DENTAL HYGIENE: DEFINITION, SCOPE, and PRACTICE STANDARDS
CDHA is dedicated to contributing to the health and well-being of Canadians by advancing the profession of dental hygiene and supporting our members.
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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; and 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 (<www.cdha.ca>) 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
- Educational tools for clients, including a Dental Hygiene Challenge Quiz, and a Dental Hygiene Client’s Bill of Rights (<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, the American Dental Hygienists’ Association, the International Federation of Dental Hygienists, Health Action Lobby, the Canadian Public Health Association, and the Commission on Dental Accreditation of Canada
• CDHA toll-free 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 and the National Dental Hygiene Certification Board
- Government
- Accreditation bodies (educational, hospital, or other)
- Dental hygiene and other professional associations
- Dental industry
- Multi-disciplinary bodies or associations
- 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.
Key Responsibility Areas
The key responsibilities of dental hygienists are the following:

- **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.
- **Research**: Strategies for systematic inquiry and reporting that supplement, revise, and validate dental hygiene practice and that may contribute to the knowledge base of other disciplines.
- **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.
- **Administration**: Management processes and policy and protocol development.

The key responsibilities occur in varying degrees, depending on 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,
- 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 competencies described in the Pew Health Professions Commission report, *Recreating Health Professional Practice for a New Century*. The full list of the 21 competencies for the twenty-first century is 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 that 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 and 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)
- Forensic laboratories

All practice environments should support quality dental hygiene practice consistent with the CDHA standards of practice.
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 jurisdictionary 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 dental hygiene process, demonstrating sound professional judgment 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 that 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 documentation and records consistent with regulatory requirements;

1.13 Know the technological and product options; select the best option for the situation, depending on client need;

1.14 Recognize, acknowledge, and ask for help with any personal, physical, or psychological condition that affects, or may affect, the ability to practise 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.

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 a secure information management system.

3. Dental Hygiene Process: Planning

Planning involves the mutual development of goals, objectives, and the selection of interventions.

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 and dental hygiene interventions depending on client need.
3.4 Reach consensus regarding goals, objectives (desired outcomes), and interventions, with clients’ interests having priority.
3.5 Identify measurement tools to determine achievement of goals and objectives.
3.6 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).
3.7 Apply critical thinking to the decision-making process and make choices to ensure optimum client outcomes.
4. Dental Hygiene Process: Implementation

Implementation involves putting the plan into action.

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 a multi-disciplinary 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.

5.1 Evaluate dental hygiene outcomes including client satisfaction using a variety of data collection, analysis, and communication techniques.
5.2 Analyze outcomes to include, if appropriate, 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 with, and refer to, other professionals as needed.
5.6 Identify further questions, care, or research requirements.
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Suggested Reading


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. The members of the Task Force were the following:

Asadoorian, Joanna, BScD: education, clinical practice, research
Clift, Anne, DipDH: hospital clinical practice, policy development, children’s oral health
Clovis, Joanne, PhD: research, education, consulting, public health, and clinical practice
Cobban, Sandy, MDE, DipDH: education, health policy, public health and research
Comeau, Anne, DipDH: public health and clinical practice
Cummins, Teresa, DipDH, SDT: clinical practice, long-term care
McAleese, Paula, DipDH: clinical practice in a free-standing dental hygiene clinic and long-term care homes
Penner, Audrey, BSc, MEd, DipDH: education, public health, and research
Valade, Louise, DipDH: education and clinical practice
Walker, Brenda, DipDH: Registrar and Chief Administrative Officer, Alberta Dental Hygienists’ Association; member of National Dental Hygiene Certification Board
Yakiwchuk, Carol-Ann, DipDH: education, community health, long-term care

With Sheryl Feller (FCMC, MBA, BA, RDH) 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 that 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 that the use of computer, Internet, and other office technologies offers to a consultation and validation process. The 1995 document was produced after two years of consultation; the 1988 document reflected five years of work.

1995 DOCUMENT, DENTAL HYGIENE: DEFINITION AND SCOPE

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 was held at the Niagara Falls Research Conference.
- There was a presentation to and discussion with the CDHA board and educators attending the conference.

1994 - There was further board input and review by other selected dental hygienists.

- There was review and input at a workshop to consider education standards. This was a national workshop with members of the public in attendance.

1995 - Further revision was carried out, based on dental hygiene expert input.

- Final review was carried out and the Professional Development Council of the CDHA Board of Directors recommended publication of the document.

More details of this process are presented in Appendix II of the 1995 document.
1988 PRACTICE STANDARDS

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, the Advisory Committee on the Development of Clinical Practice Standards for Dental Hygienists. Sheryl Feller was contracted by the Working Group to work 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 Competencies of Health Professionals for the Twenty-First Century


These competencies are the following:

1. Embrace a personal ethic of social responsibility and service
2. Exhibit ethical behavior 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 practice 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. Practice relationship-centered 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 interdisciplinary teams
16. Ensure care that balances individual, professional, system and societal needs
17. Practice 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