THE CANADIAN DENTAL HYGIENISTS ASSOCIATION

L'ASSOCIATION CANADIENNE DES HYGIÉNISTES DENTAIRES

DENTAL HYGIENE:

DEFINITION, SCOPE, AND PRACTICE STANDARDS

Draft March 25, 2002

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CANADIAN DENTAL HYGIENISTS ASSOCIATION

MISSION STATEMENT:

The Canadian Dental Hygienists Association, as the collective voice and vision of dental hygiene in Canada, is dedicated to advancing the profession in support of our members and contributing to the health and well-being of the public.

The Canadian Dental Hygienists Association (CDHA), a national professional organization since 1964, represents Canada's 14,000 dental hygienists. CDHA provides a strong, collective, influential voice for members, at the national level. The CDHA Board of Directors consists of members elected by the nine provincial dental hygienist associations. The Board also includes a representative of the Quebec members, plus representatives from the Federation of Dental Hygiene Regulatory Authorities and the Dental Hygiene Educators of Canada.

CDHA members enjoy support through the following:

- Professional resources such as Probe, a bi-monthly journal, the CDHA Member Resource Centre, as well as workshops and research materials.
- Financial incentives such as the CDHA/Oral-B Dental Hygiene Student Scholarship, CDHA/Oral-B Student Research Award, CDHA/Oral-B Dental Hygiene Research Grant, and CDHA/Colgate Community Health Award.
- CDHA members' web site with an electronic version of Probe, connections to other Internet resources, a Job Database, a Calendar of Events, National Dental Hygienists' Week resources, and a What's New section, at www.cdha.ca.
- Educational tools for your clients, including a Dental Hygiene Challenge Quiz, and a Dental Hygiene Client's Bill of Rights, at www.preventionprofessionals.com.
- Annual professional conferences, national communications campaigns and other special events such as National Dental Hygienists' Week.
- Canadian Dental Hygienists Insurance Plan including insurance coverage and services such as liability (malpractice) insurance, disciplinary/sexual abuse defence cost rider, commercial liability, long-term disability, life and home/auto insurance, as well as retirement and savings programs.
- Liaison with other organizations such as Allied Health Professionals, American Dental Hygienists Association, International Federation of Dental Hygienists, Health Action Lobby, Canadian Public Health Association and Commission on Dental Accreditation.
- CDHA toll-fee line: 1-800-267-5235.
- CDHA e-mail access: info@cdha.ca.

Part I. Definition and Scope

Introduction

Dental Hygiene: Definition, Scope, and Practice Standards has been developed to guide dental hygienists in their day-to-day practice. Other users include:

- Educators and educational institutions
- Dental hygiene students (undergraduate and graduate)
- Regulatory bodies
- Government
- Accreditation bodies (educational, hospital or other)
- Dental hygiene and other professional associations
- Dental industry
- Employers

Dental Hygiene Defined

- **Dental hygiene** is a health profession involving theory and evidence-based practice. Dental hygiene theory and practice draw on biomedical, social, and behavioural sciences, and the body of dental hygiene knowledge. The practice of dental hygiene involves collaboration with clients, other health professionals, and society to achieve and maintain optimal oral health, an integral part of well-being.
- A **client** is an individual, family, group, organization or community accessing the professional services of a dental hygienist. The term "client" may also include the client's advocate such as the parent of a young child

Dental hygienists are regulated primary oral health care professionals whose key responsibilities are:

- **Health promotion:** the process of enabling people to increase their awareness of, responsibility for, control over, and improvement of their health and well-being
- **Education:** the application of teaching and learning principles to facilitate the development of specific attitudes, knowledge, skills, and behaviours
- **Clinical therapy:** the primary, interceptive, therapeutic, preventive and ongoing care procedures that help to enable people to achieve optimal oral health that contributes to overall health
- **Change agent**: taking a leadership role in managing the process of change. This can involve: getting things started (catalyst); offering ideas for solving a problem (solution giver); helping individuals find and make the best use of resources (resource link); and understanding the change process (process helper). Acting as a change agent may also involve advocacy - promoting and supporting clients'

rights and well-being.

- **Research**: strategies for systematic inquiry and reporting that supplement, revise, and validate dental hygiene practice and that may contribute to the knowledge bases of other disciplines.

- **Administration**: management processes and policy development.

Key responsibility Areas

The key responsibilities occur in varying degrees depending upon the nature of an individual dental hygienist's practice.

The privilege of practising a health profession requires knowledge, ethics, standards, and research, all of which acknowledge dental hygienists' social responsibility in the key areas of dental hygiene practice.

In fulfilling their responsibilities, dental hygienists:
- embrace a personal ethic of social responsibility and service
- behave ethically
- work in a client-centred, relationship-centred way
- are culturally sensitive
- continue to learn and help others learn.

These characteristics are some of the 21 characteristics described in the Pew Health Professions Commission report *Recreating Health Professional Practice for a New Century*. The full listing of the 21 characteristics for the 21st century are presented in Appendix II.

Practice Environments

New practice environments for dental hygienists are emerging and will continue to emerge as a result of legislative changes and health care reform initiatives which facilitate the public's access to dental hygiene services/programs and are compatible with provincial or territorial needs and regulations.

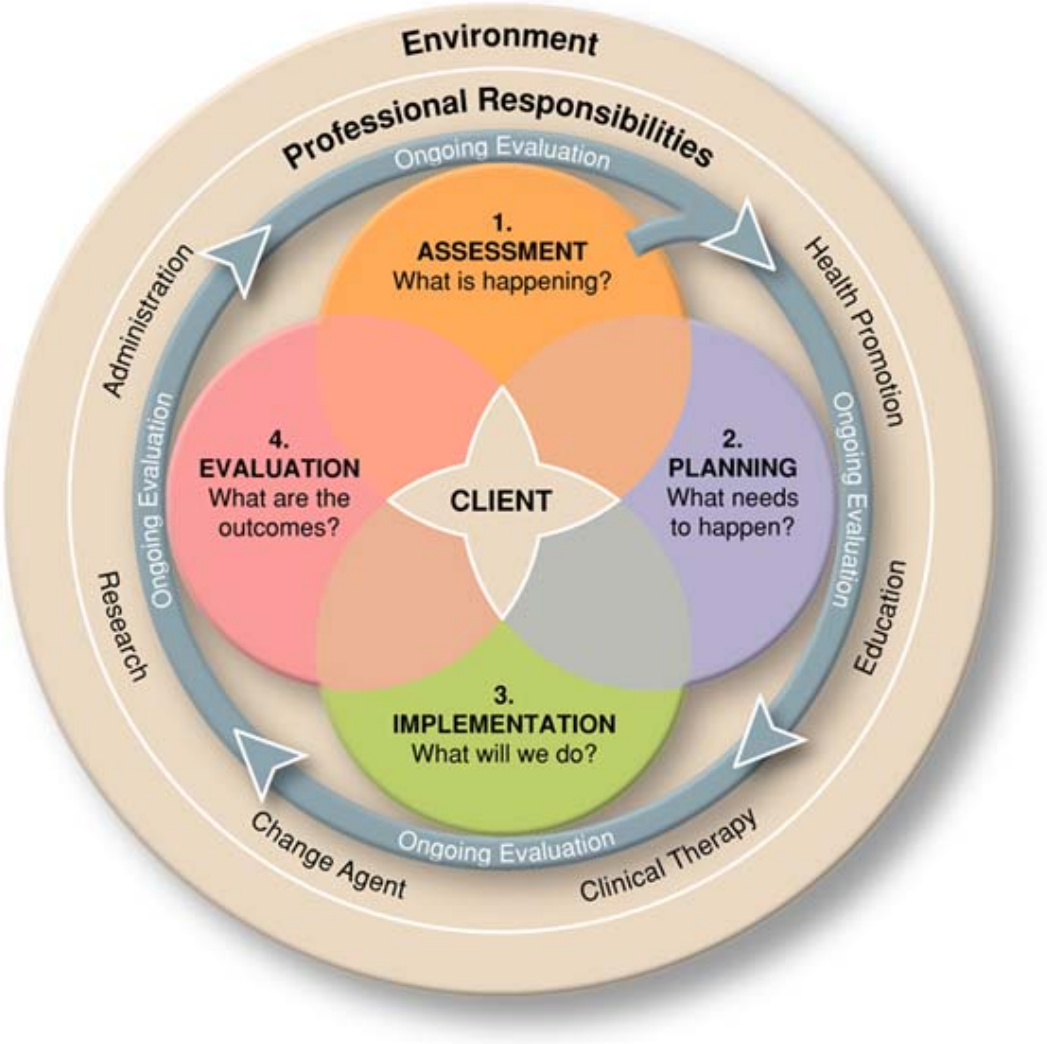
Practice environments include:

- Clinical practice
- Institutions (e.g., acute and long-term health care centres, correctional facilities)
- Public health, community health, homecare, and other outreach programs
- Primary health care centres
- Educational institutions (e.g., universities, community colleges)
- The military
- Research

- Industry (e.g., insurance and dental supply companies)
- Consulting firms
- Regulatory bodies and professional associations
- Government (e.g., policy and planning)
- Lobbyist
- Pet settings
- Forensics

Part II. Practice Standards

A Process Model to Guide Dental Hygiene Practice
This model conceptualizes dental hygiene practice as a systematic cyclical process rather than the performance of specific tasks.



DEFINITIONS
Assessment: Collection and interpretation of information to make a decision or dental hygiene diagnosis.
Planning: Development of mutual and informed goals and objectives, and selection of interventions.
Implementation: Activation of the plan.
Evaluation: Appraisal at all phases of the model and of the effectiveness of intervention outcomes.

Practice Standards

1. Professional Responsibilities

Dental hygienists are responsible and accountable for their dental hygiene practice and conduct. Dental hygienists:

1.1 Adhere to current jurisdictional legislation, regulations, codes of ethics, practice standards, guidelines and policies relevant to the profession and practice setting;
1.2 Seek and advocate for practice environments that have the organizational and human support systems as well as the resource allocations necessary for safe, competent and ethical dental hygiene practice;
1.3 Manage their dental hygiene practice within the practice setting;
1.4 Access and utilize current research-based knowledge through analyzing and interpreting the literature and other resources;
1.5 Question, and, if necessary, take action regarding policies and procedures inconsistent with desired client outcomes, evidence-based practices, and safety standards. Evidence-based decision-making is the systematic application of the best available evidence to the evaluation of options and decision making in clinical, management and policy settings.
1.6 Follow the dental hygiene process, demonstrating sound professional judgement and integrity;
1.7 Recognize client rights and the inherent dignity of the client by obtaining informed client consent, respecting privacy, and maintaining confidentiality;
1.8 Use a client-centred approach, always acting or advocating in the client's best interest;
1.9 Provide a safe environment which meets universal infection control and workplace health and safety requirements and protocols;
1.10 Respond to emergency situations;
1.11 Consult and collaborate with other colleagues, health professionals, and experts as necessary;
1.12 Maintain adequate documentation and records;
1.13 Know the technological and product options; select the best option for the situation;
1.14 Recognize, acknowledge, and ask for help with any personal, physical, or psychological condition that affects, or may affect, the ability to practice safely and effectively;
1.15 Maintain competence through lifelong learning.
1.16 Support the professional association through personal membership.

2. Dental Hygiene Process: Assessment

Assessment involves gathering information about the client. A wide range of methods may be used and will be determined by their appropriateness for each of the key responsibility areas. (*See* the Dental Hygiene Process Model: Assessment – *What is happening?)*

2.1 Locate, review and update previous information.
2.2 Collect baseline information using appropriate methodology;
2.3 Identify the client's determinants of health and risk factors. The determinants of health include: income and social status; social support networks; education; employment/working conditions; social environments; physical environments; personal health practices and coping skills; healthy child development; biology and genetic endowment; health services; gender; culture.
2.4 Identify the client's knowledge, attitudes, and skills;
2.5 Analyze all information to formulate a decision or dental hygiene diagnosis;
2.6 Record assessment findings and interpretations;
2.7 Maintain records and data in an information management system.

3. Dental Hygiene Process: Planning

Planning involves the mutual development of goals, objectives and the selection of interventions. (*See* the Dental Hygiene Process Model: Planning – *What needs to happen?)*

3.1 Facilitate the client's active participation in the development of the plan;
3.2 Discuss and coordinate client activities;
3.3 Identify resources needed;
3.4 Identify interventions;
3.5 Reach consensus regarding goals, objectives (desired outcomes) and interventions with clients' interests having priority;
3.6 Identify measurement tools to determine achievement of goals and objectives;
3.7 Identify quality improvement initiatives to be incorporated into the plan (a quality improvement initiative is a structured process that selectively identifies and improves aspects of care and service on an ongoing basis);
3.8 Apply critical thinking to the decision making process to ensure optimum client outcomes;
3.9 Make decisions that affect service to clients.

4. Dental Hygiene Process: Implementation

Implementation involves putting the plan into action. (*See* the Dental Hygiene Process Model: Implementation – *What will we do?)*

4.1 Review and confirm the dental hygiene plan;
4.2 Implement and monitor strategies to promote health and self-care;
4.3 Provide clinical or other services, consult, and refer as needed;
4.4 Provide dental hygiene expertise within an interprofessional team;
4.5 Implement the plan, making revisions as necessary;
4.6 Communicate with clients in an open, honest, clear and timely way;
4.7 Develop and promote policies supporting healthy lifestyles, environments, and communities.

5. Dental Hygiene Process: Evaluation

Evaluation involves the appraisal of intervention outcomes and the processes or activities used to achieve those outcomes. (*See* the Dental Hygiene Process Model: Evaluation – *What has happened?)*

5.1 Determine what outcomes have resulted including client satisfaction using a variety of data collection, analysis and communication techniques;
5.2 Analyze outcomes which may include the development and maintenance of practice profiles, databases or statistical profiles;
5.3 Discuss processes, outcomes, and satisfaction with the client;
5.4 Determine the need for revisions based on changing needs and new information using indices or other measurements;
5.5 Consult and refer as needed;
5.6 Identify further questions, care, or research requirements.

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Appendix I - Development and Validation Process for "Dental Hygiene: Definition, Scope and Practice Standards"

Late in 2001, the Canadian Dental Hygienists' Association established a Task Force to revise the 1995 document *"Dental Hygiene: Definition and Scope"*. Task Force members were dental hygienists from across Canada with experience in a wide variety of practice settings. Background profiles for Task Force members are available upon request to CDHA Central Office.

The members were:
Asadoorian, Joanna
Clift, Anne
Clovis, Joanne
Cobban, Sandy
Comeau, Anne
Cummins, Teresa
McAleese, Paula
Penner, Audrey
Valade, Louise
Walker, Brenda
Yakiwchuk, Carol-Ann

With Sheryl Feller as facilitator, the Task Force met in Ottawa in early February, 2002 and developed a new draft of the document. The goal was to develop a document of broad practice standards applying to all the key responsibility areas of dental hygiene with the addition of "change agent". Another goal was to create a document which was more "user friendly" than the 1995 document.

Task Force members identified dental hygiene experts and other individuals (to obtain a client perspective) to review the draft document and provide feedback. As well, the draft document was posted on the CDHA web site for member comment and input.

The Task Force met via teleconference in late February to discuss the feedback and make decisions regarding the format and content of the next draft. A revised draft was developed and sent to Task Force members for further input.

In early March, the draft was sent to CDHA board members. The board provided feedback to the Task Force after its March meeting and initiated another round of web site consultation and reviewer input. The final document was developed and published in June, 2002.

The 2002 process reflects the speed and efficiency which computer, Internet and other office technologies offer to a consultation and validation process. The 1995 document resulted after two years of consultation and the 1988 document reflected five years of work.

The process to develop the 1995 document included the following steps:
1993:

- a Task Force co-chaired by Bonnie Craig and Eleanor McIntyre met in Ottawa with Sheryl Feller as facilitator and developed an initial draft. The Task force developed standards that applied to education, administration, research and health promotion as well as clinical therapy. The group identified experts to provide input on the draft. Revisions were made using this expert feedback
- a workshop at the Niagara Falls Research Conference
- presentation to and discussion with the CDHA board and educators attending the conference

1994:

- further board input and review by other selected dental hygienists
- review and input at a workshop to consider education standards - this workshop was national with members of the public in attendance

1995:

- further revision based on dental hygiene expert input
- final review and recommendation for publication by the Professional Development Council.

More details of this process are presented in Appendix II of the 1995 document.

The first practice standards for dental hygienists (1988) were developed as a special project of the Working Group on the Practice of Dental Hygiene, an initiative of Health and Welfare Canada.

The project was directed by a Working Group committee - the Advisory Committee on the Development of Clinical Practice Standards for Dental Hygienists. Sheryl Feller was contracted by the Working Group as researcher. The steps of this project included:

- literature review and resulting articles
- workshop with dental hygiene practitioners to draft clinical practice standards (1985)
- revision by the Advisory Committee and Working Group
- survey (1986)of Canadian dental hygienists for content validation. Statistics Canada assisted with the sampling plan (stratified random sample) and questionnaire design.
- final revisions based on survey input and recommendations from the Advisory Committee, the Working Group and the Laboratory Centre for Disease Control.

More details about the process and methodologies to develop the 1988 clinical practice standards are presented in the Introduction of that document.

Appendix II - Twenty-one Characteristics of Health Professionals for the 21st Century

In a 1998 report titled *Recreating Health Professional Practice for A New Century*, the Pew Health Professions Commission identifies 21 characteristics of health professionals for the 21st century.

As presented in the Pew report, these characteristics are:

1. *Embrace a personal ethic of social responsibility and service*
2. *Exhibit ethical behaviour in all professional activities*
3. *Provide evidence-based, clinically competent care*
4. *Incorporate the multiple determinants of health in clinical care*
5. *Apply knowledge of the new sciences*
6. *Demonstrate critical thinking, reflection, and problem-solving skills*
7. *Understand the role of primary care*
8. *Rigorously practise preventive health care*
9. *Integrate population-based care and services into practice*
10. *Improve access to health care for those with unmet health needs*
11. *Practise relationship-centred care with individuals and families*
12. *Provide culturally sensitive care to a diverse society*
13. *Partner with communities in health care decisions*
14. *Use communication and information technology effectively and appropriately*
15. *Work in interprofessional teams*
16. *Ensure care that balances individual, professional, system, and societal needs*
17. *Practise leadership*
18. *Take responsibility for quality of care and health outcomes at all levels*
19. *Contribute to continuous improvement of the health care system*
20. *Advocate for public policy that promotes and protects the health of the public*
21. *Continue to learn and help others learn*