BCCOHP

British Columbia College of Oral Health Professionals

Dental Hygiene Documentation

The BCCOHP Dental Hygienist Practice Standards are part of the Bylaws and state the required criteria for practice. The Practice Standards can be found in detail on in the BCCOHP website under the Practice Standards and Policies. This Dental Hygiene Documentation resource has been compiled for registrants who provide direct clinical dental hygiene care to clients as a quick resource, to provide a guideline for maintaining documentation (client charts) in accordance with the Practice Standards.

General: (Practice Standard #8)

Client records must include evidence of appropriate and accurate documentation, as follows:

- Client records labeled with client's name
- Entries in treatment record of services provided
- Length of appointment time aligns with services provided
- Drugs administered to or taken by client (premedication; chemotherapeutic agents; local anaesthetic including injection type, location, volume and type of anaesthetic drug, if used - concentration and amount of vasoconstrictor, topical anaesthetic drug, clients response to topical and injected drug, complications, post operative instructions and if vasoconstrictor used reference to the prescription by the dentist)
- Informed refusal to consent documented
- Possible risks of not receiving recommended services
- Evaluation findings and next appointment planning details
- Precautions and instructions given where necessary
- Recommended referrals
- Details of pertinent client discussions
- Daily entries are dated and signed/initialed by clinician
- Entries are legible and in ink
- Electronic entries should be secure, non-erasable, and identify registrant's entries

Dental Hygiene Assessment: (Practice Standard #3)

Client records must include evidence of appropriate and accurate assessment information*, as follows:

- Health history information (baseline and updated) and initialed by registrant including medical alerts, pre-med required or contraindications to DH care
- Clinical assessment data. Evidence should include:
  - Demographics
  - Client concerns
  - Vital signs, if indicated
  - Extra-oral head & neck examination
  - Intra-oral soft tissue examination
  - Periodontal examination, including probing, mobility, furcations, recession, marginal attached gingival defects, hard and soft deposits, stain, etc.
  - Dental/Occlusal assessment
  - Diagnostic results (radiographs, bacterial tests and enzyme tests etc.)
  - Oral hygiene routines/ techniques
  - Client anxiety and pain levels

* Baseline assessment data must be collected as appropriate for the client (or supplement data collected by another health professional). The extent of data collected will vary with the practice setting and with clients who have specific needs or conditions. Professional judgement must be used to determine the data that is needed to assess each client.

Dental Hygiene Diagnosis: (Practice Standard #4)

Client records must include evidence of appropriate and accurate diagnosis, as follows:

- Dental hygiene diagnosis recorded, and client informed
- Short and long-term dental hygiene prognosis, if determined

Dental Hygiene Planning: (Practice Standards #1 & #5)

Client records must include evidence of a dental hygiene treatment plan, as follows:

- Dental hygiene care plan
- Informed consent obtained and recorded
- Consultation with dentist or other health care professionals (when needed)
- Goals/objectives, sequence of activities
- Discussion of fees associated with the plan

Dental Hygiene Implementation: (Practice Standard #6)

Client records must include evidence of accurate implementation of dental hygiene care, as follows:

- Implementation of dental hygiene care (e.g., debridement, fluoride treatment, discussion on nutrition, oral hygiene education, etc.)
- Implementation documentation may include indication of:
  - Attempt made to reduce client's pain and anxiety (e.g., offering or administering pain control, discussing relaxation strategies, etc.)
  - Appropriate use of chemotherapeutic agents
- Proposed changes to the plan discussed and approved by client

Dental Hygiene Evaluation: (Practice Standard #7)

Client records must include evidence of accurate evaluation of dental hygiene care, as follows:

- Care is evaluated to determine if desired outcomes achieved
- Follow up or maintenance intervals are established
- Referrals if indicated at time of evaluation

Dental Hygienists Applying Ionizing Radiation: (Practice Standard #9)

Client records must include evidence of a dental hygienist documenting:

- Informed consent or refusal for taking radiographs
- Informed consent for sharing radiographs
- The number of radiographs exposed
- The interpretation of the radiographs
- Referral/consultation for findings that fall outside of the dental hygiene (DH) Scope of Practice (SOP)
- Authorization for exposing radiographs that fall outside the DH SOP

Dental Hygiene Practitioners who own a Private Dental Hygiene Practice: (Practice Standard #10)*

Client records must include evidence of a dental hygienist documenting:

- The recommendation for the client to be examined by a dentist

*Full requirements for DH Practitioners are outlined under Practice Standard #10.