Standards of Practice

DOCUMENTATION

STANDARD STATEMENT

The dental hygienist documents clear, accurate, and comprehensive patient **records** in a timely manner.

PERFORMANCE EXPECTATIONS

The dental hygienist must…

1. Document accurate records.
2. Include their first and last name, **protected title**, and date in each record entry.
3. Ensure each component of the patient record identifies the corresponding patient.
4. Record information legibly, in English, using common and consistent terminology, symbols, and abbreviations.
5. Document using language that is free of **bias** which might imply prejudicial beliefs or perpetuate assumptions regarding the individual(s) being written about.
6. When providing clinical therapy, document clinical notes. For each **encounter**, the patient record must contain:
    a) The patient's reason(s) for attendance;
    b) The informed consent process, including the patient's informed refusal of any recommended **dental hygiene services**;
    c) Updated medical and dental history information; and
    d) An accurate and complete reflection of the patient encounter, including <u>any or all</u> of the following:
        i. Assessment findings and interpretations (e.g., radiographic, periodontal);
        ii. **Diagnosis** describing each existing oral health condition and possible etiology;
        iii. Care plan;
        iv. Dental hygiene services provided (e.g., assessments, treatments, drugs administered);
        v. Patient responses to dental hygiene services (e.g., pain or discomfort, progress toward achieving documented goals);

vi. Details of all education, recommendations, and instructions provided to the patient;
vii. Prescriptions given;
viii. **Referrals** to other health professionals;
ix. Notation of any adverse or unusual events that occur related to dental hygiene care; and/or
x. Any other care provided.

7. Include sufficient detail in the record to allow the patient's care to be managed by another health professional.
8. Complete the patient record during care or as soon as is reasonable.
9. Ensure that any communication to or with the patient (e.g., telephone, electronic) related to dental hygiene services, including before or after care, is entered in the patient record.
10. Document communications, reports, and correspondence from other health professionals in the patient record.
11. Maintain the following information when a patient record is updated, added to, or corrected:
    a) The original entries;
    b) The identity of the person making the update, addition, or correction; and
    c) The date of the update, addition, or correction.

PATIENT EXPECTATION

The patient can expect the dental hygienist to accurately document all the information relevant to the dental hygiene services they received and create a comprehensive health record that facilitates future care.

GLOSSARY

BIAS: An implied or irrelevant evaluation of (an) individual(s) which might imply prejudicial beliefs or perpetuate biased assumptions.[1]

DENTAL HYGIENE SERVICES: Any service that falls within the practice of the profession of dental hygienists as outlined in the *Health Professions Act* (Schedule 5, section 3).

DIAGNOSIS: Identification of an oral health condition informed by assessment findings, clinical judgment, professional knowledge, and the best available evidence.

ENCOUNTER: A patient's interaction with the dental hygienist related to a particular occurrence.

LEGISLATION: Federal or provincial acts, regulations, or codes.

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[1] Alberta College of Speech-Language Pathologists and Audiologists.(2022) Documentation and Information Management Standard of Practice. Accessed from: www.acslpa.ca/members-applicants/key-college-documents/standards-of-practice/4-3-documentation-and-information-management/

PROTECTED TITLE: Dental hygienist, registered dental hygienist, DH, or RDH as per section 30(1) of the Dental Hygienists Profession Regulation.

RECORD: As defined in the *Health Information Act*, means a record of health information in any form and includes notes, images, audiovisual recordings, x-rays, books, documents, maps, drawings, photographs, letters, vouchers and papers, and any other information that is written, photographed, recorded, or stored in any manner, but does not include software or any mechanism that produces records.

REFERRAL: An explicit request for another health professional to become involved in the care of a patient. Accountability for clinical outcomes is negotiated between the health professionals involved.[2]

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[2] Nova Scotia College of Nursing. (2018) Nurse Practitioner Standards of Practice. Accessed from: cdn1.nscn.ca/sites/default/files/documents/resources/NP_Standards_of_Practice.pdf