



Dental Hygiene Documentation

The CDHBC 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 CDHBC website under the [Practice Resource tab](#). This resource has been compiled for registrants who provide direct clinical dental hygiene care to clients, 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 type, volume, and injection site)
- 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 updated and initialed by registrant including medical alerts, pre-med required or contraindications to DH care
- Client's dental examination within 365 days
- Clinical assessment data. Evidence may include indication of:
 - Demographics
 - Client concerns
 - Vital signs
 - 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 examination
 - Diagnostic results (radiographs, bacterial tests, etc.)
 - Oral hygiene routines/ techniques
 - Client anxiety and pain levels

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

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