Standards of Practice

DOCUMENTATION

STANDARD STATEMENT

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

PERFORMANCE EXPECTATIONS

The dental hygienist must…

1. Document accurate records in accordance with the Code of Ethics, Standards of Practice, applicable **legislation**, guidelines, and policies.
2. Include their first and last name, title, registration number, and date in each record entry.
3. Ensure each component of the client record identifies the corresponding client.
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 client **encounter**. For each encounter, the client record must contain:
    a) Client's reason(s) for attendance;
    b) Informed consent process, including the client's informed refusal of any recommended procedures or strategies;
    c) Relevant updated client medical and dental history information;
    d) An accurate and complete reflection of the patient encounter, including any or all 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. Client 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 client;
        vii. Prescriptions given;
        viii. Referrals to other health professionals;
        ix. Notation of any adverse or unusual events that occur related to dental hygiene care;
        x. Any other care provided.
7. Include sufficient detail in the record to allow the client's care to be managed by another health professional.
8. Complete the client record during care or as soon as is reasonable.
9. Enter in the client record any communication to or with the client (e.g., telephone, electronic) related to dental hygiene services, including before or after care.

continued >>

10. Document communications, reports, and correspondence from other health professionals in the client record.
11. Maintain the following information when a client 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.

CLIENT EXPECTATION

The **client** 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
Refers to 'an implied or irrelevant evaluation of (an) individuals(s) which might imply prejudicial beliefs or perpetuate biased assumptions.' (ACSLPA)

CARE PLAN
"Statement of goals, evidence-based interventions, and appointment schedule supporting the diagnosis" (Bowen & Pieren, 2020, p. 363).

ENCOUNTER
A client's interaction with the dental hygienist, related to a particular occurrence. (CRNA)

LEGISLATION
Federal or provincial acts, regulations, or codes.

RECORD
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. (HIA)