INDIANA UNIVERSITY SOUTH BEND

Standards of Clinical Practice

Vera Z. Dwyer College of Health Sciences
Division of Dental Education

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Vera Z. Dwyer College of Health Sciences

Indiana University South Bend

SHARED VALUES

Wisdom

Integrity

Learner-centered

Excellence

Purpose

The purpose of a Standard of Care is to provide a systematic process to ensure quality and equity of patient care provided within our facility. The IUSB Clinical Standards of Care is available to provide patients of all walks of life, creed, and ability the opportunity for positive oral health outcomes and patient experiences while being seen in the dental hygiene clinic.

Intent

In alignment with the American Dental Hygienists' Association's Standards for Clinical Dental Hygiene Practice, the Indiana University South Bend, Vera Z. Dwyer, Division of Dental Education has established the following standards for clinical dental hygiene practice for students, faculty, and volunteers. The Standards follow the dental hygiene process of care to provide a framework for a patient-centered education focused clinical experience. The Standards will be modified based on emerging scientific evidence, ADHA policy development, federal and state regulations, and changing disease patterns as well as other factors to assure quality care and safety as needed.

Expectations

The student clinician with supervision of a clinical faculty member and clinical dentist will primarily treat each patient. Each patient experience is closely monitored through various evaluation methods to ensure the highest quality of patient care, respect, and professionalism. The IUSB,VZD, Division of Dental Education Clinical Standards and this document are adapted from the American Dental Hygienists' Association Standards for Clinical Dental Hygiene Practice revised 2016. The following Standards will be provided to each patient treated at the Indiana University South Bend Vera Z. Dwyer Division of Dental Education's Dental Hygiene Clinic.

Standard 1: Assessment

The ADHA definition of assessment: The collection and analysis of systemic and oral health data in order to identify patient needs including, but not limited to:

Health History Assessment

- Demographic information
- Vital signs*
- Physical characteristics
- Medical history
- Dental history
- Social history
- Pharmacologic history

Clinical Assessment

- Examination of the head, neck, and oral cavity
- Documentation of normal and abnormal findings
- Assessment of the temporomandibular function
- A current, complete, and diagnostic set of radiographs*
- Comprehensive periodontal examination including
    - Full mouth periodontal charting at each re-care visit including data points reported by location, severity, quality, written description, or numerically:
        - Probing depths
        - Bleeding points
        - Suppuration
        - Mucogingival relationships/defects
        - Recession
        - Attachment level/attachment loss
    - Presence, degree, and distribution of plaque and calculus
    - Gingival health/disease
    - Bone height/bone loss
    - Mobility and fremitus
    - Presence, location, and extent of furcation involvement
- Comprehensive hard-tissue evaluation that includes charting of existing conditions and oral habits, with intraoral photographs and radiographs that supplement the data

Risk Assessment

- Fluoride exposure
- Tobacco exposure
- Nutritional history and dietary practices including the consumption of sugar-sweetened beverages
- Systemic diseases/conditions
- Prescriptions and over-the-counter medications, and complementary therapies and practices
- Salivary function and xerostomia
- Age and gender
- Genetics and family history
- Habit and lifestyle behaviors
    - Cultural issues
    - Substance abuse (recreational drugs, prescription medication, alcohol)
    - Eating disorders/weight loss surgery
    - Piercing and body modification
    - Oral habits
    - Sports and recreation sports, energy drinks/gels
- Physical disability
- Psychological, cognitive, and social considerations
    - Domestic violence
    - Physical, emotional, or sexual abuse
    - Behavioral
    - Psychiatric
    - Special needs
    - Literacy
    - Economic
    - Stress
    - Neglect

Standard 2: Dental Hygiene Diagnosis

The ADHA defines dental hygiene diagnosis as the identification of an individual's health behaviors, attitudes, and oral health care needs for which a dental hygienist is educationally qualified and licensed to provide. The dental hygiene diagnosis uses an evidence-based approach to critically analyze assessment data to reach a conclusion about the patient's needs. To formulate the dental hygiene diagnosis the student dental hygienist will:

- Analyze and interpret all assessment data
- Formulate the dental hygiene diagnosis or diagnoses.
- Communicate the dental hygiene diagnosis with patients and/or caregivers.
- Determine patient needs that can be improved through the delivery of dental hygiene care within the scope of the student dental hygiene clinical setting.
- Identify referrals needed within dentistry and other health care disciplines based on dental hygiene diagnoses.

Standard 3: Planning of Services

Planning consists of prioritizing patient needs, establishing realistic goals and objectives of treatment, and appropriate referrals to help the patient obtain optimal oral health. During the planning phase, the student clinician will:

- Identify, prioritize, and sequence all needed dental hygiene interventions including change management, preventive services, therapeutic services, treatment, and referrals.
- Sequencing of appointments will allow for flexibility for the patient within the confines of the dental clinic scheduling parameters.
- Identify and coordinate resources needed to facilitate comprehensive quality care
- Collaborate and work effectively with the dentist and other health care providers and community-based oral health programs to provide high-level, patient-centered care.
- Present and document dental hygiene care plan to the patient/caregiver.
- Counsel and education the patient/caregiver about the treatment rationale, risks, benefits, anticipated outcomes, evidence-based treatment alternatives, and prognosis.
- Obtain and document informed consent and/or informed refusal.

Standard 4: Implementation

Implementation is the act of carrying out the dental hygiene care plan as established through a thorough assessment, diagnosis, and successful planning. Implementation includes the following:

- At returning appointments-review and confirmation of the dental hygiene care plan with the patient/caregiver.
    - Modify the plan as necessary and obtain additional consent when necessary
- Implement the plan beginning with the mutually agreed upon first prioritized intervention.
- Monitor patient comfort throughout the appointment
- Provide any necessary post-treatment instruction
- Implement the appropriate self-care intervention; adapt as necessary throughout future interventions.
- Confirm the plan for continuing care or maintenance
- Maintain patient privacy and confidentiality
- Follow up with the patient as necessary

Standard 5: Evaluation

Evaluation is the measurement of the extent to which the client achieved the goals specified in the dental hygiene care plan. Evaluation is built throughout the process of care, from the collection of baseline data at the initial appointment during assessment, to the evaluation of treatment outcomes at the re-care appointment. Evaluation includes the following:

- Use measurable assessment criteria to evaluate the tangible outcomes of dental hygiene are
- Communicate to the patient, dentist, and other health/dental care providers the outcomes of dental hygiene care.
- Evaluate patient satisfaction of the care provided through oral and written questionnaires.
- Collaborate to determine the need for additional diagnostics, treatment, referral, education, and continuing care based on treatment outcomes, and self-care behaviors
- Self-assess the effectiveness of the process of providing care, identifying strengths, and areas for improvement. Develop a plan to improve areas of weakness through mentoring activities.

Standard 6: Documentation

Dental hygiene records are legal documents. As such the IUSB Vera Z. Dwyer Division of Dental Education dental hygiene records documentation should be detailed, comprehensive, and includes:

- All components of the dental hygiene process of care, including the purpose of the visit in the patient's own words
- Evidence of treatment plans being consistent with the dental hygiene diagnosis and include no evidence that the patient is placed at inappropriate risk by diagnostic or therapeutic procedure
- Objective record of all information and interactions between the patient and the practice including failure to return for treatment or follow through with recommendations.
- Legible, concise, and accurate information including
- Dates and signatures
- Ensure all components of patient record or current and accurately labeled
- Use common terminology and universal abbreviations
- Students and faculty will recognize the ethical and legal responsibilities of recordkeeping including guidelines outlined in state regulations and statutes.
- Students and faculty will ensure compliance with the federal Health Information Portability and Accountability Act (HIPAA), including electronic communications.

References

American Dental Hygienists' Association. (2016) Standards for Clinical Dental Hygiene Practice [PDF]. Retrieved from http://www.adha.org/resources-docs/2016-Revised-Standards-for-Clinical-Dental-Hygiene-Practice.pdf

VERA Z. DWYER COLLEGE OF HEALTH SCIENCES

INDIANA UNIVERSITY SOUTH BEND

Dental Education

*The faculty, staff, and administration at IUSB Vera Z. Dwyer Division of Dental Education take your health and safety seriously. Due to this we require thorough assessment procedures to ensure we are provide you an appropriate dental hygiene care plan fo r your health status. Part of this assessment includes taking your blood pressure, and diagnostic radiographs. If your **blood pressure exceeds 140/100,** we may not be able to treat you. We adhere to the following radiographic guidelines established by the American Dental Association:

Necessary Radiographs

	Child (Primary Dentition)	Child (Mixed Dentition)	Adult
New Patient	BWX	BWX w/PAN	BWX w/PAN or FMX
Recare Patient	BWX q 2-3years	BWX q 2-3 years PAN q 3-5 years	BWX q 2-3years PAN or FMX q 5 years
Recare Patient (increased caries risk)	BWX q year	BWX q year PAN q 3-5 years	BWX q year PAN or FMX q 3-5
Recare Patient (with periodontal disease)			BWX q 1-2 years (VBWX as needed) FMX q 3 years
Patient Development	Clinical judgment to monitor dentofacial growth	Clinical judgment to monitor 3rd molars	

Prior to having cancer treatment, and patients taking bisphosphonate medication should have a baseline panoramic radiograph.

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