR Initiated:
  - EMS Called:
  - EMS Arrived:
  - Patient Released:

Patient Response to Treatment:

---
Patient Released to: ________________________________________
Client Driven Home by: ___________________________________
Follow up call (time and name): ____________________________

Signature of Supervising Dentist: ___________________________
Signature of Student: _____________________________________
Signature of Instructor: ___________________________________
APPENDIX VIII – INCIDENT REPORT FORM

Missouri Southern State University
Dental Hygiene
Incident Report Form

DEPARTMENT REPRESENTATIVE SHOULD FILL OUT THIS FORM

Name: ______________________________                                    Date of incident: ________________

Room or location in which incident occurred. _____________________________________________________________

Did anyone observe the incident? If so, list who. _____________________________________________________________

Description of incident: Please describe how the incident happened. What was the individual doing? List any specific acts by individuals or conditions that led to the incident. (include any tools, machinery or instrument involved)

<table>
<thead>
<tr>
<th>Nature of Incident</th>
<th>Part of Body Injured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abrasion</td>
<td>Abdomen</td>
</tr>
<tr>
<td>Bite</td>
<td>Ankle</td>
</tr>
<tr>
<td>Bruise</td>
<td>Back</td>
</tr>
<tr>
<td>Bump</td>
<td>Chest</td>
</tr>
<tr>
<td>Burn</td>
<td>Ear</td>
</tr>
<tr>
<td>Cut</td>
<td>Elbow</td>
</tr>
<tr>
<td>Dislocation</td>
<td>Eye</td>
</tr>
<tr>
<td>Other specify)</td>
<td>Other (specify)</td>
</tr>
<tr>
<td>Fracture</td>
<td>Face</td>
</tr>
<tr>
<td>Pain/tender</td>
<td>Finger</td>
</tr>
<tr>
<td>Puncture</td>
<td>Foot</td>
</tr>
<tr>
<td>Scrape</td>
<td>Forearm</td>
</tr>
<tr>
<td>Scratch</td>
<td>Hand</td>
</tr>
<tr>
<td>Sprain</td>
<td>Head</td>
</tr>
<tr>
<td>Splinter</td>
<td>Knee</td>
</tr>
</tbody>
</table>

Was first aid administered?   Y or N

Additional Comments: ________________________________________________________________

Did you go to the Willcoxon Health Center or other facility for treatment:    Y or N _______________________

Name of physician: ________________________________________________________________

Diagnosis: ________________________________________________________________

Signed: ________________________________ Date ________________________________

Department Representative signature ________________________________ Date ________________

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APPENDIX IX – BOARD PATIENT POST-OPERATIVE CARE AGREEMENT

Missouri Southern State University
Dental Hygiene Clinic
Board Patient Post-Operative Care Agreement

As a Clinical Board patient for Missouri Southern State University Dental Hygiene Students, I accept responsibility for the following:

__________ Additional services may be necessary to complete my dental care.

__________ I choose to receive any additional services at a Missouri Southern State Dental Hygiene Clinic, and it is my responsibility to schedule the appointments. I am responsible for any additional costs for these services.

__________ I choose to receive any additional services by a dental provider of my choice. I am responsible for any additional costs for these services.

____________________________________________  ______________________
Patient                                                Date

____________________________________________  ______________________
Student                                                Date

____________________________________________  ______________________
MSSU Faculty                                           Date