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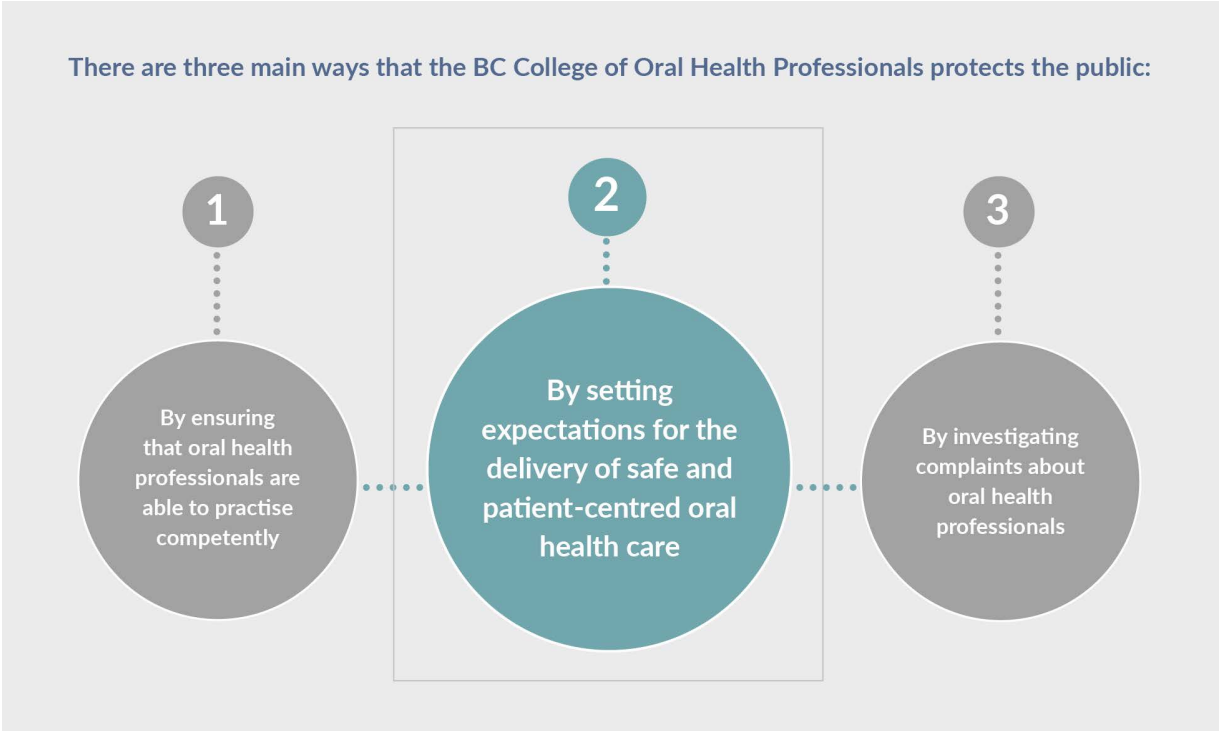
Practice Standards and Clinical Documentation Webinar FAQ

Applies to Dental Hygienists



The British Columbia College of Oral Health Professionals (BCCOHP) was created on September 1, 2022 through the amalgamation of four health regulatory colleges: the College of Dental Hygienists of BC, the College of Dental Surgeons of BC, the College of Dental Technicians of BC, and the College of Denturists of BC. All current requirements for standards of clinical and ethical practice issued by the four colleges remain in place upon amalgamation. This document was created by the College of Dental Hygienists of British Columbia and will be updated to reflect the amalgamation.

Practice Standards and Clinical Documentation Webinar FAQs

The Practice Standards and Clinical Documentation webinar incorporated information, scenarios, and questions related to the required documentation practice standards. The webinar format allowed time for questions and answers at the end of each interactive presentation. The presenters noted some common themes in the questions posed by various registrants during the initial webinar sessions, which were repeated in the subsequent webinar presentations. In light of this, the CDHBC decided to publish a Frequently Asked Questions (FAQ) in order to share the information with all CDHBC registrants.

How often does full periodontal assessments and charting need to be completed (e.g., probing, recession, mobility, furcation involvement, etc.)?

CDHBC Practice Standard #3 indicates that dental hygienists must collect baseline assessment data as appropriate for the client and update the data as required, including periodontal examination data.

The CDHBC does not make specific recommendations regarding the frequency of periodontal assessments and charting of the findings. However, it is considered to be an essential part of informing the dental hygiene diagnosis and treatment plan and should be regularly assessed. At periodontal maintenance appointments, updates for periodontal assessments (such as CAL, BOP, probing depths etc.) should be completed in a manner, which aligns with the severity of the periodontal condition for the individual client. It is up to the dental hygienist's professional judgment to determine if only an update is required or if the changes warrant more comprehensive data gathering (e.g., full mouth probing, recession charting and determination of CAL etc.)

Providing there is comprehensive baseline periodontal assessment data recorded, the following provides some examples for possible ways to incorporate periodontal information at maintenance and/or continuing care appointments. Please note, this is not an all-inclusive list, rather a small example.

- Probing the full mouth and only writing down any changes in pocket depths as well as any pockets over 4mm. This information needs to be supported with a written notation in the clinical treatment notes stating that full mouth probing was completed and all pockets greater than 4mm were recorded.
- Completing full mouth probing & recession and only recording any changes from baseline for in recession, probing and CAL
- Assessing probing and recession but if there were no changes the registrant documents in the treatment record that full mouth probing, recession and calculation of CAL were completed and that there were no changes from date X.

Overall, it is important to ensure that assessments were completed and subsequently documented appropriate in the client's legal record of care.

How should I document informed consent?

CDHBC Practice Standard #1 states that a dental hygienist must obtain informed consent from the client or the client's representative before initiating dental hygiene care.
Informed consent includes the client being made aware of the:

- benefits of the planned treatment and how the proposed treatment plan relates to the client's oral/overall health,
- risks associated with care, along with risks of not receiving a portion of the planned treatment,
- alternative treatments available; and,
- client consent being given voluntarily.

Informed consent is given by the client after the development and presentation of the dental hygiene diagnosis and treatment plan, which is based on assessment information. It is prudent for the dental hygienist to document in the client's treatment record that informed consent was provided by the client prior to implementing the proposed care. This may be accomplished in one of two ways:

1. The client may sign in the treatment record indicating that they understand their oral condition and the proposed treatment plan
2. The dental hygienist may document in the treatment record that the client gave informed consent for treatment

Further information on informed consent may be found in the Fall 2013 Issue of *Access*.

Following obtaining informed consent at the initial appointment, does informed consent need to be documented at each continuing care appointment?

At continuing care and periodontal maintenance appointments, the dental hygienist is still required to obtain informed consent prior to initiating any interventions or exposing radiographs. There may be changes in the assessment data that could warrant changes to the dental hygiene treatment plan, which need to be discussed with the client. In some instances, this may be a very brief discussion with the client if no changes have been noted and the client's periodontal status remains stable. In other cases, a more thorough discussion may be necessary to share changes that have been noted during the assessments as these may affect require modifications to the original treatment plan and possible referrals.

How often should you be taking blood pressure readings for clients?

Dental hygienists are responsible for providing safe and ethical care during all aspects of treatment. CDHBC Practice Standard #3 identifies the responsibility of a dental hygienist to assess the client's needs, which includes the baseline readings and updates required based on the individual needs of the client.

Registrants have a professional responsibility to base practice decisions on accepted "best practices", which are supported by evidence and uphold the principles of safe and ethical care. It is incumbent upon registrants to remain current and to evolve their practice to align with the literature, as well as to incorporate the CDHBC Code of Ethics into their individual practice setting. This would include:

- #1 - Hold paramount the health and welfare of those served professionally;
- #2 - Provide competent and appropriate care to clients;
- #9 - Maintain a high level of skill by participating in programs of continued study to update and advance their body of knowledge.

An accurate medical history and updating a client's blood pressure prior to commencing dental hygiene care is important when it comes to identifying risks and potentially preventing complications associated with proposed care, such as the administration of local anesthetic. Measuring blood pressure also serves as a screening for clients who may be unaware of an underlying medical condition that may require a referral.

The CDHBC encourages best practice for obtaining a baseline blood pressure for each client and then updating based on the needs of the client and on the interventions planned. As such, a client's blood pressure should be measured prior to the administration of local anaesthetic.

Further information on blood pressure may be found in the Root of The Matter: Blood Pressure Matters Updates.

How long are we legally required to keep client charts?

Independent dental hygienists who own clinics or mobile practices, own their client's records. CDHBC Practice Standard #8.6 sets out the College's record retention requirement for regulatory purposes. This requirement changed from a 10-year to a 16-year retention timeframe, effective April 1, 2014. Practice Standard #8.6 now states the following: "When the dental hygienist owns the client's records, dental hygienists must retain records in a secure manner for no less than 16 years after the last client appointment."

This change was made in order to align the CDHBC requirement with the new *Limitation Act* which

came into force in June 2013. Therefore, records for which the most recent entry was created on or after June 1, 2013 must be kept for 16 years from the date of last entry and records for which the most recent entry was created before June 1, 2013, must be kept for 31 years (the ultimate limitation period under the former Limitation Act, plus one year for service).

Retention of client records for a minor differs from that of an adult. The client's record must be kept until the minor turns 19 years of age, plus another 16 years. Therefore, if the minor was last treated when they were 12 years old, the RDH would be required to retain the records for an additional 23 years (7 years until the age of 19 plus the required 16 years = 23 years). There are also special considerations that need to be given for persons with a disability.

While a health practitioner's regulatory college establishes how long client records must be kept in the event that they are needed for regulatory purposes such as complaint investigations or quality assurance proceedings, the *Limitation Act* establishes the time limits in place for a client to file a lawsuit in civil court. Aligning the CDHBC records retention requirement with the new *Limitation Act* helps to ensure that records are not prematurely disposed of when the regulatory requirement elapses, while other relevant legislation still prevails.

The College recommends that independent dental hygienists obtain legal advice that is specific to their practice and circumstances, as needed.

Further information on records retention may be found in the Summer 2014 Issue of *Access*.