COMPETENCY ASSESSMENT FRAMEWORK FOR UNDERGRADUATES

Contents

Clinical Procedures

INDEX:

COMPETENCY ASSESSMENT FRAMEWORK

FOR EXAMINATION, DIAGNOSIS AND TREATMENT PLANNING

Sl.No	Criteria	Grading	Score
1.	**Demographic details**	0- No relevant information 1- Partial information 2- Complete information	
2.	**History recording:** a. Chief complaint b. History of presenting illness c. Medical history d. Dental history	0- No relevant history. 1- Incomplete history recorded 2- Complete history recorded	
	e. Personal history (Adverse habits)	0- No relevant information 1-Partial information 2-Complete information	
	f. Oral hygiene habits	0-No relevant information 1-Partial information 2-Complete information	
3.	**General examination:** (Monitor Vital data: Pulse rate, blood pressure, respiratory rate, temperature	0- Not recorded 1- Partiallyrecorded 2-Completelyrecorded	
7.	**Extraoral examination:** (TMJ, muscles of mastication, lymph nodes and salivary glands	0.Not examined 1.Partially examined 2.Completely examined	
8.	**Intra oral examination:** (Soft tissue examination and hard tissue examination)	0.Not examined 1.Partially examined 2. Completely examined	
9.	**Indices (appropriate index recorded):** DMFT, DMFS, OHI, OHIS, Russell's Periodontal, Gingival and plaque, CPI, CPITN, Dean's fluorosis & WHO	0-Not recorded 1- Partially recorded 2- Completely recorded	
10.	**Diagnosis:**	0-Not formulated 1-Partially formulated 2-Completely formulated	
11.	**Investigations and**	0 - Not followed	

	interpretation: (Haematological and radiological investigations)	1 - Partially done 2 - Completely done	
12.	**Comprehensive treatment plan:**	0- Not formulated 1- Incompletely formulated 2 -Completely formulated	
13.	**Adverse Habit counselling:**	0-No information given 1-Complete information given	
14.	**Whether patient is appraised of clinical findings/diagnosis and proposed treatment plan:**	0-No information given 1-Complete information given	

COMPETENCY ASSESSMENT FRAMEWORK

FOR INDICES RECORDING

S. no	Criteria	Grading system	Score
1	Relevance of Index	0-Irrelevant 1-Relevant	
2	Instruments used	0-Incomplete selection 1-Complete selection	
3	Methodology followed	0-Not followed 1-Partially followed 2-Completely followed	
4	Scoring criteria	0-Not followed 1-Partially followed 2-Completely followed	
5	Calculation of index scores	0-Incorrect 1-Correct	
6	Interpretation of scores	0-Incorrect 1-Correct	
7	Patient education according to index score	0-Needs improvement 1-Competent 2-Exemplary	

COMPETENCY ASSESSMENT FRAMEWORK

FOR DIET CHARTING

S. no	Criteria	Grading system	Score
1	Type of diet	0-Not recorded 1- Recorded	
2	Diet chart	0-Not recorded 1-Incompletely recorded 2- Completely recorded	
3	Assessment of Nutritional Status	0- Not assessed 1- Partially assessed 2-Completely assessed	
4	Calculation of sugar score	0- Incorrect 1- Correct	
5	Interpretation of sugar score	0- Incorrect 1-Correct	
6	Dietary instructions	0-Inappropriate/ Not explained 1- Partially explained 2-Appropriate/completely explained	

COMPETENCY ASSESSMENT FRAMEWORK

FOR PATIENT EDUCATION

S. no	Criteria	Grading system	Score	Remarks
1	Problem/condition explanation	0-Not explained/inappropriate 1-Partially explained 2-Completely explained		
2	Explanation of probable reasons for problem/conditions	0-Not explained/inappropriate 1-Partially explained 2-Completely explained		
3	Explanation of treatment options	0-Not explained/inappropriate 1-Partially explained 2-Completely explained		
4	Explanation of risks and benefits of various treatment procedures	0-Not explained/inappropriate 1-Partially explained 2-Completely explained		
5	Information related to treatment cost and time required	0-Not explained/inappropriate 1-Partially explained 2-Completely explained		
6	Explanation of general preventive and promotive measures	0-Not explained/inappropriate 1-Partially explained 2-Completely explained		

COMPETENCY ASSESSMENT FRAMEWORK

FOR RADIOGRAPHIC PROCEDURE

S.No	Criteria	Grading	Score
1.	Capturing patient demographic details	0. Not entered 1. Complete details of the patient entered	
2.	Infection control protocol 1. Wear mouth mask 2. Wear gloves 3. Covering RVG sensor with plastic sleeve	0. Not followed 1. Partially followed 2. Completely followed	
3.	Selection of appropriate film holder	0.Not using holder 1.placing improper film holder 2.placing proper film holder	
4.	Radiation protective measures: a. Lead apron b. Thyroid collar c. Use of lead barrier	0. Not followed 1. Followed	
5.	Set exposure parameters 1. Select the region of interest 2. Set exposure time 3. Positioning of X ray tube (Bisecting technique) 4. Alignment X ray tube head to XCP instrument (Paralleling and bitewing techniques)	0. Not followed 1. Partially followed 2. Completely followed	
6.	Post exposure disinfection of sensor and its holders	0. Not followed 1. Partially followed 2. Completely followed	
7.	Disposal of gloves and plastic sensor sleeve after procedure	0.Disposed 1.Not disposed	
8.	Image saving and exporting	0. Not followed 1. Partially followed	

		2. Completely followed	
9.	Radiographic Analysis 1. Checking for the region of interest 2. Check radiographic faults (if any) 3. Radiographic interpretation 4. Radiographic diagnosis	0.Not analysed 1.Partially analysed 2. Completely analysed	

COMPETENCY ASSESSMENT FRAMEWORK

FOR PHOTOGRAPHY

Sl.No	Critera	Grading	Score
1.	Mode Setting	0. Incorrect 1. Correct	
2.	Extra Oral Photography ISO	0. Inappropriate 1. Appropriate	
3.	Extra Oral Photography Aperture Size	0. Incorrect 1. Correct	
4.	Extra Oral Photography Shutter speed	0. Incorrect 1. Correct	
5.	Background	0. Inappropriate 1. Appropriate	
6.	Area of focus	0. Incorrect 1. Correct	
7.	Camera Lens and Patient Level	0. Notatthesamelevel 1. Samelevel	
8.	Photographs taken Frontal view Frontal with smile Oblique view	0. No 1. Yes 0. No 1. Yes 0. No 1. Yes	
9.	Intra Oral Photography: ISO	0. Incorrect 1. Correct	
10	Intra Oral Photography: Aperture Size	0. Incorrect 1. Correct	
11.	Intra Oral Photography: Shutter speed	0. Incorrect 1. Correct	
12.	Area of focus	0. Incorrect 1. Correct	

13	Retraction of Soft tissues	0. Incomplete 1. Complete	
14.	Isolation	0. Adequate 1. Inadequate	
15	Photographs taken Overbite view	0. No 1. Yes	

COMPETENCY ASSESSMENT FRAMEWORK

FOR VENIPUNCTURE PROCEDURE

S.No	Scoring Criteria	Grading system	Score
1	Initial interaction with the patient	0 - Not done 1 - Self introduced and interacted well	
2	Check for a) Patient identity b) Requisition	0 – Not Checked 1 – Checked	
3	Infection control practices	0 – Not done 1 – Hand hygiene followed by donning of gloves done	
4	Preprocedural armamentarium to be arranged a) Collecting tubes b) Tourniquet c) Disposable syringe d) Alcohol swab e) Dry cotton wool ball	0 – Not done 1 – Appropriately selected and arranged	
5	Procedure informed to the patient	0 – Not informed 1 – Informed well	
6	Performing venipuncture procedure a) Selected area disinfected b) Tourniquet tied 3-4 finger widths above the venipuncture site c) Patient is asked to make a fist d) Selected vein identified, raised and prepared for puncture e) Needle inserted into the lumen of the vein at desirable angulation (10-15^0 angle to skin) f) Blood is collected into appropriate collecting tube	0 – Incompetent in executing all the steps 1 – Incompetent with any of the 3 steps 2 - Executed all the steps well	

7	Post procedural precautions include a) Gentle pressure applied over puncture site with dry cotton ball b) Informed to extend arm, keep raised and not to bend	0 – Not done 1 – Done	
8	Labelling of specimen and safe Transportation to the laboratory (Wearing gloves and Tube covered with cotton plug)	0 – Not labeled and transported 1 – Labelled and transported following necessary precautions	
10	Used needle and cotton are discarded following BMW management guidelines	0 – Not followed 1 – discarded as per the guidelines	

COMPETENCY ASSESSMENT FRAMEWORK

FOR BASIC LIFE SUPPORT SKILL (onsimulation models)

S.No	Performance Steps	Single Rescuer Adult CPR	
		First attempt	Second attempt
1	Proclaims that the situation is safe		
2	Checks for response A) Tapping on shoulder B) Shouts loud		
3	Screams out for help		
4	Tells someone to call for the emergency number or Ambulance and request for an AED		
5	Checks for pulse and breathing or only gasping a) Palpates the Carotid pulse b) Observes the chest movements Checks for minimum of 5 seconds to a maximum of 10 seconds		
6	Locates hand placement for compressions a) 2 fingers on xiphisternum b) Heel of the hand over sternum		
7	Position of the operator a) Lying perpendicular to victim b) Arms straight, not bent at elbows		
7	Delivers first set of compressions Gives 30 compressions continuously with adequate chest recoil		
8	Gives 2 breaths with amask a) At least 1 breath results in visible chest rise b) Breaths given and compressions started within 10 seconds		
9	Delivers second set of compressions Gives 30 compressions(at least 27 out of 30 continuously) and breaths with a mask		
10	Instructor says, "You have just		

	completed 5 sets of compressions and breaths." a) Checks for pulse and breathing again b) Determines the need for CPR again		
11	Uses the AED immediately after it arrives		
	a) Switches on the AED		
	b) Attaches pads onto bare chest		
	c) Plugged the device		
	d) Stays “clear” during analysing and delivering shock		
	e) Starts the CPR without any interruption after the shock is delivered		

COMPETENCY ASSESSMENT FRAMEWORK FOR INFECTION CONTROL PRACTICES

S.No	Criteria	0- Grading systems	SCORE
1	Hand hygiene performed correctly	1- Improper hand hygiene practices 2- Proper hand hygiene practice	
2	Appropriate use of PPE	0- Inappropriate use 1- Appropriate use	
3	Clinical contact surfaces are either barrier protected or cleaned and disinfected with a disinfectant before and after each patient.	0- Not followed 1- Partially followed 2- Completely followed	
4	All waterlines are run through for 2 min before starting the procedure	0- Not performed 1- Performed	
5	Pre-procedural mouth rinse use	0- Not performed 1- Performed	
6	Work practice controls (e.g., one-handed scoop technique for recapping needles, removing burs before disconnecting handpieces) are used to prevent injuries	0- Not followed 1- Partially followed 2- Completely followed	
7	Regulated medical waste is handled and disposed according to colour coded bins	0- Inappropriately disposed 1- Appropriately disposed	
8	All sharps are disposed in puncture-resistant sharps container	0- Inappropriately disposed 1- Appropriately disposed	

COMPETENCY ASSESSMENT FRAMEWORK FOR INFECTION ORAL PROPHYLAXIS

Criteria	Grading systems	0	1	2	Remarks
Recording case history	0-No relevant history recorded(medical,drug,allergy,personal,family) 1-Incomplete history recorded 2-Complete history recorded				
Informed consent	0-Not obtained 1-Partially explained and obtained 2-Completely explained and obtained				
Infection control protocols	0-Not followed 1-Partially followed 2-Completely followed				
Plaque and calculus detection	0-Inadequate detection 1-Partial detection 2-Complete detection				
Position of operator and patient	0-Inappropriate 1-Either operator or patient position followed 2-Appropriate				
Instrumentation technique	0-Not appropriate 1-Partially advocated 2-Completely advocated				
Completeness of oral prophylaxis	0-Inadequate 1-Partially performed 2-Completely performed				
Post operative care and instructions	0-Inappropriate and not explained 1-Partially explained 2-Appropriate and completely explained				
Overall communication with the patient	0-Improper 1-Communicated with hesitation 2-Communicated with confidence				

Prescription writing (if required)	0-Inappropriate 1-Partially written 2-Completely written				
Tailor made treatment plan &instructions (based on general &medical condition of the patient) When indicated	0-No knowledge 1-Partial knowledge 2-Able to provide evidence based treatment for the patient				

COMPETENCY ASSESSMENT FRAMEWORK FOR PREVENTIVE RESTORATIONS (PRR and P & F Sealants)

S.NO	Criteria	Grading systems	Score
1	Patient selection	0- Inappropriate case selected 1- Appropriate case selected	
2	Informed consent	0-Not obtained 1-Partially explained and obtained 2-Completely explained and obtained	
3	Armamentarium	0-Instruments not arranged 1-Arranged with inappropriate instruments 2-Arranged with appropriate instruments	
4	Position of operator and patient	0-Inappropriate 1-Either operator or patient position followed 2-Appropriate 0	
5	Magnification & Illumination	0-Not used 1-Wears the loupes, but does not see through loupes, no illumination used 2-Wears & sees through the loupes with illumination	
6	Cavity preparation (In case of PRR)	0-Over/ under preparation 1-Optimum preparation	
7	Isolation	0- No Isolation 1-Improper Isolation 2-Thorough Isolation	
8	Restoration (Etching,bonding,flowable composite)	0-No protocol followed 1-Improper protocol followed 2-Proper protocol followed	

9	Handling of Etchant,DBA, Flowable composite & light cure unit	0-Improperly handled 1-Properly handled	
10	Pit and Fissure Sealant	0-Not sealed 1-Under/Over sealed pit and fissures 2-completely sealed all the pit and fissures	
11	Occlusion evaluation (Using articulating paper)	0-Not evaluated 1- Evaluated but not corrected 2- Evaluated and corrected	
12	Post-operative Instructions	0- No Instructions given 1-Improperly communicated 2-Thoroughly communicated	

COMPETENCY ASSESSMENT FRAMEWORK FOR TOPICAL FLUORIED (APF GEL AND FLOURIDE VARNISH)

S.NO	Criteria	Grading systems	score
1	Patient selection	0- Inappropriate case selected 1- Appropriate case selected	
2	Informed consent	0-Not obtained 1-Partially explained and obtained 2-Completely explained and obtained	
3	Arranging appropriate instruments	0-Instruments not arranged 1-Arranged with inappropriate instruments 2-Arranged with appropriate instruments	
4	Position of operator and patient	0-Inappropriate 1-Either operator or patient position followed 2-Appropriate	
5	Isolation	0-No Isolation 1-Improper Isolation 2-Thorough Isolation	
6	Dispension of APF gel in foam trays	0- Excess 1-Inadequate 2-Optimum	
7	Technique of application	0-Improper technique followed 1-Correct technique, but not performed properly 2-Perfomed with proper technique	
8	Post operative Instructions	0- No Instructions given 1-Improper communication 2-Thoroughly communicated	

COMPETENCY ASSESSMENT FRAMEWORK FOR EXTRACTION

S.NO	Criteria	Grading system	Score
1	**Recording case history**	0 - No relevant history recorded (medical, drug, allergy, personal, family 1 - Incomplete history recorded 2 - Complete history recorded	
2	**Informed consent**	0 - not obtained 1 - partially explained and obtained 2 - completely explained and obtained	
3	**Disinfection and sterilisation**	0 - not followed 1 - partially followed 2 - completely followed	
4	**Selection of appropriate instruments**	0 - wrong selection 1 - partially selected 2 - appropriate instruments selected	
5	**Local anaesthetic technique**	0 - not followed (landmarks & technique) 1 - partially followed 2 - completely followed	
6	**Position of operator & patient**	0 - inappropriate 1 - either operator or patient position followed 2 – appropriately followed	
7	**Extraction technique**	0 - not appropriate (engaging forceps, tooth movements) 1 - partially performed 2 - appropriate	
9	**Postoperative care and instructions**	0 - inappropriate and not explained 1 - partially explained 2 - appropriate and completely explained	
10	**Overall communication with the patient**	0 - Improper 1 - communicated with hesitation 2 - communicated well with confidence	

11	**Prescription writing**	0 - Inappropriate 1 - partially complete 2 - completely written	
12	**Any other treatment plan & treatment (based on general & medical condition of the patient) when indicated**	0 - No knowledge 1 - Partial knowledge 2 - Able to provide evidence based treatment for the patient	

COMPETENCY ASSESSMENT FRAMEWORK FORSUTURING OF INTRAORAL SITES

S.No	CRITERIA	GRADING SYSTEM	SCORE GIVEN
1	**Instrument selection** a) Needle holder b) Suture cutting scissors c) Addson's tissue holding forceps	0 - Wrong instrument selection 1 – Appropriate instrument selection	
2	**Instrument handling** a) Hand and finger grip b) Instrument movement	0 - Inappropriate handling 1 - Competent handling	
3	**Positioning of needle in the needle holder** (needle should be held at $1/3^{rd}$ distance from eye)	0 – Needle held in the middle or more towards the tip 1 – Held appropriately	
4	**Insertion of needle through the tissue**	0 - Entered tissue at other than 90^0angulation 1 – Entered through tissue at 90^0 angulation (perpendicular to the tissue)	
5	**Handling of tissue during procedure**	0 – Inappropriate leading to button holes and tears in the tissue 1 – Appropriate handling	
6	**Needle bite and depth**	0 – Needle passed at different thickness and distance from margins of buccal and lingual/palatal tissue 1 – Needle passed at equal depth and distance on both the sides of the wound	

7	**Tying and securing of suture** A) Technique of Surgical or square knot B) Knot should lie on buccal side	0 – Technique not followed and knot lying on the incision line or the margin of the flap 1 – Either of A or B not followed 2 – Technique followed and knot placed towards buccal	
8	**Apposition of flap margins**	0 – Tissue closed under tension, papilla or flap on both sides are not approximated 1 – Appropriately achieved approximation of flap	
9	**Postoperative and follow up instructions**	0 – not provided 1- communicated well	

COMPETENCY ASSESSMENT FRAMEWORK FORALVEOLOPLASTY PROCEDURE

Criteria	Grading system	Score
Examined and analyzed treatment plan (based on the medical condition of the patient)	0 - Not Planned 1 - Well planned	
Informed consent	0 - Neither informed nor obtained consent 1 - Consent obtained without informing patient 2 - Thoroughly explained and obtained	
Disinfection and sterilisation protocols	0 - Not followed 1 - Improperly followed 2 - Completely followed	
Armamentarium to be arranged a) BP handle and blade b) Molt's periosteal elevator c) Bone nibbler d) Bone file e) Suturing instruments	0 - One or two of the specified instruments are not arranged. 1 – Appropriate armamentarium arranged	
Placement of Incision a) Shape of the incision b) Length of the Incision c) Depth of the incision	0 - Improper and inadequate incision 1 - Either A, B, or C is inaccurately performed 2 - The incision is well-designed	
Elevation of Mucoperiosteal flap	0 – Improper tissue handling resulting in buttonholes or tears in the tissue 1 - Mucosa elevated with periosteum left attached to the bone 2 – Appropriate handling	
Instrument handling a) Hand and finger grip b) Bone file used in a pull motion	0 - Inappropriate handling 1 - Competent handling	

Suturing of flap a) Approximation of margins b) Knot lying on buccal side	0 - Margins not approximated 1- Knot Lying on the incision line or lingually 2 - Achieved adequate approximation without tension with knot on buccal side	
Postoperative care and follow-up instructions	0 - Not given 1 - Incompletely given 2 - Completely explained	
Overall communication with the patient	0 - Not communicating 1 - Communicated with hesitation 2 - Communicated well with confidence	
Prescription writing	0 - Written Inappropriately 1 - Completely written following the guidelines	

COMPETENCY ASSESSMENT FRAMEWORK FORGIC RESTORATION

S.NO	Criteria	Grading system	Score
1	**Recording clinical findings**	0 –Noclinical findings recorded 1 –Incomplete clinical findings recorded 2 - Complete clinical findings recorded	
2	**Informed consent**	0 - Not obtained 1 - Not explained and obtained 2 –Thoroughlyexplained and obtained	
3	**Magnification& Illumination**	0 –Not used 1 –Wears the loupes, but does not see through loupes, no illumination used 2 –Wears & sees through the loupes with illumination	
4	**Position of operator &patient**	0 - Improperoperator&patient position 1 – Patient/operatorposition is improper 2 – Both are appropriate	
5	**Armamentarium**	0 - Arranged the necessary armamentarium 1 –Arranged, but included unwanted instruments 2 – Arranged and used the armamentarium	

6	**Occlusion evaluation** **(When indicated)**	0 – Not evaluated 1 –Improper evaluation 2 –Thorough evaluation	
7	**Caries excavation**	0 – No caries removed 1 – Partial caries removed 2 – Complete caries removed	
8	**Cavity preparation**	0 – Removal of sound tooth structure/over preparation 1 – Undefined cavity margins 2 – Well defined cavity margins with optimum tooth structure removal	
9	**Restoration** **(Conditioning, GIC restoration& Surface protection)**	0 – Inappropriate 1 – Partially appropriate 2 – Appropriate	
10	**Post operative instructions**	0 –Not instructed to patient 1 –Improperly communicated 2 –Thoroughly communicated	

COMPETENCY ASSESSMENT FRAMEWORK FORCOMPOSITE RESTORATION

S No	Criteria	Grading system	Score
1	Recording clinical findings	0 –No clinical findings recorded 1 – Incomplete clinical findings recorded 2 - Complete clinical findings recorded	
2	Informed consent	0 –Not obtained 1 –Not explained and obtained 2 –Thoroughlyexplained and obtained	
3	History of present illness	0 –Not obtained 1 –Partiallyobtained 2 – Completely obtained	
4	Pre-operative radiographic interpretation **(when indicated)**	0 – Not interpreted 1 – Partiallyinterpreted 2 – Thoroughly interpreted	
5	Local anaesthetic landmarks & technique **(when indicated)**	0 - Not performed 1 – Partially anaesthetized 2 – Completely anaesthetized	
6	Magnification& Illumination	0 –Not used 1 –Wears the loupes, but does not see through loupes, no illumination used 2 –Wears & sees through the loupes& used illumination	
7	Position of operator & patient	0 - Improper operator & patient position 1 –Operator/patient position is improper 2 – Both are appropriate	
8	Occlusion evaluation (Using articulating paper)	0 –Not evaluated 1 –Improperly evaluated 2 –Thoroughly evaluated	

9	Rubber dam application &shade selection	0 – Not applied and Not selected 1 – Improperly applied/ not selected 2 – Thoroughly applied and appropriately selected	
10	Caries excavation	0 – No caries removed 1 – Partial caries removed 2 – Complete caries removed	
11	Cavity preparation	0 – Removal of sound tooth structure/over preparation 1 – Undefined cavity margins 2 – Well defined cavity margins with optimum tooth structure removal	
12	Tooth separation **(when indicated)**	0 – No separation carried out 1 – Inadequate separation achieved 2 – Adequate separation achieved	
13	Restoration (Etching, bonding & composite restoration Finishing & Polishing)	0 – No protocol followed 1 – Improper protocol followed 2 – Correct protocol followed	
14	Handling of Etchant, DBA, Composite resin & Light cure unit	0 – Not arranged 1 – Arranged but handled improperly 2 – Arranged and handled properly	
15	Postoperative radiograph **(when indicated)**	0 – Not captured/not interpreted 1 – Captured/improperly interpreted 2 – Captured & correctly interpreted	
16	Post operative instructions	0 –Not instructed to patient 1 –Improperly communicated 2 – Thoroughly communicated	

COMPETENCY ASSESSMENT FRAMEWORK FORDEEP CARIES MANAGEMENT

S No	Criteria	Grading system	Score
1	Recording clinical findings	0 –No clinical findings recorded 1 – Incomplete clinical findings recorded 2 - Complete clinical findings recorded	
2	Informed consent	0 - Not obtained 1 –Not explained and obtained 2 –Thoroughlyexplained and obtained	
3	History of present illness	0 –Not obtained 1 –Partially obtained 2 – Thoroughly obtained	
4	Pre-operative radiographic interpretation **(when indicated)**	0 – Not interpreted 1 – Partially interpreted 2 – Thoroughly interpreted	
5	Pulp sensibility tests	0 – Notrecorded 1 – Improperly recorded 2 – Appropriately recorded	
6	Magnification	0 –Not used 1 –Wears the loupes, but does not see through loupes, no illumination used 2 –Wears & sees through the loupes with illumination	

7	Position of operator & patient	0 - Improper operator & patient position 1 – Operator/patient position is improper 2 – Both are appropriate	
8	Occlusion evaluation (Using articulating paper)	0 – Not evaluated 1 – Improper evaluation 2 – Thorough evaluation	
9	Local anaesthetic Landmarks &Technique **(when indicated)**	0 – Not performed 1 –Partiallyanaesthetized 2 – Completely anaesthetized	
10	Rubber dam application &shade selection	0 – Not applied and Not selected 1 – Improperlyapplied/ not selected 2 – Thoroughly applied and appropriately selected	
11	Caries excavation	0 – No caries removed 1 – Partial caries removed 2 – Complete caries removed	
12	Cavity preparation	0 - Removal of sound tooth structure/over preparation 1 – Undefined cavity margins 2 – Well defined cavity margins with optimum tooth structure removed	
13	Tooth separation **(when indicated)**	0 – No separation carried out 1 – Inadequate separation achieved 2 – Adequate separation achieved	

14	Pulp protection	0 – Not provided 1 – Inadequate protection 2 – Adequate protection	
15	Restoration (Etching, bonding & composite restoration)	0 – No protocol followed 1 – Improper protocol followed 2 – Correct protocol followed	
16	Handling of Etchant, DBA, Composite resin & Light cure unit	0 – Not arranged 1 – Arrangedbut handled improperly 2 – Arranged and handled properly	
17	Postoperative radiograph **(when indicated)**	0 – Not captured/not interpreted 1 – Captured/ improperly interpreted 2 – Captured &interpreted correctly	
18	Post operative. instructions	0 –Not instructed to patient 1 –Improperly communicated 2 –Thoroughly communicated	

COMPETENCY ASSESSMENT FRAMEWORK FORROOT CANAL TREATMENT

S No	Criteria	Grading system	SCORE
1	Informed consent	0 – Not obtained 1 – Not explained and obtained 2 – Thoroughly explained and obtained	
2	History of present illness	0 – Not obtained 1 – Partially obtained 2 – Completely obtained	
3	Recording clinical findings	0 – No clinical findings recorded 1 – Incomplete clinical findings recorded 2 - Complete clinical findings recorded	
4	Pre-operative radiographic interpretation	0 – Not interpreted 1 – Partially interpreted 2 – Thoroughly interpreted	
5	Diagnosis	0 – Irreversible pulpitis 1 – Necrosis/ Non vital tooth 2 – Periapical pathosis	
6	Treatment plan	0 – RCT+Access filling 1 – RCT+Crown 2 – RCT+Post&core+Crown	
7	Position of operator & patient	0 - Improper operator & patient position 1 – Operator/patient position is improper 2 – Both are appropriate	
8	Magnification & Illumination	0 – Not used 1 – Wears the loupes, but does not see through loupes, no illumination used 2 – Wears & sees through the loupes	

		&used illumination	
9	Local anaesthetic landmarks & technique	0 - Not performed 1 - Partially anaesthetized 2 - Completely anaesthetized	
10	Rubber dam application	0 – Not applied 1 – Improperly applied 2 – Properly applied	
11	Access Cavity preparation	0 – No caries removal/Removal of sound tooth structure/not able to identify pulp chamber. 1 – Partial caries removal/ improper de-roofing of pulp chamber /improper location of root canals 2 – Complete caries removal/complete deroofing/ proper location of root canals	
12	Working length determination with Apex locator	0 –Appropriate application of apex locator 1 – Partial application of apex locator 2 – Improper application of apex locator	
13	Working length determination with radiograph	0 –File short of radiographic apex more than 2mm/beyond radiographic apex 1 – File short of radiographic apex 1-2mm 2 – File short of radiographic apex0.5-1mm	
14	Biomechanical preparation & Master cone selection	0 – G.P short of radiographic apex more than 2mm/beyond radiographic apex 1 – G.P short of radiographic apex 1-2mm 2 – G.P short of radiographic apex0.5-1mm & 2-3mm apical binding.	
15	Obturation Length/ Density/Taper of root canal	0 – **Unacceptable:** Root filling ending >2 mm short of the radiographic apex (under-filling),Root filling ending beyond the radiographic apex(over-filling)/several visible voids/Not consistently tapered	

		from the apex to the coronal part (over- or under-shaped). 1 – **Acceptable:** Root filling ending at the radiographic apex (tip-totip) or 1-2 mm shorter than the radiographic apex/ Root canal obturation with only one visible void/Not enough taper 2 **– Perfect:**Root filling ending 0.5-1 mm short of theradiographic apex (adequate)/ No void present in the root canal obturation (adequate)/ Consistently tapered from the apex to the coronal part (adequate)	
16	Post-endo treatment	0 – Referral. 1 – Not acceptable. 2 – Good.	
17	Post-endo radiograph	0 – Not captured/not interpreted 1 – Captured/improperly interpreted 2 – Captured & correctly interpreted	
18	Post operative instructions	0 – Not instructed to patient 1 –Improperly communicated 2 – Thoroughly communicated	

COMPETENCY ASSESSMENT FRAMEWORK FORPRELIMINARY IMPRESSIONS – CD/RPD

Evaluation criteria for Preliminary impression	Grading Criteria		No 0	Yes 1
1. Impression tray selection	Correct impression tray selected	U		
		L		
	Identified need for tray modification/extension and necessary corrections done	U		
		L		
2. Impression material manipulation and loading in the tray	Manipulation/mixing of the impression material is uniform	U		
		L		
	Impression material loaded in the tray and evenly distributed	U		
3. Evaluation of impression making procedure	Correct Operator and Patient position	U		
		L		
	Functional molding of soft tissues done to record borders	U		
		L		
4. Evaluation of impressions:	Impression tray positioned correctly intraorally	U		
		L		
	All the denture bearing, peripheral seal areas; and teeth (for RPD Cases) recorded in the impression	U		
		L		
	Absence of large surface defects or tray exposure	U		
		L		
5. Disinfection of impressions	Followed recommended impression disinfection protocol	U& L		

COMPETENCY ASSESSMENT FRAMEWORK FORBORDER MOLDING AND FINAL IMPRESSIONS – CD/RPD

Evaluation criteria for border moulding and final impression	Grading Criteria		No 0	Yes 1
1. Intraoral inspection of custom impression tray	Custom tray is covering all the denture bearing areas	U		
		L		
	Uniform 2-3 mm space present between custom tray borders and vestibule in functional position	U		
		L		
2. Evaluation of Border molding procedure	Adequate functional molding of soft tissues done to record borders	U		
		L		
	Posterior palatal seal marked and transferred to the tray	U		
	Good retention and stability	U		
		L		
	Excess material removed inside the tray	U		
		L		
	Wax spacer removed and 2 mm diameter escape/relief holes are placed in relief areas	U		
		L		
3. Evaluation of final impressions including pickup impressions for RPD cases	Impression tray seated correctly while making impression	U		
		L		
	All the denture bearing areas and teeth (for RPD Cases) recorded in the impression & borders are recorded in functional position (adequate border thickness)	U		
		L		
	Absence of large surface defects or tray exposure	U		
		L		
	Good retention and stability	U		
		L		

4. Disinfection of impressions	Followed recommended impression disinfection protocol	U& L		

COMPETENCY ASSESSMENT FRAMEWORK FORJAW RELATIONS – CD/RPD

Evaluation criteria for Jaw relation	Grading Criteria		No 0	Yes 1
1. Intraoral inspection of temporary denture base	Temporary denture base border extension and border thickness in harmony with functional depth and width of the sulcus	U		
		L		
	Posterior palatal seal marked and posterior denture base border adjusted accordingly	U		
	Adequate frenal relief provided	U		
		L		
	Good retention and stability	U		
		L		
2. Evaluation of maxillary and mandibular occlusal rims adjustment	Provided adequate labial fullness and lip support	U		
		L		
	Adjusted occlusal rim height & Incisal visibility during rest and smile(for maxillary occlusal rim)	U		
		L		
	Maxillary occlusal plane adjusted parallel to ala-tragus line Mandibular occlusal plane adjusted to coincide with anterior 2/3rd of retromolar pad	U		
		L		
	Midline marked coinciding with facial midline	U		
		L		
	Canine lines marked coinciding with ala of nose/corner of the mouth.	U		
3. Adjustment of	Recorded VDR in physiological rest position	-		

vertical dimension	Adjusted VDO by providing 2-4mm of freeway space	-		
4. Tentative centric bite registration	Established centric and recorded	-		
5.Selection of teeth	Shade selected based on facial complexion	-		
	Shape of anterior teeth selected based on facial form	-		
	Size of teeth selected according to arch dimensions	-		

COMPETENCY ASSESSMENT FRAMEWORK FORTRY-IN – CD/RPD

Evaluation criteria for Try-in	**Grading Criteria**		**No 0**	**Yes 1**
1. Inspection of maxillary and mandibular trial dentures	Good fit of trial denture bases	U		
		L		
	Adequate labial fullness and lip support	U		
		L		
	Adequate incisal visibility during rest and smile	-		
	Adequate overjet and overbite	-		
	Absence of Occlusal cant	-		
	Acceptable speech	-		
	Adequate speaking space	-		
	Adequate lower 3rd facial height	-		
	Centric occlusion coinciding with centric relation	-		

COMPETENCY ASSESSMENT FRAMEWORK FORDENTURE INSERTION – CD/RPD

Evaluation criteria for Denture insertion	Grading Criteria		No 0	Yes 1
1. Inspection of maxillary and mandibular dentures	Laboratory remounting of dentures done and corrected occlusal interferences	-		
	Tissue surface of dentures examined and denture borders are smoothened	-		
	Denture characterization maintained	-		
	Denture border extensions verified and necessary corrections done *Posterior palatal seal marked and maxillary posterior denture border corrected accordingly	-		
	Good retention and stability of dentures	U		
		L		
	Adequate labial fullness and lip support	U		
		L		
	Adequate incisal visibility during rest and smile	-		
	Adequate overjet and overbite	-		
	Absence of Occlusal cant	-		
	Acceptable speech	-		
	Adequate speaking space	-		
	Adequate lower 3rd facial height	-		
	Occlusal contacts verified and necessary occlusal corrections done (Clinical remount done if required)	-		
	Instructions given to patient about use, care and maintenance of dentures (post insertion instructions)	-		

Evaluation criteria for Followup– CD/RPD

Evaluation criteria for follow up	Grading Criteria		No 0	Yes 1
1. Examination of intra oral soft tissues , denture bearing areas and dentures	Checked for inflammation or ulceration of soft tissues	-		
	Communicated with the patient regarding any discomfort associated with dentures and necessary corrections done	-		
	Occlusal contacts verified and necessary occlusal corrections done	-		

COMPETENCY ASSESSMENT FRAMEWORK FORTOOTH PREPARATION

(FIXED PARTIAL DENTURE)

Evaluation Criteria		No 0	Yes 1
1. Occlusal reduction /Incisal reduction	**Premolars and Molars:** Adequate reduction done following cuspal inclination • Functional cusps: $\geq$ 1.5 mm • Non-functional cusps: $\geq$ 1 mm **Incisors and Canines:** $\geq$ 1.5 mmreduction done on Incisal edges and cuspal inclines		
2. Functional cusp bevel	$\geq$1.5 mm bevel width provided		
3. Buccal reduction	$\geq$1.5 mm reduction done		
	6^0 - 10^0 taper given		
4. Lingual/palatal reduction	$\geq$1.5 mm reduction done		
	6^0 - 10^0 taper given		
5. Proximal reduction (Mesial)	$\geq$1.5 mm reduction done		
	Interproximalcontact broken		
	6^0 - 10^0 taper given		
6. Proximal reduction (Distal)	$\geq$1.5 mm reduction done		
	Interproximal contact broken		
	6^0 - 10^0 taper given		
7. Finish line	Recommended finish line configuration selected		
	Position of finish line issupragingival/equigingival/subgingival-depending on the clinical scenario)		
	Finish line is continuous, smooth and definitive		
	Finish line width is 1-1.5 mm		

8. Overall finishing	Acceptable (no gross irregularities/roughness)		
TOTAL SCORE OBTAINED		**/17**	

COMPETENCY ASSESSMENT FRAMEWORK FORGINGIVAL DISPLACEMENT AND IMPRESSION MAKING

Evaluation criteria		**No 0**	**Yes 1**
1. Evaluation of Gingival displacement	Correct size of retraction cord selected		
	Retraction cord packed into the sulcus correctly		
2. Evaluation of Isolation of operating field	Achieved optimum moisture control		
3. Evaluation of Impression making	Correct stock tray size selected / adaptation and extension of custom tray is correct		
	Correct operator and patient position		
	Selection, manipulation and loading of impression materials is correct		
	Followed correct impression technique		
4. Evaluation of Impressions	Intraoral positioning of impression tray is correct		
	All the required areas recorded accurately (prepared teeth, finish line of prepared teeth, remaining teeth in the arch, edentulous areas, 5-6 mm of gingival tissue surrounding the abutment teeth)		
5. Evaluation of Impression Disinfection	Followed recommended impression disinfection protocol		
TOTAL SCORE OBTAINED		**/10**	

COMPETENCY ASSESSMENT FRAMEWORK FORCEMENTATION OF PROVISIONAL/PERMANENT CROWNS/ FIXED PARTIALDENTURES

Evaluation criteria		No 0	Yes 1
1. Evaluation of Provisional/ Definitive crowns/FPD	Contour and dimension of provisional/definitive prosthesis is acceptable		
	Margins of the prosthesis are closely adapted to the finish line of the abutment tooth		
	Interproximal contact is considerably tight allowing passage of floss		
	Optimal pontic design selected		
	Occlusal interferences removed in centric		
	Occlusal interferences removed in protrusion and lateral excursions		
	Shade of the prosthesis is matching with remaining natural teeth		
2. Evaluation of Isolation of operating field	Achieved optimum moisture control		
3. Evaluation of Cementation procedure	Selected correct luting cement		
	Luting cement mixed with correct powder-liquid ratio and applied as a thin layer on the tissue surface of retainers		
	Prosthesis seated with firm pressure and ensured complete seating		
	Excess cement removed from the margins on labial/buccal, lingual/palatal and interproximal areas		
	Verified occlusal contacts after cementation, and necessary corrections done (if required)		

	Post-cementation instructions given to patient		
TOTAL SCORE OBTAINED		**/14**	

COMPETENCY ASSESSMENT FRAMEWORK FOR ORTHODONTIC DIAGNOSIS

Sl.No	Criteria	Grading	Score	Remarks
1.	**History recording** a) chief complaint b) personal history c) oral hygiene status	0. No relevant history. 1. Incomplete history recorded 2. Complete history recorded		
2.	**Family history** (for any relevant malocclusions)	0. No relevant information 1. Partial information recorded 2. Complete information recorded		
3.	**History of Habits** a) Frequency b) Duration c) Intensity	0. No recorded 1. Partially recorded 2. Completely recorded		
4.	**Extra oral examination** (Body built, Gait, Shape of the head, Facial form, Facial symmetry, Facial Profile, Facial Divergence, Smile analysis)	0. Not examined 1. Partially examined 2. Completely examined		
5.	**Functional Examination** (Respiration, mastication, maximum protrusion, path of closure, TMJ Examination, speech, peri-oral muscle activity)	0. Not examined 1. Partially examined 2. Completely examined		
6.	**Intra Oral Examination: Soft tissue:** Gingival status, Brushing Habits, Frenal attachment, Tongue, palate, oral mucosa)	0. Not examined 1. Partially examined 2. Completely examined		
7.	**Intra Oral Examination: Hard tissue:** (Shape of the arch, Arch symmetry, Arch alignment, Freeway space, curve of spee, Molar relationship, Canine relationship, Incisor relationship, Vertical relationship,	0. Not examined 1. Partially examined 2. Completely examined		

	Transverse relationship)			
8.	**Provisional Diagnosis** (Skeletal, Dental & Soft tissue Diagnosis)	0. Not formulated 1. Incompletely formulated 2. Completely formulated		
9.	**Study models & Radiographs**	0. No relevant records 1. Partial records 2. Complete records		
10.	**Model analysis**	0. Not recorded 1. Partially recorded 2. Completely recorded		
11.	**Model analysis Interpretation**	0. Incorrect 1. Correct		
12.	**Cephalometric Analysis: Identification of landmarks Measurements**	0. Appropriate 1. Inappropriate		
13.	**Cephalometric Analysis:**	0. Incorrect 1. Correct		
14.	**Cephalometric Analysis: Interpretation**	0. Incorrect 1. Correct		
15.	**Final Diagnosis** (Skeletal, Dental & Soft tissue Diagnosis)	0. Not formulated 1. Incompletely formulated 2. Completely formulated		
16.	**Treatment plan** Problem lists, Treatment objectives, Treatment plan (extractions, anchorage planning, appliance selection, retention plan and follow up)	0. Not formulated 1. Incompletely formulated 2. Completely formulated		