Clinical Supervision Model – Placement Providers (UoS Dental Hygiene & Therapy Programme)

Purpose. This document sets out how the University assures safe, appropriate clinical supervision for Dental Hygiene & Therapy (DHT) students across *all* placement providers (including the Suffolk Community Interest Company (CiC) and other contracted sites). It aligns supervision intensity to the activity and the student's stage of development and provides clear numerical supervision ratios, role definitions, and governance processes. It is intended for inclusion in our GDC inspection materials and for local induction at placement sites.

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1) Principles

1. **Patient safety first.** Students provide patient care only after passing defined gateway assessments for each skill; supervision intensity is matched to the activity and student stage.
2. **Proportionate, sustainable model.** Clinical supervision is delivered primarily by **placement-employed GDC registrants** (dentists, dental therapists/hygienists and dental nurses) who are audited, inducted and trained by the University; University staff provide calibration, QA and assessment oversight rather than routine onsite cover at each placement.
3. **Clarity of roles.** We do not use the term *Educational Supervisor* in placements. The onsite role is **Clinical Supervisor (Placement)**. University-based staff are **University Clinical Tutors/Assessors** (assessment and QA), and **Link Tutors** (placement QA/liaison).
4. **Consistency across providers.** Ratios, supervision levels and escalation rules below apply at all approved sites; any local variation must be risk-assessed and approved through the University's placement QA process.

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2) Definitions

- **Direct supervision:** Supervisor is present in the clinic, checks in/out every patient, and is immediately available to enter the surgery to observe, support or intervene. In open clinics the supervisor may be supervising multiple students within the space. In closed clinics, multiple students can be supervised via open door access to surgeries in rooms that are directly adjacent/opposite to one another.

- **Close supervision (chairside):** Supervisor is in the surgery for irreversible or higher risk elements (e.g., LA administration, pulpotomy), provides real time oversight and signs off the critical step(s).
- **Indirect supervision:** Supervisor is on-site and readily available; used only for low risk activities *after* competence is demonstrated and where local protocols allow.
- **Roving dental nurse capacity:** Placement ensures adequate dental nurse support and roving capacity for IPC compliance and patient flow.

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3) Supervision ratios and surgery models by stage & activity

Important: Ratios below are *maximum* students per onsite GDC registered clinical supervisor during active patient care. Where multiple surgeries run concurrently, there must be a named supervisor responsible for each bank of surgeries.

Year 1 (Level 4) – Foundation & Observation → Low complexity preventive care

- **Observation clinics and examinations (EOE/IOE, BPE, indices):** up to **1:6** under **direct supervision** (checkin/out and case discussion for each patient).
- **Preventive care (OHI, TFV), supra-gingival PMPR, paediatric supra PMPR, radiographs:** up to **1:6** under **direct supervision**; chairside presence for first cases and as indicated.
- **No irreversible procedures**; no LA/restorative in Year 1.
- **Suggested surgery model when multiple students attend:** rotating roles (operator / peer observer / reception-decon support) to ensure throughput and learning.

Year 2 (Level 5) – Consolidation & Expanded Scope (perio step-care; paediatric therapy introduction)

- **Perio care (supra + sub-gingival instrumentation incl. USS/MINST), radiography, fissure sealants, PRR:** up to **1:4** under **direct supervision** (with mandatory supervisor check-out before patient leaves).
- **Paediatric therapy (PMCs, PRR) and *first* extractions: 1:2** with **close (chairside) supervision** for critical steps.
- **Local anaesthesia (infil/IDB) – early cases: 1:2** with **close (chairside) supervision** for administration; progression to **1:4** once competent and signed off for that technique.
- **Restorative (glass ionomer/composite) – initial cases: 1:2–1:3** with **close supervision** for cavity prep and placement; **1:4** once progressing.
- **Example 6-surgery clinic set-up:** Two supervisors each oversee 3 surgeries (maximum **1:3 operators**), with students rotating operator/support/observer roles to reduce nursing demand while maintaining IPC.

Year 3 (Level 6) – Consolidation to Safe Beginner (broader therapy and restorative)

- **Routine perio and restorative, radiography, TFV, sealants, matrix/rubber dam:** up to **1:4** under **direct supervision** with mandatory check-out.

- **LA (infil/IDB) once competent:** up to **1:4** under **direct supervision**; chairside presence for complex/anxious cases.
- **Paediatric pulpotomy/PMCs/extractions: 1:2** with **close supervision** for the irreversible step(s) (e.g., canal hemostasis, crown seating, luxation) until the student's case log evidences independent reliability; then **1:4**.

Escalation rule: Supervisors may *reduce* the ratio at any time (e.g., to 1:2) in response to case complexity, student performance, or patient need. Ratios may *not* be exceeded above the maximum without prior risk assessment and approval.

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4) Skill gateways, quotas and timings (how supervision scales)

Supervision intensity is tied to the programme's **gateway assessments** and **quota/timing expectations** that are circulated to all placement providers. Illustrative examples (non exhaustive):

- **Year 1 / L4** (foundation competencies; observation → supervised preventive care). Example activity expectations include EOE/IOE (10 minutes each), BPE/CPE, plaque/bleeding indices, OHI, TFV (15 min), fissure sealants (20 min) and supra-gingival PMPR (30–60 min) – all under direct supervision and check-out.
- **Year 2 / L5** adds: ultrasonic and sub-gingival instrumentation; radiography and reporting; fissure sealants and PRR; early local anaesthesia (chairside supervision); paediatric PMC (conventional and Hall technique), *first* extractions and pulpotomy (chairside). Suggested appointment durations: TFV 20 min; adult sub-gingival PMPR ~60 min/quadrant; radiography 30 min; fissure sealants 20 min; LA administration under chairside oversight; PMC/pulpotomy/extraction ~60–90 min depending on case.
- **Year 3 / L6** consolidates to safe beginner with increasing independence across LA (infil/IDB), restorative (temporary GI and direct composite), rubber dam, matrix systems, PRR/FS, pulpotomy, PMCs and extractions—still under direct supervision with chairside presence for irreversible steps as indicated.

(The full skill lists, quotas and timings used in placement induction packs are appended to this submission and available to all providers. They drive our case allocation, supervision level and sign-off expectations.)

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5) Roles, responsibilities & sign-off

Clinical Supervisor (Placement). GDC registered dentist/therapist/hygienist employed by the placement provider who:

- Inducts students to the placement area including conducting the initial interview and documenting this within student practice documentation;
- assures patient selection and case allocation is appropriate to student stage;
- provides direct/close supervision as defined above, including mandatory check-in/out;
- completes formative feedback and endorses competency *observation* (not award of final competency);
- completes mid-year and/or final reviews as necessary; and
- participates in calibration and governance activities.

University Clinical Tutor/Assessor. Conducts assessments (DOPS/OSCEs; summative sign-off), calibration and QA; reviews clinical logs; supports remediation; is **not** routinely embedded at every placement session.

Link Tutor (Placement QA). Liaises with provider, conducts site audits, reviews incident logs/feedback, collates data and escalates risks.

Dental Nurse Support. Providers ensure appropriate nursing support (minimum 1:2 nursing when students doublebank, and roving capacity for IPC). Students may support each other for decon/receptional tasks as per local SOPs but **are not** left to work unsupported.

Mandatory patient check-out. No patient leaves without supervisory review and documentation.

Escalation & candour. All staff/students are empowered and required to raise concerns; placement posters and handbooks include how to escalate and how concerns are acted upon for individuals (fitness to practise) and placement areas (securing educational standards).

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6) Placement quality assurance (all providers)

- **Approval & audit:** Pre-placement site approval (facilities, governance, SOPs), annual audit, and immediate review following any incident.
- **Supervisor onboarding:** Registration checks, induction to the programme, equality & diversity training sign-off, and calibration to student scope/assessment tools.
- **Data & monitoring:** Central tracking of student clinical experience, attainment against learning outcomes and patient feedback.
- **Feedback loops:** Routine collection of student/patient/supervisor feedback with action plans; School placements risk register reviewed monthly at practice education forum; provider notified of material risks; clinics reduced/cancelled if safe ratios cannot be maintained.

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7) Mapping to GDC Standards for Education (summary)

Standard 1 – Protecting patients

- *Req.1* Gateways before care (pre-clinical competence) and progression controls.
- *Req.2* Patients informed/consent recorded; signage and documentation.
- *Req.3* Safe environments; H&S, IPC, EDI compliance at all sites.
- *Req.4* Supervision matched to activity and stage (ratios above); named supervisors per clinic; sessional ratio records.
- *Req.5* Supervisors are appropriately registered and trained (incl. EDI) and calibrated to our assessment tools.
- *Req.6–8* Raising concerns/candour policies; incident reporting; Student FtP alignment; embedding *Standards for the Dental Team*.

Standard 2 – Quality evaluation and review

- *Req.9–11* Programme QA framework; internal/external QA; external examiners; patient feedback; changes tracked.
- *Req.12* Placement QA system across *all* providers (approval, monitoring, ratios, feedback, audits, reporting).

Standard 3 – Student assessment

- *Req.13–21* Central assessment strategy, clinical experience monitoring, case breadth, robust methods, feedback/reflection, trained assessors, external examiners, fairness and standards.

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8) Local deployment and rota guidance (all providers)

- **Planning template:** For each clinic, publish the number of surgeries, named supervisor(s), nursing allocation, planned student roles and the **maximum ratio** not to be exceeded.
- **Early-stage intensification:** For first-time or rarely performed irreversible procedures (e.g., first LA/IDB, first extraction, first pulpotomy), set chairside **1:2** and extend appointment time.
- **Rotation model:** Where staffing is constrained, rotate four students per surgery bank (operator/support/observer/reception-decon) under **1:3** supervisory ratio to preserve operator experience while ensuring IPC.
- **Cancellation rule:** Reduce the number of active operators or cancel sessions if supervisor or nursing cover falls below safe thresholds.

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9) Documents available to supervisors & providers

- Placement handbook
- Consent templates and surgery posters

- Student PAD documentation for review and familiarity
- Securing Educational Standards and Fitness to Practise policies and reporting forms
- Supervisor training slides and calibration pack (including equality & diversity)
- Skills, quotas and timing schedules for L4–L6 (appended)

Appendix A – Example skills/quotas & indicative timings by level (extract)

(These extracts illustrate how skill expectations drive supervision intensity. Full tables are issued in provider packs.)

Level 4 (Year 1): EOE/IOE (10 min each); BPE (10 min); CPE (15 min); plaque/bleeding indices (15 min); OHI; TFV (15 min); fissure sealants (20 min); supra-gingival PMPR (30–60 min).

Level 5 (Year 2): Ultrasonic instrumentation (supra/sub-gingival); sub-gingival hand instrumentation; radiography (30 min incl. report); fissure sealants/PRR (20–60 min); initial LA (chairside); PMC (Hall/conventional), first pulpotomy/extractions (chairside); perio sessions typically 60 min/quadrant.

Level 6 (Year 3): LA (infil/IDB); restorative (temporary GI and direct composite) with rubber dam/matrix; PRR/FS; pulpotomy; PMCs; extractions; increasing independence with maintained check-out.

Approved by: Programme Lead (DHT)
Applies to: All placement providers (incl. CiC and others)
Effective from: 1 October 2025
Next review: September 2026