adha AMERICAN DENTAL HYGIENISTS' ASSOCIATION™

Standards For Clinical Dental Hygiene Practice

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STANDARDS FOR CLINICAL DENTAL HYGIENE PRACTICE

STANDARDS FOR CLINICAL DENTAL HYGIENE PRACTICE COMMITTEE

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History

One hallmark of a true profession is its willingness to assume responsibility for the quality of care that its members provide. In 1985, the American Dental Hygienists' Association (ADHA®) took a major step toward fulfillment of that responsibility with the development of the Applied Standards of Clinical Dental Hygiene Practice[1]. This document is the fourth version to build on those standards and promote dental hygiene practice based on current and relevant scientific evidence.

Introduction

The ADHA Standards for Clinical Dental Hygiene Practice play a crucial role in maintaining consistency and quality within the profession. These standards serve as a framework guiding dental hygienists in delivering safe, ethical, and evidence-based care. They ensure that individuals receive comprehensive and effective treatment while promoting ongoing professional growth and accountability. Importantly, the standards are not a substitute for clinical judgment; rather, they complement the expertise of licensed professionals who are responsible for the care they provide.

Dental hygienists must be mindful of the legal obligations that come with their practice, as these standards must be applied in accordance with the laws of their specific jurisdictions. They are also expected to respect diverse values, health beliefs, and cultural practices, recognizing that each person brings unique perspectives to their care. By adhering to these guidelines, dental hygienists and the broader dental team ensure a shared understanding of professional expectations, which leads to better treatment planning, collaborative care and ultimately, improved patient outcomes.

This document, based on the 2016 revision of the ADHA Standards for Clinical Dental Hygiene Practice[2], further refines best practices in clinical settings, education, research, and public health, helping to uphold the integrity of the dental hygiene profession.

Assessment Standards

Assessment includes the identification of risk factors that may influence outcomes, alter the person's ability to withstand treatment, and/or increase the likelihood of a medical emergency. The frequency of a comprehensive health/oral health assessment is based on the individual's presentation, response to treatment, adherence to recommendations, and frequency of continuing care. Assessment is an ongoing process and includes both health history and clinical assessment data.

I. Health History

A health history assessment includes multiple data points that are collected through a written document and an oral interview. The process helps build a rapport with the individual and verifies key elements of health status. Information is collected and discussed in a location that ensures privacy and complies with the Health Insurance Portability and Accountability Act (HIPAA).[3]

Demographic information is any information that is required for healthcare purposes. It includes but is not limited to: address, date of birth, emergency contact information, email, phone numbers, and the names and contact information for the referring/previous dentist, all physicians of record, and preferred pharmacy.

A comprehensive health history assessment includes a review of systemic health status, mental health status, known allergies, over-the-counter and prescription medication use, date of last physical examination and blood tests, substance use, and vital signs.

II. Systemic Diseases/Conditions

Medical history is the documentation of overall systemic health. This information can identify the need for physician consultation or any contraindications for treatment. This would include mental health, cognitive impairments, behavioral disorders, disabilities, and functional capacity. Clinicians should assess the person's ability to withstand treatment (e.g. appointment length) as well as the need for modifications (e.g. modified positioning, need for antibiotic prophylaxis, need for stress reduction protocol, use of a quiet room, etc.). Laboratory tests such as A1c, INR, glucose levels, CBC, platelets, and absolute neutrophil count may need to be requested to guide treatment planning. Liver and kidney function should be assessed if administering medications and local anesthetics during the dental hygiene process of care.

Pharmacologic history includes the list of medications, including dose and frequency, which the individual is currently taking. This includes, but is not limited to, over-the-counter (OTC) drugs or products such as vitamins, herbal and dietary supplements, and pre-/probiotics. The practitioner should confirm any history of or current adverse drug reactions, including allergy, systemic and oral side effects, abnormal responses to medications, and risk for drug interactions.

Vital signs, including height, weight, temperature, pulse, respiration, and blood pressure, provide a baseline of known conditions or help identify potential or undiagnosed health conditions.

Social history information such as relationship status, children, occupation, cultural practices, and other beliefs, might affect health or influence treatment acceptance. In addition, the following risk behaviors that impact health should be assessed, including tobacco, alcohol, and prescription drug misuse; recreational drug use and vaping; a history of substance use disorders; and sexual history.

III. Clinical Assessment

Planning and providing optimal care require a thorough and systematic clinical assessment. Assessment begins by physically observing the person, noting pallor, gait, orientation to time and place, mood, use of assistive devices to support ambulation, ability to and preferences for communication, presence of sensory impairments (e.g., vision and hearing), general appearance, and hygiene. Additional components of this assessment include a comprehensive examination of the head and neck and oral cavity, skin integrity, swallowing ability, and assessment of the temporomandibular joints. Documentation should include normal and abnormal findings and need for further evaluation.

A current, complete, and diagnostic set of radiographs provides needed data for a comprehensive dental, periodontal, and pathology assessment, and formation of dental hygiene diagnoses. The type and frequency of radiographs needed are based on observations from the clinical examination and thorough risk assessment and evaluation. Radiographs should be assessed for quality, the need for retakes and additional imaging based on the ALARA principle.[4]

A comprehensive periodontal examination is part of the clinical assessment and includes a full-mouth periodontal charting:

1. Probing depths
2. Bleeding points
3. Suppuration
4. Mucogingival relationships/defects
5. Recession
6. Attachment level/loss
7. Bone height/bone loss
8. Mobility and fremitus
9. Furcation involvement
10. Tooth loss
11. Biofilm and calculus deposits
12. Smoking, diabetes and A1c

Data gathered are used to assess gingival and periodontal health status, including health, gingivitis, staging and grading of periodontitis, and implant disease.

A comprehensive hard-tissue evaluation should be performed that includes the charting of existing conditions and oral habits using intraoral photographs, radiographs and advanced technology to supplement data. These data include:

1. Missing teeth
2. Primary, mixed or permanent dentition
3. Demineralization
4. Caries and recurrent decay
5. Defects and anomalies
6. Sealants
7. Existing restorations
8. Implants
9. Occlusion
10. Fixed and removable prosthesis retained by natural teeth or implant abutments

Additional evaluation includes the identification of hard and soft tissue pathologies that may require the need for referral and further evaluation. Examples include:

1. Periapical pathology
2. Bony growths and lesions
3. Abscesses
4. Ulcerations and alterations in mucosal integrity
5. Soft tissue swelling or tumor formation
6. Presence of bacterial, viral, and/or fungal infection
7. Salivary gland abnormalities/dysfunction
8. Trauma
9. Oral malodor
10. Craniofacial abnormalities
11. Neuralgias
12. Oral manifestations of malnutrition

IV. Risk Assessment

Risk assessment is a qualitative and quantitative evaluation based on health history and clinical assessment to identify any risk to general and oral health. Data provides the clinician with information to develop and design strategies for preventing or limiting disease, and promoting health. The level of risk should be identified and documented (extremely high, high, moderate, low). Examples of factors that should be evaluated include, but are not limited to, health behaviors, social determinants of health, and other risk factors that can influence oral health.

A comprehensive evaluation of the individual's health behaviors should be performed, including:

1. Health/oral health literacy
2. Physical activity/functional capacity
3. Diet
4. Sleep
5. Sexual activity
6. Social support
7. Health screening examinations
8. Alcohol, tobacco, vaping, and recreational drug use; history of substance use disorder
9. Health care seeking behaviors
10. Adherence to prescribed medical treatments
11. Self-care practices
12. Cultural practices and beliefs relevant to oral health
13. Dental history
14. Oral product use

A comprehensive evaluation of social determinants of health should be conducted, including:

1. Socioeconomic status
2. Housing
3. Education
4. Work/employment
5. Culture
6. Race/ethnicity inequalities
7. Environmental factors/physical safety
8. Access to nutritious foods/food insecurity
9. Insufficient access to affordable health and dental care
10. Limited community resources
11. Childcare concerns
12. Social support
13. Financial concerns
14. Stress
15. Transportation

Other risk factors to be identified include:

1. Fluoride exposure
2. Demographics (age, gender, genetics, family history)
3. Disability and special health care needs
4. Sleep apnea
5. Systemic diseases/conditions
6. Bleeding
7. Salivary function and xerostomia
8. Behavioral health/mental health disorders
9. Physical and emotional safety (domestic violence, physical, emotional, or sexual abuse, neglect, human trafficking)
10. Oral habits

Dental Hygiene Diagnosis (DHDx) Standards

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.[5] The ultimate goals of dental hygiene practice and care provided are to maintain health and prevent disease. By recognizing and addressing dental hygiene diagnoses, dental hygienists have the opportunity for early intervention and prevention.[6]

Dental hygiene diagnosis/diagnoses (DHDx) involve critically evaluating the individual's assessment information collected through written health history, oral interview, and clinical assessment.[6] Full assessment data includes factors pertaining to an individual's health/medical history, vital signs, physical characteristics, social history, pharmacologic history, comprehensive periodontal evaluation, hard-tissue evaluation, hard and soft tissue pathologies, risk assessments for health behaviors, social determinants of health[7,8], signs and symptoms of disease, and other specific risk factors relevant for that person. For person-centered care that is specific for each individual, the person's needs, values, and preferences must be considered when formulating the DHDx.[9,10]

The dental hygienist analyzes assessment data to determine hindrances to optimal oral and systemic health outcomes. The dental hygienist then determines each DHDx and correlates contributing factors pertaining to each diagnosis. Dental

hygiene diagnostic statements are formulated. These DHDx will direct the dental hygiene care plan to ensure all needs are addressed.[6,11-13] Elements in the care plan based on the DHDx include education, self-care practices, prevention strategies, treatment, evaluation, counseling, and referral needs.[11-13]

Individuals need to be given the opportunity to understand their specific health problems/DHDx in order to make the best decisions for their health.[9]

Categories for DHDx include:

1. Systemic health factors
2. Behavioral health factors
3. Social determinants of health factors
4. Periodontal disease classification
5. Hard and soft tissue conditions
6. Individual needs, values and preferences

The process of DHDx involves the following steps:

1. Analyze and interpret all assessment data.
2. Formulate the dental hygiene diagnoses.
3. Determine the person's needs that can be improved through the delivery of dental hygiene care.
4. Identify referrals needed within dentistry and other health care disciplines based on DHDx.
5. Communicate the DHDx with the individual to engage the person in formulating their dental hygiene care plan.
6. Document the DHDx and follow-up at future appointments to determine the status of these diagnoses.

A comprehensive DHDx includes multiple diagnoses for each person.[11-13] DHDx should be determined for individuals and community groups.

Planning Standards

Planning is the process by which diagnosed person-centered needs are prioritized, goals and evaluative measures are established, intervention strategies are determined, and an appointment schedule is proposed.[6] The purpose of the dental hygiene care plan is to develop a strategy of care that results in the resolution of an oral health problem amenable to dental hygiene care, the prevention of a problem, or the promotion of oral health and well-being.[6] A formal, written dental hygiene care plan is based on sound clinical decision-making and reflects evidence-based best practices. Depending on the workforce model and state practice law, the written care plan may support direct payment for dental hygiene services.

In a traditional clinician-dentist practice model, the dental hygiene care plan is part of and supports the overall dental treatment plan. A similar coordination of care occurs in a collaborative agreement relationship between the dental hygienist and dentist in a teledentistry workforce model. In a medical-dental integrated workforce model, the dental hygiene care plan may be a collaboration with an interdisciplinary care team. However, a dental hygienist providing direct care without dental supervision or collaboration will formulate a stand-alone dental hygiene care plan based upon the assessment and dental hygiene diagnosis, implement the plan, and refer the individual for needed dental care or primary healthcare services.[5] When medical or dental needs are urgent, the dental hygienist will refer the individual prior to or in conjunction with dental hygiene services.[14] In all workforce models, the dental hygienist will make care planning decisions in accordance

with legal, professional and ethical principles. The dental hygienist will continue to collaborate with the dentist and interdisciplinary health care providers for optimal person-centered care.

The dental hygiene care plan is written following Dental Hygiene Diagnosis. The dental hygiene diagnosis serves as the foundation for formulating a person-centered dental hygiene care plan. In collaboration with the dentist and/or interdisciplinary care team, the dental hygienist considers each discipline's diagnoses and determines their urgency. Dental hygiene diagnoses are prioritized by considering those that threaten the well-being of the individual, may be addressed simultaneously with other diagnoses, and are a priority or chief concern of the individual.[6] To assure that the person's comprehensive diagnosed needs are addressed, the dental hygiene care plan is sequentially developed and linked to the dental hygiene diagnoses. Linking the care plan to the dental hygiene diagnoses is crucial to its development. The dental hygiene care plan specifies the following:

- Goals and evaluative measures
- Dental hygiene interventions
- Appointment schedule

The dental hygiene care plan should identify a cohesive relationship between the dental hygiene diagnoses, goals and intervention strategies. The individual's psychosociocultural and physical needs as well as readiness for change must be supported by the care plan.

I. Goals and Evaluative Measures

A care plan goal is the desired outcome to be achieved through specific dental hygiene intervention strategies to satisfy an identified need or problem.[2] Care plan goals establish a framework that defines the expectation of the person, that is, their desired health outcome and self-responsibilities for goal attainment. A well written care plan goal states the[6] :

- person responsible for achieving the goal, that is, the individual or caregiver;
- desired action of the person and/or caregiver specifying how the goal will be measured;
- criterion for measurement, that is, the desired observable behavior or tangible outcome;
- time frame for when the individual is to achieve the goal.

In a guided discussion with the individual and/or caregiver, the dental hygienist will define one or more goals for each dental hygiene diagnosis. The dental hygienist will consider both clinical and behavioral or person-centered goals.

- Clinical goals address oral health status needs and are defined by the specific signs and symptoms or evidence of the identified oral health problem/need or risk of a condition/problem.
- Person-centered goals address cognitive, psychomotor and affective behaviors. They are defined by contributing factors of the identified oral health problem/need or risk of a condition or problem.

Including both clinical and person-centered goals emphasizes a clinician-person team approach to attaining desired oral health outcomes and communicates the importance of the individual's or caregiver's role in achieving and maintaining oral health.

II. Intervention strategies

Dental hygiene interventions are evidence-based strategies that, when applied, reduce, eliminate or prevent a diagnosed problem or need.[6] Intervention strategies are selected to address the etiology or underlying contributors to a diagnosed condition or problem, such as identified barriers preventing the person from achieving positive oral health outcomes. Preventive, educational, therapeutic, and supportive counseling, and inter- and intra-disciplinary referrals within the scope of dental hygiene practice are considered. The dental hygienist will select strategies that reflect evidence-based, clinically sound, equitable care to support the attainment of the care plan goals or desired care plan outcomes. Selecting intervention strategies tailored to address a person's unique needs increases the likelihood that care plan goals will be achieved.

III. Appointment Schedule

An appointment schedule is planned for implementing the dental hygiene intervention strategies. The schedule will guide the clinician and the individual through the implementation of planned care. The dental hygienist considers the:

- number of visits (preventive or wellness visit, complex multiple therapeutic visits, supportive periodontal maintenance visit);
- time needed for each visit (pain management, patient management, planned services, evaluation of goals or patient outcomes);
- interventions to be implemented at each visit;
- integration of educational interventions and sequencing small increments of oral self-care strategies into each visit.

The dental hygienist will determine the sequencing and length of each appointment in accordance with the complexity of planned individual needs.

IV. Care Plan Presentation and Consent

Presentation of the dental hygiene diagnoses and dental hygiene care plan is best accomplished by establishing a collaborative, co-therapeutic relationship with the individual and/or caregiver. The dental hygienist will ask open-ended questions to encourage active dialogue for shared decision-making. Presentation of the care plan should include the[6]:

- nature of the condition
- proposed care plan, rationale, and number of appointments
- alternative evidence-based treatment options, when available
- risks involved, if any
- potential for failure
- prognosis if the problem goes untreated
- individual's questions are answered

The dental hygienist will obtain and document consent from the individual and/or guardian prior to the implementation of the planned services. The dental hygienist will assure that the individual has the information needed to make an informed decision, specifically informed consent and/or informed refusal.

Implementation Standards

Implementation is the actual process of carrying out the dental hygiene care plan. The implementation phase involves actively incorporating evidence-based research and guidelines to ensure safe and effective care while engaging the individual as a co-therapist. As a primary oral health care provider, the dental hygienist delivers dental hygiene services based on the care plan, including any required modifications, while minimizing risk and optimizing oral and systemic health. [5,6]

Person-centered care is essential throughout the implementation process. The dental hygienist should consider the individual's unique needs, preferences, and values when selecting and delivering interventions. Culturally sensitive care and culturally sensitive communication are vital to establish trust, build rapport, and ensure effective communication. Additionally, appropriate technology and diagnostics for monitoring, management, and treatment of diseases can enhance the implementation process, but they must be evidence-based and used ethically and responsibly, prioritizing individual privacy and confidentiality.[6,14]

Depending on the number of interventions, the dental hygiene care plan may be implemented in one preventive/wellness visit or several therapeutic visits before a continuing or maintenance plan is established. Health promotion and

self-care education are integral aspects of the care plan that should be customized and implemented according to the individual's interest and ability.[5,6,14]

Key steps involved in the implementation phase include:

1. Review and confirm the dental hygiene care plan:
    - Ensure mutual understanding with the individual or caregiver
    - Address any questions or concerns
2. Modify the plan as necessary, ensure mutual understanding, obtain informed consent if necessary:
    - Reassess the individual 's needs and adjust the plan accordingly
    - Consider any changes in the person's health status or circumstances
3. Implement the plan:
    - Prioritize evidence-based interventions on the individual's needs and urgency
    - Deliver services in a timely and efficient manner
    - Monitor the individual's comfort throughout the process
4. Provide post-treatment instructions:
    - Educate the individual on evidence-based oral hygiene practices (e.g., toothbrushing for two minutes twice daily) and products (antiseptic mouthrinses, antimicrobial toothpaste, electric rechargeable toothbrushes), dietary recommendations (reduce intake of ultraprocessed foods, sugar-sweetened beverages, processed meats, and refined grains), and topical or systemic medication usage (prescription strength fluoride, topical fluorides, other re-mineralization agents, and dentin hypersensitivity agents) as needed
    - Address any concerns or questions
5. Implement self-care interventions:
    - Implement the appropriate self-care interventions. Tailor self-care recommendations to the individual's specific needs and abilities
    - Educate and encourage participation in self-care activities by using evidence-based strategies to motivate and empower the individual to take ownership of their oral health
    - Adapt as necessary throughout future interventions
6. Confirm the plan for continuing care or maintenance:
    - Schedule follow-up appointments as needed
    - Develop a long-term care plan to maintain oral health including routine screenings for early detection
    - Coordinate with other healthcare providers as necessary. This may involve referrals to dental specialists, such as periodontists or oral surgeons, or collaboration with primary care physicians to address systemic health concerns
7. Maintain patient privacy and confidentiality:
    - Adhere to HIPAA regulations and professional ethics to protect information from unauthorized access
8. Follow-up as necessary:
    - Monitor the individual's progress and address issues by making modifications
    - Provide additional support, education, pain management, or referral as needed
    - Emphasize the importance of continuing care for maintaining optimal oral health

Evaluation Standards

Evaluation is the measurement of the extent to which the person has achieved the goals specified in the dental hygiene care plan, that is, fulfillment of the person's diagnosed needs, values and preferences that impact care.[5] Integrating evaluation into person-centered care fulfills the dental

hygienist's ethical and legal responsibility that planned and implemented dental hygiene care is moving the person toward achieving positive care outcomes.[5] Evaluation is a continuous process of ongoing monitoring and interpretation of the effectiveness of the dental hygiene care provided. The dental hygienist uses evidence to continue, discontinue, or modify the care plan. The individual's reported outcomes (patient-reported outcome measures) are used to capture their perspective about their health status, symptoms and ability to function, including how well the treatment has worked from their viewpoint. Further, this information supports evaluation about how the individual's oral health status impacts their quality of life, a metric which can be overlooked by using only clinical measures. Reported outcome measures are used to guide shared decision-making for continued care, which leads to more informed treatment decisions.

Elements of evaluation are integrated into each Standard to support person-centered care, as follows[6]:

- Assess and Dental Hygiene Diagnosis. The dental hygienist collects and analyzes assessment findings to establish individual needs. The identified needs guide the dental hygienist to formulate the dental hygiene diagnostic statements and provide the foundation for developing evaluation strategies.
- Plan. The dental hygienist, in collaboration with the individual, formulates care plan goals, that is, evaluation measures and methodology as defined by the dental hygiene diagnostic statements. The dental hygiene care plan suggests a timeline for goal achievement.
- Implement. Throughout the implementation of planned interventions, the dental hygienist continually monitors the person's progress toward goal achievement. The dental hygienist uses periodic reassessment to collect, interpret and conclude when care plan strategies are moving the individual toward attaining desired health outcomes or when modifications to the care plan are needed. The dental hygienist shares findings with the individual and documents progress made in the person's dental hygiene record.
- Evaluate and Document. At the completion of the dental hygiene care plan, the dental hygienist measures the individual's response to treatment. An evaluative statement is documented that includes the attainment of care plan goals to determine the person's prognosis for continued health, recommendations for a supportive continued cycle of care, and referrals made for additional services, as needed. To evaluate the care plan goals, the dental hygienist selects measurable assessment criteria that reflect the intent of the goal being measured such as cognitive, psychomotor, affective or clinical. The dental hygienist uses critical thinking to analyze the findings and draw conclusions to the extent of goal attainment.

At subsequent cycles of care or continued care appointments, the dental hygienist applies reassessment strategies to measure long term success at achieving or maintaining the resolution of a need or problem addressed by the previous care plan. The dental hygienist will apply the new assessment findings against the previous care plan goals to determine the extent to which the goals continue to be met. When there is a recurrence of a condition or new condition, the dental hygienist will further investigate to determine the underlying contributor. The process of care then continues.

Evaluation of individual care outcomes communicates critical and necessary feedback to the dental hygienist, individual, dentist and interdisciplinary care providers.

- To the individual, awareness that self-responsibility for oral self-care and a commitment to a supportive continued care schedule is critical to achieving and maintaining oral health;
- To the dental hygienist, understanding the individual's satisfaction of the care provided, obtained through an oral or written questionnaire, influences shared decision-making and strengthens the individual's commitment to care;
- To the dental hygienist, self-evaluation is used throughout the process of providing care and identifying opportunities for quality improvement;
- To the dental hygienist, dentist, individual, and interdisciplinary team, collaboration helps to determine the need for additional diagnostic, treatment, referral, education, counseling (e.g., dietary and tobacco cessation), and continuing care based on treatment outcomes and self-care behaviors.

Documentation Standards

The goals of documentation are to maintain continuity of care, provide a means of communication among the individual's interdisciplinary care providers and minimize practitioners' risk of exposure to malpractice litigation. The individual's dental hygiene record represents an ethical and legal account of care provided. At the completion of each person's encounter, the provider will make an entry to the dental hygiene record detailing the events of the appointment. Documentation should establish a link between assessment, dental hygiene diagnosis, care planning, implementation of planned strategies and evaluation. Entries must be detailed enough to show how the individual progressed through each phase of care. These actions establish a chronological account of care provided and evidence to support a person-centered process of care.

Documentation is a complete and accurate recording of all collected data, diagnosed needs, individual involvement in care planning, consent for treatment, implementation of planned services and monitoring of progress, evaluation of treatment outcomes, prognosis, continued care recommendations, related communication and other interactions and information relevant to care provided.[5] Entries into the dental hygiene record must:

- Be objective, concise, legible and accurate;
- Ensure that common terminology, abbreviations, acronyms are universal and may be easily understood by subsequent providers;
- Be written by the provider who performed the service, signed and dated (month/day/year);
- Include all information and interactions between the individual or caregiver and the practice (e.g., communications, emergencies, prescriptions, referrals) including failure to return for treatment or follow through with recommendations, with date and time (when relevant) of the interaction;
- Include informed consent with signature and date, and when indicated, informed refusal detailing steps taken to assure individual's or caregiver's understanding of their decision and risk of no treatment;
- Not be erased once saved. When there is an error in previously stored electronic information, the provider will mark the entry as mistaken, add correct information, and date and initial the entry.

Documenting entries to a person's electronic health record (EHR) makes needed care information available to the interprofessional healthcare providers for coordination and communication of services.[6] Providers must:

- Comply with state regulations and statutes for recordkeeping and storage;
- Ensure compliance with the Federal Health Information Portability and Accountability Act (HIPAA) including electronic communication to protect confidentiality and security of documentation;
- Respect and protect the confidentiality of the person's information;
- Complete periodic monitoring of dental hygiene records to ensure that documentation adheres to legal and ethical standards of care.

Conclusion

The Standards for Clinical Dental Hygiene Practice serve as a vital resource for dental hygienists committed to delivering person-centered, evidence-based care. They underscore the importance of continuous professional growth to ensure ongoing competence and adaptability in a dynamic healthcare landscape. These standards will continue to evolve in response to advancements in scientific research, changes in ADHA policies, updates to federal and state regulations, and shifts in disease trends. By adhering to these standards, dental hygienists can confidently provide safe, high-quality care, meeting the ever-changing needs of their patients and the profession.

Keywords

ALARA – As Low as Reasonably Achievable referring to avoiding exposure to radiation that does not have a direct benefit to the individual, even if the dose is small.[4]

Evidence-Based Practice – the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individuals. The practice of evidence-based dental hygiene requires the integration of individual clinical expertise and an individual's preferences with the best available external clinical evidence from systematic research.[5]

Health Insurance Portability and Accountability Act (HIPAA) – a federal law that sets a national standard to protect medical records and other personal health information.[3]

Informed Consent – a process of providing an individual with the information needed to make a decision about treatment.[6]

Informed Refusal – documentation that an individual declines all or part of a proposed care plan.[6]

Person-Centered Care – integrated health care services delivered in a setting and manner that is responsive to individuals and their goals, values and preferences, in a system that supports good provider-individual communication and empowers individuals receiving care and providers to make effective care plans together.[15]

Social Determinants of Health – the non-medical factors that influence health outcomes including conditions in which individuals are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.[16]

Supportive Continued Cycle of Care – a system designed to organize and maintain an appropriate schedule of dental hygiene care for each individual based on their needs; also referred to as continuing care, continued-care intervals, or recare.[6]

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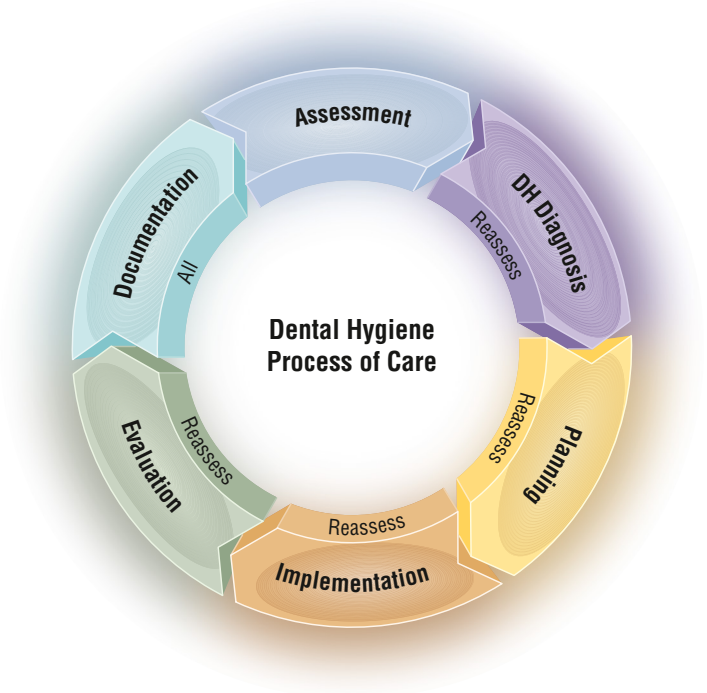
Appendix A

DENTAL HYGIENE PROCESS OF CARE[6]

There are six components to the dental hygiene process of care. These include: assessment, dental hygiene diagnosis, planning, implementation, evaluation, and documentation. The six components provide a framework for person-centered care activities.



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