APPENDIX 5.1

INSTRUCTIONAL SYSTEM – OHSC 501 COMPONENT 1: FIXED AND REMOVABLE PROSTHODONTICS

Clinical Assessment Document

As at December 2006

NB: This document supersedes all previous documents

1. Introduction

The clinical assessment system is based on two factors: the number of procedures satisfactorily completed, and the clinical grading marks.

There is a minimum requirement laid down for each of these assessments, as detailed below. It is the ***student's sole responsibility*** to ensure that (s)he obtains these minimum requirements, as failure to do so, will mean that a 50% clinical mark cannot be awarded. A 50% clinical mark is required for promotion.

2. Quantity requirements

2.1 Quotas to be achieved

It is a requirement that students perform a minimum number of procedures, which are accumulated each year. There are, of course, other procedures that can be performed, but the time constraints of the curriculum, as well as patient availability mitigate against all procedures being regarded as minimum requirements.

The procedures set out in Tables 1 and 2 have therefore been divided into those that ought to be performed, and additional procedures that may count in a student's favour if they have also been performed, or if they have been performed through force of circumstances instead of one or two of the minimum requirements. This will allow for some flexibility, but the skill requirements *must* match those of the minimum requirements for any discrepancy in quantities to be allowed.

If a student has fulfilled the minimum quota requirements, and has performed additional procedures, an award of up to an additional 5% may be added to the Clinical Year Mark.

Tables 1 and 2 will be modified from time to time to take into account changes to the curriculum, to the patient base, new developments, and so on. The term "follow-through" means that the student performs all laboratory procedures except packing, flasking and de-flasking. The term "non follow-through" means that all laboratory procedures are carried out by dental technicians, unless you wish to carry out some or all of the procedures yourself.

Table 1: Removable Prosthodontics: minimum clinical procedures

CODE	PROCEDURE	3rd YEAR QUOTA	4TH YEAR QUOTA#	5TH YEAR QUOTA	CUMULATIVE QUOTA
MINIMUM REQUIREMENTS :					
FTDP	Follow-through denture, students in pairs*	2			2
FTCD	Follow-through complete denture	1			1
NFCD	Non follow-through complete denture	(1)**	2(1)	(1)	2
SACD	Non follow-through complete denture using semi-adjustable articulator and face-bow mounting~			1	1
TCCD	Test (Hossack) case complete denture†			1	1
IRCD	Immediate Replacement complete denture††		(1)	1	1
SICD	Single complete denture (non – follow through)			1	1
ABPD	Acrylic-based removable partial denture		1(2)	2 (2)	4
MBPD	Metal-based removable partial denture: Kennedy Class III or IV		1(1)	1	2
DEPD	Metal-based removable partial denture: Kennedy Class I or II		1(1)	2 (1)	2
REPF	Repair: Fracture^		1(1)	(1)	2
REPT	Addition of a tooth^		1(1)	(1)	2
RELB	Reline / rebase		1(1)	1	1
TICO	Tissue conditioner per denture			1	1
	Clinical sessions	18	24	30	72
	ADDITIONAL PROCEDURES:				
IRPD	Immediate Replacement partial denture				1
FITR	Functional impression technique				1
TICM	Tissue conditioner with medication per denture				1
DUPD	Duplication				1
RFLA	Repair: Addition of a flange^				1

* Carried out in pairs, students swop lab procedures with second case

** If a student completes 4 or more dentures in 3rd year, 5% will be added to the Clinical Ranking Mark

˜ Student must do the face-bow transfer and mounting onto articulator themselves

† Student carries out set-up for trial base: all other lab procedures can be sent out

†† Minimum 5 teeth, of which 2 must be adjacent

^ Students must do all the laboratory work themselves

The numbers in brackets mean that that procedure may be completed in that year or either year.

The cumulative quota is the absolute minimum required to complete the course. There will be no exceptions.

#The 4th year quota is a **minimum** of the following:

2 x complete dentures

2 x removable partial denture (any type)

1 x repair (any type) or reline/rebase

Table 2: Fixed Prosthodontics: minimum clinical procedures

TECHNIQUES COURSE

PROCEDURE	QUOTA
Inlay tooth 25: prep, imp, wax-up, cast*, fit*	1
Onlay tooth 36: prep, imp, wax-up, cast*, fit*	1
Veneer (incisal prep), indirect: tooth 22	1
Full gold crown, prep and temp: tooth 46	1
Ceramo-metal crown, anterior, prep and temp: tooth 21	1
Ceramo-metal crown, posterior, prep and temp: tooth 16 or 26	1
All ceramic crown, prep, temp: tooth 11	1
3-unit ceramo-metal bridge, preps and temp: central to canine: 21 to 23	1
Preformed post and core	1
Cast post and core: direct	1
Cast post and core: indirect: prep and impression.	1
Full gold crown, prep: tooth 37	1
Three quarter crown, prep: tooth 35	1
Michigan-type occlusal splint, made by a class colleague, to be worn for one week continuously	1

* If laboratory facilities available.

CLINICAL REQUIREMENTS		
CODE	**PROCEDURE**	**QUOTA**
GOIN	Gold inlay or onlay	2
POCR	Posterior crown, FGC or C-M	2
ANCM	Anterior ceramo-metal crown	1
ANAC	Anterior all ceramic crown	1
POCO	Post and core	2
BRDG	3-unit bridge	1
	Clinical sessions	60
	*ADDITIONAL PROCEDURES**	
ACBR	3-unit bonded (Maryland type) bridge	1
3QCR	Three quarter crown	1
INVE	Veneer (indirect)	2
CDCM	CAD/CAM restoration	1

*Additional procedures over and above minimum will qualify the student for an addition 5% on the Clinical Ranking Mark

2.2 Quality requirements for quotas

Please refer to the separate publication on the BEST system for details of the Minimum Total Quality Score. Set out here, are the criteria to be used for the assessment of each of the stages for the procedures.

2.2.1. Assessment criteria for the clinical stages of complete denture construction

The following criteria will be used to aid the assessment of the clinical stages:

Primary impressions: common criteria

1. The sulcus has been recorded evenly
2. There are no voids in the impression which will affect the construction of special trays
3. In a lower impression, there is extension into the retro-mylohyoid area, and full extension of the buccal shelves
4. The extension of the special trays has been indicated correctly by the marking-pencil line
5. The line indicating the lingual extension of the lower special tray is to, and not beyond, the mylohyoid ridge

Primary impressions: criteria specific to the use of alginate in a stock tray

1. The stops are all showing, indicating that the tray has been fully seated
2. In a lower impression, there is support for the alginate (from periphery wax) in the retro-mylohyoid area.

Final impressions: common criteria

1. The tray has been seated symmetrically
2. The impression material is adequately supported
3. The functional sulcus has been recorded for both depth and width
4. There are no voids in the impression which will adversely affect the periphery or the fitting surface

Final impressions: criteria specific to the use of a special tray

1. If a spaced upper tray is used, stops should show through impression, or have less than 0.5mm impression material covering them
2. If a spaced lower tray is used, green stick should have been used to record the posterior lingual sulci and retro-mylohyoid areas
3. Close-fitting special trays must also have had greenstick added to the posterior palatal seal area

Final impressions: criteria specific to the use of compound and ZOE in one visit

1. There has been adequate relief of the compound for the paste
2. There is an even thickness of impression paste over the surface of the compound
3. In the lower, there is adequate support for the ZOE, particularly in the retro-mylohyoid area

Final impressions: criteria specific to the use of the double alginate technique

1. There must be adequate support for the alginate, as evidenced by modifications to the stock tray, particularly in the retro-mylohyoid area
2. There is an even thickness of the second alginate layer over the surface of the first layer

Jaw relation record

1. The mid-line must be recorded
2. The occlusal plane is acceptable
3. The vertical height of occlusion is acceptable
4. On closing there is no perceptible shift of either base in the mouth
5. If Alminax used, there should be **no** signs of it having been heated with a wax knife
6. The inter-occlusal recording material does not extend onto the untrimmed surface of the occlusal rim, when the posterior section of that rim has been prepared to receive the inter-occlusal material
7. The occlusal rims are well localised against each other by the inter-occlusal records, which correspond to the key-ways in the upper rim
8. The posterior flanges of the bases do not touch when articulated
9. Use of the occlusal rim to record the registration is not acceptable

Trial Base / Try-in

5. Models are articulated correctly and neatly
6. Teeth to be placed where original teeth were most likely to have been, so that the arch form should follow the original arch of the teeth
3. On average:
   - upper anteriors are 8-10mm anterior to the incisive papilla
   - incisal inclination is related to the anterior ridge inclination - it is helpful to imagine the roots of the teeth
   - a tangent to the labial surface of lower incisors passes through the sulcus
   - a perpendicular through the buccal cusp of the lower first molar meets the buccal side of the crest of the ridge

4. Generally only the lower premolars are set directly over the ridge, because of the pattern of resorption.
5. Teeth set according to compensating curves

6. External surfaces of the trial bases to be contoured correctly
7. Wax gingival margins correctly festooned around the necks of the teeth, no wax on teeth or occlusal surfaces, and wax smooth with no blackened areas.
8. Root effects and stippling may be used to enhance the appearance
9. Maximal intercuspal contact in centric occlusion
10. Evidence of customisation of aesthetics, at least to the upper anteriors

Face bow record

1. When completed, bite fork should be symmetrical within the face bow, and all components tightened sufficiently
2. If a bite fork assembly is used it must be removed carefully and mounted using the correct mounting jig on the articulator
3. Students should mount the models themselves

Remounting and finishing

1. Occlusion adjusted correctly for maximal intercuspal contact in centric and for balanced articulation
2. Dentures correctly trimmed and polished without damage to peripheries or teeth
3. External contour of denture surface retained: neither teeth nor flange contour polished away
4. Gingival contouring retained
5. Any root effects and stippling retained
6. Fitting surface to be clean and free of surface blebs, pimples, etc.

Delivery

1. The desired result from the laboratory remounting procedure is to have dentures with the correct vertical dimension of occlusion / inter-alveolar distance, and the occlusion properly adjusted for balanced articulation. Either the dentures are returned from the lab. with the upper mounted on the articulator (having been remounted and ground in), or if the models were destroyed, new models are available for clinical remounting
2. The external contours, height and width of periphery (including the post-dam) have been maintained after polishing
3. Pressure areas have been identified and corrected
4. Occlusal adjustments have been made on the articulator after clinical remounting
5. Final intra-oral occlusal adjustment has produced acceptable balanced articulation
6. Patient instructions to be given on care and maintenance such that patient understands what is required, and a recall visit to be scheduled

Recall

1. Complaints and problems reported by patient to be correctly diagnosed
2. Occlusal interferences to be investigated first unless obvious areas of over-extension are present
3. Pressure-indicating paste to be used to detect pressure areas
4. 'Dr Thomson' disposable applicators to be used for peripheral extensions
5. Patient instructions to be reinforced

2.2.2. Assessment criteria for the clinical stages of removable partial denture construction

Primary impressions

1. Tray does not show through the alginate, indicating correct placement and correct use of palatal or buccal shelf stops
2. There are no voids in the impression which will affect the construction of special trays
3. Occlusal surfaces of teeth are recorded without air bubbles
4. Support for alginate has been provided where necessary in edentulous areas, with compound or wax
5. Periphery allows for adequate extension of special tray

Tooth preparation

1. Occlusal rests should be of correct shape and depth, with no sharp edges
2. Cingulum rests should be sufficient to provide resistance to an instrument when pressed against them in an occlusal direction
3. No excessive damage to external contours when undercuts created by tooth reduction
4. Composite highly polished when used for undercut creation by addition

Final impressions

1. If special tray used, stops should not be on teeth that have been prepared
2. Special trays should have adequate relief holes
3. No sign of bubbles on occlusal surfaces and rest preparations
4. Adequate extension in edentulous areas
5. Distal extension areas to be treated as for a complete denture

Try-in: acrylic-based

1. Final models to be assessed for correct reproduction of detail and extension to edentulous areas
2. Final models to be assessed for correct path of insertion and block-out of undercuts

3. Aesthetics to be assessed for adequate tooth selection and placement

Try-in: metal framework

1. Framework to be assessed on model for correct placement of components and conformity to design
2. Framework to be assessed intra-orally for adequacy of fit and for occlusion

Distal extension frameworks

1. Special trays to have correct extensions
2. Altered cast impression assessed for correct extensions and for correct fit of framework.

Delivery

1. Fitting surfaces assessed and adjusted as necessary
2. Occlusal adjustments carried out
3. Patient instructions and immediate and future recall arrangements made.

Recall

1. Complaints and problems reported by patient to be correctly diagnosed
2. Occlusal interferences to be investigated first unless obvious areas of over-extension are present
3. Pressure-indicating paste to be used to detect pressure areas
4. 'Dr Thomson's' disposable applicators to be used for peripheral extensions
5. Patient instructions to be reinforced

2.2.3. Assessment criteria for the clinical stages of procedures used in fixed prosthodontics

History, examination, diagnosis, primary impression

1. Mouth is caries free and free of periodontal disease
2. Diagnosis to be arrived at after use of panoramic and periapical radiographs, after assessing occlusion and having done vitality tests if necessary.
3. Primary impressions should be free of voids so that diagnostic models can be articulated without interference.
4. Face-bow recording taken as necessary.

Face bow and jaw registration

1. When completed, bite fork should be symmetrical within the face bow, and all components tightened sufficiently
2. If a bite fork assembly jig is used it must be removed carefully and mounted using the correct mounting jig on the articulator
3. Students should mount the models themselves, using a two-stage technique with impression plaster first and then white plaster
4. Jaw registration should be at the correct pre-determined vertical and horizontal relationship and the material must record all occlusal surfaces of both arches, using Temp Bond if necessary, and be cut away through the buccal cusps to check accuracy of fit of the model

Impressions

1. The tray should have adequate rigidity and be symmetrically seated.
2. The impression material is adequately supported.
3. There are no voids or drags in critical areas of the impression.
4. The impression material has not pulled away from the tray.
5. All finish lines have been captured and are visible, with impression material clearly visibly beyond the finish line.
6. There is no step-formation between putty and wash with silicone impression materials.
7. There should be no un-set impression material on the surface of the impression.

Provisional Restoration

1. The provisional should provide positional stability not allowing the tooth to drift or extrude in any way and therefore be in occlusal function
2. The restoration should be well contoured and highly polished
3. Margins must be accurate and not impinge on the gingival tissues with absolutely no overhangs.
4. The restoration must provide a good cosmetic result (contour and appropriate shade selection).

Cementation, burnishing and finishing

1. Correct proximal contact of the restoration (neither too tight nor too light).
2. The restoration should be completely seated (proper marginal adaptation).
3. The margins should not be overextended nor under extended, too thick or open.
4. The restoration should be in occlusal function (not in hyper- or hypo occlusion).
5. Restoration should be highly polished.
6. All excess cement should have been removed.
7. Gold inlays and onlays must be finally burnished one week post-cementation

Gold Inlay/Onlay

Preparation

1. Gingival bevels, buccal bevel, lingual bevel and proximal flares must all be continuous with each other (i.e., bevels should be blended into the respective flares).
2. Presence of functional cusp bevel.
3. Onlay has a 1.0 mm wide occlusal shoulder with bevel on the functional cusp/s.
4. Occlusal reduction to follow contours of cusp (1.5 mm on functional cusp and 1.0 mm on non - functional cusp).
5. Pulpal floor should preferably be flat.
6. Proximal boxes should be extended buccally and lingually to break contact with the adjacent tooth. The gingival floor of the box should be perfectly flat. *There should be no undercuts on the walls. Students should not err in the opposite direction by over tapering the walls*.
7. Adjacent teeth should not be damaged by preparation.

Posterior Crowns

Preparation

Preparation features:	Occlusal reduction	Finish line depth and configuration
Full Gold Crown	1mm non - functional cusps	0 – 1.0 mm
	1.5 mm functional cusps	Chamfer knife edge
		Shoulder or shoulder with bevel
Ceramo-Metal crown	1.5 mm non - functional cusp	1.2 mm labial chamfer, or shoulder with bevel if metal margin aesthetically acceptable
	2.0 mm functional cusp	0.5 mm lingual chamfer
		1.5mm axial reduction

1. There should be no damage to the adjacent teeth during proximal reduction.
2. There should be no undercuts
3. There should be smooth transitional line angles.
4. Finish lines should be ideally placed supra-gingivally and on sound tooth tissue (aesthetics and retention sometimes dictate that margins be placed sub-gingivally but if so, they should extend no more than half the depth of the sulcus (epithelial attachment should not be violated)
5. No unsupported tooth structure should be left at the edge of finish lines.

Anterior crowns

Preparation

Preparation features:	Occlusal reduction	Finish line depth and configuration
All porcelain crown	2 mm incisally	0.8 – 1.0 mm shoulder
	1 mm lingual aspect	
Ceramo-metal crown	2 mm incisally	1.2 mm labial shoulder or heavily chamfer
	0.5 – 1.0 mm lingual aspect (porcelain guidance requires greater clearance)	0.5 mm lingual chamfer

1. Reduction should be in 2 planes labially
2. No damage to adjacent teeth
3. Presence of lingual/palatal wall for retention and resistance form
4. There should be clearance in lateral and protrusive movements

Post and core

Preparation

1. Some coronal dentine should be retained (ferrule effect).
2. Post length should be long enough to be retentive ($\pm$ 9mm). The length of the post should equal the crown length or two thirds the length of the root, whichever is greater.
3. The length of the remaining GP apical fill should be at least 4-5mm.
4. Unsupported tooth structure should be removed.
5. Anti-rotation slots or pins should be placed in circular or round preparations.
6. Post-diameter should be no more than one third the root diameter at the C-E junction. It should be at least 2.00 mm less than the crown diameter at mid-root.
7. Posts to be kept in the long axis of the root, the core can diverge.
8. Sharp line angles to be avoided.

Cementation

1. Post-core is properly seated.
2. No voids between apex of post and GP.

3-Unit Bridge

1. Abutment preparations as per criteria for relevant crown type.
2. Preparations must have no undercuts relative to each other unless design is fixed-movable.
3. Assessment and diagnosis of correct extent and shape of pontic.
4. Pontic should be made and adjusted to approved type.
5. Student should display knowledge of pontic designs (ridge lap, modified ridge lap, hygienic and ovate pontics).
6. Correct design of embrasure spaces between pontic and retainers.

Indirect Veneer

Preparation

1. Preparation has preferably been maintained within enamel.
2. Finish line should be defined to a slight chamfer at the level of the gingival crest, or slightly subgingival. Proximal finish lines should not extend beyond contact point with adjacent teeth.
3. Finish lines for incisally reduced veneers should be 1.0 mm from centric contacts.
4. There should be no sharp internal line angles.
5. There should be no undercuts especially in proximal wrap preparations.

Cementation

1. Isolation of abutment teeth with rubber dam.
2. Veneers should be properly seated.
3. No excess cement.
4. Veneers should be of an appropriate shade.
5. Veneers should be functional occlusally.

3 Unit resin bonded (Maryland type) bridge

Preparation

1. The tooth preparation should include axial reduction and guide planes on the proximal surfaces with slight extension onto the buccal surface to achieve a bucco-lingual lock.
2. The preparation should encompass at least 180 degrees of the tooth.
3. Presence of vertical stops (rests) on all preparations.
4. Presence of grooves for resistance.
5. Preparation should preferably be confined to enamel.
6. No undercuts should be present.

Bond and cementation

1. Isolation of abutment teeth with rubber dam.
2. No excess cement.
3. Proper seating of bonded bridge.
4. Light occlusal contact – no interference in centric and lateral and protrusive excursions.

Three quarter Crown

Preparation

1. Occlusal reduction to follow contour of tooth
2. Functional cusp bevel
3. Bevel onto buccal cusp for aesthetics
4. No damage to adjacent teeth
5. Presence of proximal boxes
6. Buccal, bevel, proximal flare and chamfer finish line to be continuous

CAD/CAM restoration

Preparation

1. All aspects of the relevant restoration as above to be covered.
2. Student will receive assistance with the other aspects of imaging, design, milling, and placement of the restoration.

2.3 Clinical stages and their Relative Value Unit

Each prosthesis has been designated as consisting of a variety of different clinical stages, as per the tables following. Occasionally, not all these stages may be used; in this case, the MTQS is calculated on only those stages actually carried out.

2.3.1. Removable prosthodontics

Table 3: Clinical stages and RVW: complete dentures (codes FTDP, FTCD, or NFCD)

STAGE	RVW
History, examination and diagnosis	1
Primary impressions	2
Secondary impressions	3
Jaw registration	2
Try-in	2
First re-try	1
Second re-try	1
Finish	1
Recall	2

Table 4: Clinical stages and RVW: complete dentures using a semi-adjustable articulator and face-bow mounting (code SACD)

STAGE	RVW
History, examination and diagnosis	1
Primary impressions	2
Secondary impressions	3
Jaw registration	2
Try-in, face-bow and protrusive bites	2
First re-try	1
Second re-try	1
Finish	1
Recall	2

Table 5: Clinical stages and RVW: test (Hossack) case complete denture (code TCCD)

STAGE	RVW
History, examination, and diagnosis	2
Try-in	3
Finish	3
Recall	1

Table 6: Clinical stages and RVW: immediate dentures (code IRCD)

STAGE	RVW
History, examination, diagnosis and treatment planning	2
Primary impressions	1
Secondary impressions	3
Jaw registration	1
Try-in	1
Set-up	3
Model trimming	2
Finish	1
Recall	2

Table 7: Clinical stages and RVW: acrylic-based partial dentures (code ABPD)

STAGE	RVW
History, examination and diagnosis	1
Primary impressions	1
Design	3
Secondary impressions	3
Jaw registration	1
Try-in	2
First re-try	1
Finish	1
Recall	2

Table 8: Clinical stages and RVW: metal-based partial dentures: Class III or IV (code MBPD)

STAGE	RVW
History, examination and diagnosis	1
Primary impressions	1
Design	3
Secondary impressions	3
Jaw registration	1
Try-in	2
First re-try	1
Finish	1
Recall	2

Table 9: Clinical stages and RVW: metal-based partial dentures: Class I or II (code DEPD)

STAGE	RVW
History, examination and diagnosis	1
Primary impressions	1
Design	3
Secondary impressions	3
Altered cast impression	3
Jaw registration	1
Try-in	2
First re-try	1
Finish	1
Recall	2

Table 10: Clinical stages and RVW: repair of a fracture (code REPF)

STAGE	RVW
Finish	procedure must be clinically acceptable at first presentation to obtain a credit

Table 11: Clinical stages and RVW: addition of tooth to denture (code REPT)

STAGE	RVW
Finish	procedure must be clinically acceptable at first presentation to obtain a credit

Table 12: Clinical stages and RVW: addition of flange to denture (code RFLA)

STAGE	RVW
Finish	procedure must be clinically acceptable at first presentation to obtain a credit

Table 13: Clinical stages and RVW: reline or rebase (code RELB)

STAGE	RVW
History, examination and diagnosis	1
Impression	3
Finish	2
Recall	2

Table 14: Clinical stages and RVW: tissue conditioner (code TICO)

STAGE	RVW
History, examination, diagnosis and treatment plan	2
Placement	3
Recall	1

Table 15: Clinical stages and RVW: immediate replacement partial dentures (code IRPD)

STAGE	RVW
History, examination, diagnosis and treatment planning	2
Primary impressions	1
Design	3
Secondary impressions	3
Jaw registration	1
Try-in	1
Set-up	3
Model trimming	2
Finish	1
Recall	2

Table 16: Clinical stages and RVW: functional impression technique (code FITR)

STAGE	RVW
Two-stage impression	procedure must be clinically acceptable at first presentation to obtain a credit

Table 17: Clinical stages and RVW: tissue conditioner with medication (code TICM)

STAGE	RVW
History, examination, diagnosis and treatment plan	2
Placement	3
Recall	1
Recall	1

Table 18: Clinical stages and RVW: duplication (code DUPD)

STAGE	RVW
History, examination and diagnosis	1
Mould creation for wax dentures	3
Try-in	2
Impressions	3
Finish	1
Recall	2

2.3.2. Fixed Prosthodontics

Table 19: Clinical stages and RVW: gold inlay or onlay (GOIN)

STAGE	RVW
History, examination, diagnosis, primary impressions, face-bow if indicated	1
Preparation	3
Impression	3
Face bow and jaw registration	2
Temporary restoration	2
Cementation	2
Burnish and finish	2

Table 20: Clinical stages and RVW: posterior crown, FGC or C-M (POCR)

STAGE	RVW
History, examination, diagnosis, primary impressions, face bow if indicated	1
Preparation	3
Impression	2
Face bow and jaw registration	2
Temporary restoration	2
Adjustment of occlusion	2
Cementation	2

Table 21: Clinical stages and RVW: anterior ceramo-metal crown (ANCM)

STAGE	RVW
History, examination, diagnosis, primary impressions, face bow if indicated	1
Shade selection	1
Preparation	3
Impression	2
Face bow and jaw registration	2
Temporary restoration	2
Assessment and adjustment of occlusion	1
Cementation	2

Table 22: Clinical stages and RVW: anterior all ceramic crown (ANAC)

STAGE	RVW
History, examination, diagnosis, primary impressions, face bow if indicated	1
Shade selection	1
Preparation	3
Impression	2
Face bow and jaw registration	2
Temporary restoration	2
Assessment and adjustment of occlusion	1
Cementation	2

Table 23: Clinical stages and RVW: post and core (POCO)

STAGE	RVW
History, examination and diagnosis	1
Preparation	3
Impression	3
Temporary restoration	2
Cementation	2

Table 24: Clinical stages and RVW: 3-unit bridge (BRDG)

STAGE	RVW
History, examination, diagnosis, primary impressions, face bow if indicated	1
Knowledge and diagnosis of pontic design	1
Preparations	3
Impression	3
Face bow and jaw registration	2
Temporary restoration	3
Assessment and adjustment of occlusion	1
Cementation	2

Table 25: Clinical stages and RVW: 3-unit resin bonded (Maryland type) bridge (ACBR)

STAGE	RVW
History, examination and diagnosis	1
Preparation	3
Impression	2
Temporary restoration	1
Bond and Cementation	3

Table 26: Clinical stages and RVW: three quarter crown (3QCR)

STAGE	RVW
History, examination, diagnosis, primary impressions	1
Preparation	3
Impression	2
Face bow and jaw registration	2
Temporary restoration	2
Occlusion	2
Cementation	2

Table 27: Clinical stages and RVW: indirect veneer (INVE)

STAGE	RVW
History, examination and diagnosis	1
Preparation	3
Impression	2
Temporary restoration	1
Cementation	3

3. Quality requirements: the Clinical Ranking Mark

Please refer to the publication on the BEST clinical assessment system for the derivation of the clinical mark: it is a combination of the average weighted mark received for sessions, and any clinical examinations taken in each term.

The minimum average weighted mark to be achieved to be the equivalent of a 50% Clinical Ranking Mark, is 3.0.

4. Summary

In order for a student to be granted approval on *clinical* grounds for promoting to the next year of study, the following requirements must be met:

1. Perform the minimum number of clinical procedures as set out in Tables 1 and 2, to the minimum quality required, as indicated by the Minimum Total Quality Score for each procedure.

2. Achieve a minimum Clinical Ranking Mark of 50%, as indicated by the average weighted mark received for all clinical sessions.

The Clinical Ranking Mark also contributes to the Year Mark, as set out in a separate publication of the Department.

5. The case of the disappearing patient

Disappearing patients are defined as those who are definitely not going to return by reason of death or having moved away, or other similar reason, which reason *must* be verified by the supervisor.

5.1 For complete dentures

$ If the student has reached the try-in stage with complete dentures then the student at that visit will be asked to do an aesthetic set up and best balance without grinding teeth.
$ Then the dentures are to be finished in our lab (not sent out) and the student must then remount the models, and produce a perfect balance on the articulator.
$ If the dentures have already been processed, the student must still remount the models, and produce a perfect balance on the articulator.
$ When presenting this to the Supervisor the student must demonstrate that (s)he knows and can describe precisely, the clinical procedures to be followed at delivery, and at recall.
$ THEN and only then can the student be given a quota credit.

5.2 For Immediate replacement dentures

$ The student must have reached the finish stage and completed all model trimming, etc.
$ Then the student must assist a colleague or member of staff at the delivery stage of their dentures, and for at least 3 recalls, in order to obtain a credit.

5.3 For partial dentures

Acrylic-based

$ The student must have reached the try-in stage, having performed all other procedures satisfactorily, especially the tooth preparations and the surveying and blocking-out of the master model.
$ Models, try-in, and design must all be present, with suitable and appropriate articulation.
$ As it is not possible to simulate any further stages, the n/a column must be completed for the remainder of the stages on the quota form, and this form must be retained by the student and will be worth a half credit only.
$ Details will not be entered into the system, but this half credit will only be considered at the end of the year if the student has a problem with the required quotas.

Kennedy Class III or IV metal-based

$ The student must have successfully tried in the framework, and have reached the waxed-up try-in, stage, in which case a half credit will be given, using the same principles as above for the acrylic partial.
$ If the waxed-up try-in has not been completed, the student must carry this out before being granted the half credit.

Kennedy Class I or II metal-based

$ If the student has reached the same stages as for a Class III or IV above without having carried out an altered-cast impression, the same criteria apply, to obtain a half credit.
$ If the student has successfully carried out an altered cast impression, and has reached the waxed try-in stage, then the student must proceed as for a complete denture, and then can receive a full credit.