This document outlines the Standards of Care for the UAMS Dental Hygiene Clinic. The origin of these standards is the American Dental Hygienists’ Association’s *Standards for Clinical Dental Hygiene Practice* (March 2008) and have been reviewed and adopted by the faculty in the Department of Dental Hygiene. The faculty assesses the degree to which these standards are met by students in the dental hygiene clinic through clinical competency examinations and faculty observation. The department’s quality assurance (QA) program also monitors these standards to ensure compliance. The patient care standards and the QA program are reviewed for currency and accuracy throughout the academic year and in detail at the summer clinical meeting and curriculum retreat.

Consistent with the University’s mission of educating practitioners capable of meeting the health care needs of the communities they serve, the Department of Dental Hygiene is committed to providing services and patient care to the community we serve. Our goals are: 1) to provide our patients with quality care, 2) to deliver that care in a timely and compassionate manner, 3) to use evidence-based decision making to provide current and effective treatment and patient education; and 4) to provide our students with a diverse and meaningful educational experience. To facilitate accomplishment of these goals, the following Standards of Care have been adopted:

**Standard 1: Assessment**

I. Patient History
   a. Record personal profile information such as demographics, values and beliefs, cultural influences, knowledge, skills, and attitudes
   b. Record current and past dental and dental hygiene oral health practices
   c. Collection of health history data includes the patient’s:

II. Performs a comprehensive clinical evaluation which includes:
   a. A thorough examination of the head and neck and oral cavity including an oral cancer screening, evaluation of trauma, and a tempromandibular joint (TMJ) assessment.
   b. Evaluation for further diagnostics including radiographs.
   c. A comprehensive periodontal evaluation that includes the documentation of:
      1. Full mouth periodontal charting:
         - Probing depths
         - Bleeding points
         - Suppuration
         - Mucogingival involvement/defects
- Recession
- Attachment levels/attachment loss

2. Presence, degree, and distribution of plaque and calculus
3. Gingival health/disease
4. Bone height/bone loss
5. Mobility and fremitus
6. Presence, location, and extent of furcation involvement

d. A comprehensive hard tissue evaluation that includes the charting of existing conditions and oral habits.
   1. demineralization
   2. caries
   3. defects
   4. sealants
   5. existing restorations and potential needs
   6. anomalies
   7. occlusion
   8. fixed and removable prostheses
   9. missing teeth

III. Risk Assessments such as:
   a. Fluoride exposure
   b. Tobacco exposure including smoking, smokeless/spit tobacco and second hand smoke
   c. Nutrition history and dietary practices
   d. Systemic diseases/conditions (e.g. diabetes, cardiovascular disease, autoimmune, etc.)
   e. Prescriptions and over-the-counter medications, and complementary therapies and practices (e.g. fluoride, herbal, vitamins and other supplements, daily aspirin)
   f. Salivary function and xerostomia
   g. Age and gender
   h. Genetics and family history
   i. Habitual and lifestyle behaviors
      Cultural issues
      Substance abuse (recreational drugs, alcohol)
      Eating disorders
      Piercing and body modification
      Oral habits (citrus, toothpicks, lip/cheek biting)
      Sports and recreations
   j. Physical disability
   k. Psychological and social considerations
      Domestic violence
      Physical, emotional, or sexual abuse
      Behavioral
Psychiatric
Special needs
Literacy
Economic
Stress
Neglect

Standard 2: Dental Hygiene Diagnosis
I. Analyze and interpret all assessment data to evaluate clinical findings and formulate the dental hygiene diagnosis.

II. Determine patient needs that can be improved through the delivery of dental hygiene care.

III. Incorporate the dental hygiene diagnosis into the overall dental treatment plan.

Standard 3: Planning
I. Identify, prioritize and sequence dental hygiene intervention (e.g. education, treatment, and referral)

II. Coordinate resources to facilitate comprehensive quality care (e.g. current technologies, pain management, adequate personnel, appropriate appointment sequencing and time management)

III. Collaborate with the dentist and other health/dental care providers and community-based oral health programs.

IV. Present and document dental hygiene care plan to patient.

V. Explain treatment rationale, risks, benefits, anticipated outcomes, treatment alternatives, and prognosis.

VI. Obtain and document informed consent and/or informed refusal.

Standard 4: Implementation
I. Review and implement the dental hygiene care plan with the patient/caregiver.

II. Modify the plan as necessary and obtain consent.

III. Communicate with the patient/caregiver appropriate for age, language, culture, and learning style.

IV. Confirm the plan for continuing care.

Standard 5: Evaluation
I. Use measurable assessment criteria to evaluate the outcomes of dental hygiene care (e.g. probing, plaque control, bleeding points, retention of sealants, etc.)
II. Communicate to the patient, dentist, and other health/dental care providers the outcomes of dental hygiene care.

III. Collaborate to determine the need for additional diagnostics, treatment, referral, education and continuing care based on treatment outcomes and self-care behaviors.

Standard 6: Documentation

I. Document all components of the dental hygiene process of care (assessment, dental hygiene diagnosis, planning, implementation, and evaluation).

II. Objectively records all information and interactions between the patient and the practice (i.e. telephone calls, emergencies, prescriptions).

III. Records legible, concise and accurate information (i.e. dates and signatures, clinical information that subsequent providers can understand, ensure all components of the patient record are accurately labeled).

IV. Recognizes ethical and legal responsibilities of record keeping including guidelines outlined in state regulations and statutes.

V. Ensures compliance with the federal Health Information Portability and Accountability Act (HIPAA).

VI. Respects and protects the confidentiality of patient information.