

# STANDARDS FOR CLINICAL DENTAL HYGIENE PRACTICE



American  
Dental  
Hygienists'  
Association

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# TABLE OF CONTENTS

Introduction .....	3
Definition of Dental Hygiene Practice .....	4
Educational Preparation .....	5
Practice Setting .....	5
Professional Responsibilities and Considerations.....	5
Dental Hygiene Process of Care .....	6
Standards of Practice.....	6
Standard 1: Assessment.....	6
Standard 2: Dental Hygiene Diagnosis.....	8
Standard 3: Planning .....	8
Standard 4: Implementation.....	8
Standard 5: Evaluation.....	9
Standard 6: Documentation .....	9
Summary .....	9
Key Terms.....	10
References.....	11
Resources .....	12
Appendix A .....	13
Appendix B.....	14
Appendix C .....	14
Appendix D.....	15

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## Document History

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### Item

Standards for Clinical Dental Hygiene Practice

### Action

Adopted by ADHA BOT

## Introduction

One hallmark of a true profession is its willingness to assume responsibility for the quality of care that its members provide. In 1985, the ADHA took a major step toward fulfillment of that responsibility with the development of *Applied Standards of Clinical Dental Hygiene Practice*.<sup>1</sup> This document builds on those Standards and promotes dental hygiene practice based on current and relevant scientific evidence.

The *Standards for Clinical Dental Hygiene Practice* outlined in this document guide the individual dental hygienist's practice, whereas the *Accreditation Standards for Dental Hygiene Education Programs*<sup>2</sup> are chiefly concerned with the structure and conduct of dental hygiene education programs. Dental hygienists remain individually accountable to the standards set by the discipline and by applicable federal, state and local statutes and regulations that define and guide professional practice.<sup>3,4</sup> These *Standards* should not be considered as a substitute for professional clinical judgment.

In the context of an evolving healthcare system for the 21st century, dental hygienists are valued members of the healthcare workforce. Dental hygienists have the knowledge, skills and professional responsibility to provide oral health promotion and health protection strategies for individuals as well as groups. These updated *Standards* for clinical dental hygiene practice outline the expectations of the professional role within which dental hygienists should practice. These *Standards* promote the knowledge, attitudes, beliefs, practices and behaviors that support and enhance oral health with the ultimate goal of improving overall health.

The primary purpose of the *Standards for Clinical Dental Hygiene Practice* is to assist dental hygiene clinicians in the provider-patient relationship. In addition, dental hygienists employed in other professional roles such as educator, researcher, advocate, and administrator/manager can use these *Standards* to facilitate the implementation of collaborative, patient-centered care in multidisciplinary teams of health professionals. This collaboration can occur in a variety of practice settings including community and public

health centers, hospitals, school based programs, long term care facilities, outreach and home care programs. The secondary purpose of these *Standards* is to educate other healthcare providers, policy makers, and the public about the clinical practice of dental hygiene.

The purpose of medical and dental science is to enhance the health of individuals as well as populations. Dental hygienists use scientific evidence in the oral healthcare decision making process impacting their patient care. The dental hygienist is expected to respect the diverse values, beliefs and cultures present in individuals and groups or communities served. In working with patients, dental hygienists must support the right of the individual to have access to the necessary information and provide opportunities for dialogue to allow the individual patient to make informed care decisions without coercion. Facilitating effective communication may require an interpreter and/or translator based on the patient and practitioner's need to communicate. Dental hygienists must realize and establish their professional privileges in accordance with the rights of individuals and groups. In addition, when participating in activities where decisions are made that have an impact on health, dental hygienists are obligated to assure that ethical and legal issues are addressed as part of the decision-making process. Dental hygienists are bound by the ethical provisions of the American Dental Hygienists' Association.<sup>3</sup>

The *Standards for Clinical Dental Hygiene Practice* provide a framework for clinical practice that focuses on the provision of patient-centered comprehensive care. The *Standards* describe a competent level of dental hygiene care<sup>2, 5-7</sup> as demonstrated by the critical thinking model known as the process of care. As noted in various dental hygiene textbooks,<sup>6,7</sup> the five components of the dental hygiene process of care include assessment, dental hygiene diagnosis, planning, implementation, and evaluation. The dental hygiene process encompasses all significant actions taken by dental hygienists, and forms the foundation of clinical decision-making. This document expands the process to include a sixth component, documentation (Appendix A).

## Definition of Dental Hygiene Practice

Dental hygiene is the science and practice of the recognition, treatment, and prevention of oral diseases.<sup>6</sup> The dental hygienist is a preventive oral health professional who has graduated from an accredited dental hygiene program in an institution of higher education, licensed in dental hygiene who provides educational, clinical, research, administrative, and therapeutic services supporting total health through the promotion of optimal oral health.<sup>7</sup> In practice, dental hygienists integrate the roles of clinician, educator, advocate, manager, and researcher to prevent oral diseases and promote health (Appendix B).

Dental hygienists work in partnership with dentists. Dentists and dental hygienists practice together as colleagues, each offering professional expertise for the goal of providing optimum oral healthcare to the public. The distinct roles of the dental hygienist and dentist complement and augment the effectiveness of each professional and contributes to a co-therapist environment. Dental hygienists are viewed as experts in their field, are consulted about appropriate dental hygiene interventions, are expected to make clinical dental hygiene decisions, and are expected to plan, implement, and evaluate the dental hygiene component of the overall care plan.<sup>8</sup> The dental hygienist establishes the dental hygiene diagnosis which is an integral component of the comprehensive dental diagnosis established by the dentist.

Each state has defined its own specific regulations for dental hygiene licensure. Depending on the state regulations, dental hygienists:

- perform oral healthcare and risk assessments that include the review of patients' health history, taking and recording blood pressure, dental and periodontal charting, oral cancer screening and evaluation of oral disease/health;



- evaluating a patient's current health status including all medications;
- perform an extraoral and intraoral examination and oral cancer screening;
- complete a comprehensive dental and periodontal charting that includes a detailed description and evaluation of the gingiva and periodontium;
- develop a dental hygiene diagnosis<sup>2, 5-10</sup> (as a component of the dental diagnosis) based on the oral health findings;
- expose, process, and interpret dental radiographs (x-rays);
- remove biofilm plaque and calculus (soft and hard deposits) from teeth both coronal and apical to (above and below) the gingival margin (gumline) using dental instruments;
- apply caries-preventive agents such as fluorides and sealants to the teeth;
- discuss the progress being made toward isolating evidence that notes the potential association between systemic and oral health and disease;
- administer local controlled and sustained release antimicrobial agents;
- administer pain control agents such as local anesthetic and /or nitrous oxide analgesia;
- provide patient education on biofilm plaque control and home care protocol by incorporating techniques and products that will become part of an individualized self-care oral hygiene program;
- counsel and coordinate tobacco cessation programs; and
- educate patients on the importance of good nutrition for maintaining optimal oral health.<sup>11</sup>

## Educational Preparation

The registered dental hygienist (RDH) or licensed dental hygienist (LDH) is educationally prepared for practice upon graduation from an accredited dental hygiene program (certificate, associate, or baccalaureate) within an institution of higher education and qualified by successful completion of a national written board examination and state or regional clinical examination for licensure. In 1986, the ADHA declared its intent to establish the baccalaureate degree as the minimum entry level for dental hygiene practice (Appendix C).<sup>11,12</sup>

## Practice Setting

Dental hygienists can apply their professional knowledge and skills in a variety of public and private work settings as clinicians, educators, researchers, administrators, managers, health advocates, and consultants. Clinical dental hygienists may be employed in a variety of healthcare settings including private dental offices, schools, public health clinics, hospitals, managed care organizations, correctional institutions, or nursing homes.<sup>6,7</sup>



## Professional Responsibilities and Considerations

Dental hygienists are responsible and accountable for their dental hygiene practice, conduct, and decision making. Throughout their professional career in any practice setting a dental hygienist is expected to:

- Understand and adhere to the ADHA Code of Ethics.
- Maintain a current license to practice including certifications as appropriate.
- Demonstrate respect for the knowledge, expertise and contributions of dentists, dental hygienists, dental assistants, dental office staff, and other healthcare professionals.
- Articulate the roles and responsibilities of the dental hygienist to the patient, interdisciplinary team members, referring providers, and others.
- Apply problem-solving processes in decision-making and evaluate these processes.
- Demonstrate a professional image and demeanor.
- Maintain compliance with established infection control standards following the most current guidelines to reduce the risks of healthcare-associated infections in patients, and illnesses and injuries in healthcare personnel.
- Recognize diversity. Incorporate cultural and religious sensitivity in all professional interactions.
- Access and utilize current, valid, and reliable evidence in clinical decision making through analyzing and interpreting the literature and other resources.
- Maintain awareness of changing trends in dental hygiene, health and society that impact dental hygiene care.
- Support the dental hygiene profession through ADHA membership.
- Interact with peers and colleagues to create an environment that supports collegiality and teamwork.
- Take action to prevent situations where patient safety and well-being could potentially be compromised.
- Contribute to a safe, supportive and professional work environment.
- Participate in activities to enhance and maintain continued competence, address professional issues as determined by appropriate self-assessment.
- Commit to lifelong learning to maintain competence in an evolving healthcare system.



## Dental Hygiene Process of Care

The purpose of the dental hygiene process of care is to provide a framework where the individualized needs of the patient can be met; and to identify the causative or influencing factors of a condition that can be reduced, eliminated, or prevented by the dental hygienist.<sup>6,7</sup>

There are five components to the dental hygiene process of care (assessment, dental hygiene diagnosis, planning, implementation and evaluation). This document expands the process to include a sixth component, documentation (Appendix A).

The dental hygiene diagnosis is a key component of the process and involves assessment of the data collected, consultation with the dentist and other healthcare providers, and informed decision making. The dental hygiene diagnosis and care plan are incorporated into the comprehensive plan that includes restorative, cosmetic, and oral health needs that the patient values. The dental hygienist is a licensed professional who is responsible for making informed, evidence-based decisions and is accountable for his/her actions.<sup>8</sup> All components of the process of care are interrelated and depend upon ongoing assessments and evaluation of treatment outcomes to determine the need for change in the care plan. These *Standards* follow the dental hygiene process of care to provide a structure for clinical practice that focuses on the provision of patient-centered comprehensive care.

## STANDARDS OF PRACTICE

### Standard 1: Assessment

Assessment is the systematic collection, analysis and documentation of the oral and general health status and patient needs. The dental hygienist conducts a thorough, individualized assessment of the person with or at risk for oral disease or complications. The assessment process requires ongoing collection and interpretation of relevant data. A variety of methods may be used including radiographs, diagnostic tools, and instruments.

#### 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:
  1. current and past health status
  2. diversity and cultural considerations (e.g. age, gender, religion, race and ethnicity)
  3. pharmacologic considerations (e.g. prescription, recreational, over the counter (OTC), herbal)
  4. additional considerations (e.g. mental health, learning disabilities, phobias, economic status)
  5. record vital signs and compare with previous readings
  6. consultation with appropriate healthcare provider(s) as indicated.

## II. Perform 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 temporomandibular 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 relationships/defects
    - Recession
    - Attachment level/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 Assessment:

Risk assessment is a qualitative and quantitative evaluation gathered from the assessment process to identify any risks to general and oral health. The data provides the clinician with the information to develop and design strategies for preventing or limiting disease and promoting health.

Examples of factors that should be evaluated to determine the level of risk (high, moderate, low):

- 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, vitamin 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 recreation
- 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**

The dental hygiene diagnosis is a component of the overall dental diagnosis. The dental hygiene diagnosis is the identification of an existing or potential oral health problem that a dental hygienist is educationally qualified and licensed to treat.<sup>2, 5-10,13-15</sup> The dental hygiene diagnosis requires analysis of all available assessment data and the use of critical decision making skills in order to reach conclusions about the patients dental hygiene treatment needs.<sup>5-7,15</sup>

- 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**

Planning is the establishment of goals and outcomes based on patient needs, expectations, values, and current scientific evidence. The dental hygiene plan of care is based on assessment findings and the dental hygiene diagnosis. The dental hygiene treatment plan is integrated into the overall dental treatment plan. Dental hygienists make clinical decisions within the context of ethical and legal principles.

- 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**

Implementation is the delivery of dental hygiene services based on the dental hygiene care plan in a manner minimizing risk and optimizing oral health.

- 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 patient/caregiver appropriate for age, language, culture and learning style.
- IV. Confirm the plan for continuing care.



## Standard 5: Evaluation

Evaluation is the process of reviewing and documenting the outcomes of dental hygiene care. Evaluation occurs throughout the process of care.

- 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

Documentation is the complete and accurate recording of all collected data, treatment planned and provided, recommendations, and other information relevant to patient care and treatment.

- I. Documents 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.

## SUMMARY

The *Standards for Clinical Dental Hygiene Practice* is a resource for dental hygiene practitioners seeking to provide patient-centered and evidence-based care. In addition dental hygienists are encouraged to enhance their knowledge and skill base to maintain continued competence. It is expected these *Standards* will be modified based on emerging scientific evidence, federal and state regulations, and changing disease patterns as well as other factors to assure quality care and safety.

## KEY TERMS

**Cultural and religious sensitivity:** the ability to adjust one's perceptions, behaviors, and practice styles to effectively meet the needs of different ethnic, racial or religious groups.<sup>16</sup>

**Dental Hygiene Care Plan:** an organized presentation or list of interventions to promote the health or prevent disease of the patient's/client's oral condition; plan is designed by dental hygienist and consists of services that the dental hygienist is educated and licensed to provide.<sup>5</sup>

**Evidence-based Care:** the integration of best research evidence with clinical expertise and patient values.<sup>17</sup>

**Intervention:** dental hygiene services rendered to clients as identified in the dental hygiene care plan. These services may be clinical, educational, or health promotion related.

**Multidisciplinary teams:** a group of healthcare professionals and their client who work together to achieve shared goals. The team can consist of the dental hygienist, dentists, physician, nutritionist, smoking cessation counselor, nurse practitioner, etc.

**Outcome:** result derived from a specific intervention or treatment.

**Patient:** refers to the potential or actual recipients of dental hygiene care, and includes persons, families, groups and communities of all ages, genders, socio-cultural and economic states.

**Patient-Centered:** approaching services from the perspective that the client is the main focus of attention, interest, and activity; the client's values, beliefs, and needs are of utmost importance in providing care.

**Risk:** a characteristic, behavior, or exposure that is associated with a particular disease, i.e. smoking, diabetes, or poor oral hygiene.

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American Academy of Pediatric Dentistry:  
<http://www.aapd.org/>.

American Academy of Periodontology:  
<http://perio.org/>.

American Dental Association: <http://www.ada.org/>.

American Diabetes Association:  
<http://www.diabetes.org/>.

American Heart Association:  
<http://www.americanheart.org/>.

Association of State and Territorial Dental Directors:  
<http://www.astdd.org/>.

Canadian Dental Hygienists' Association:  
[www.cdha.org](http://www.cdha.org).

Centers for Disease Control and Prevention (caries, mineralization strategies, and health protection goals):

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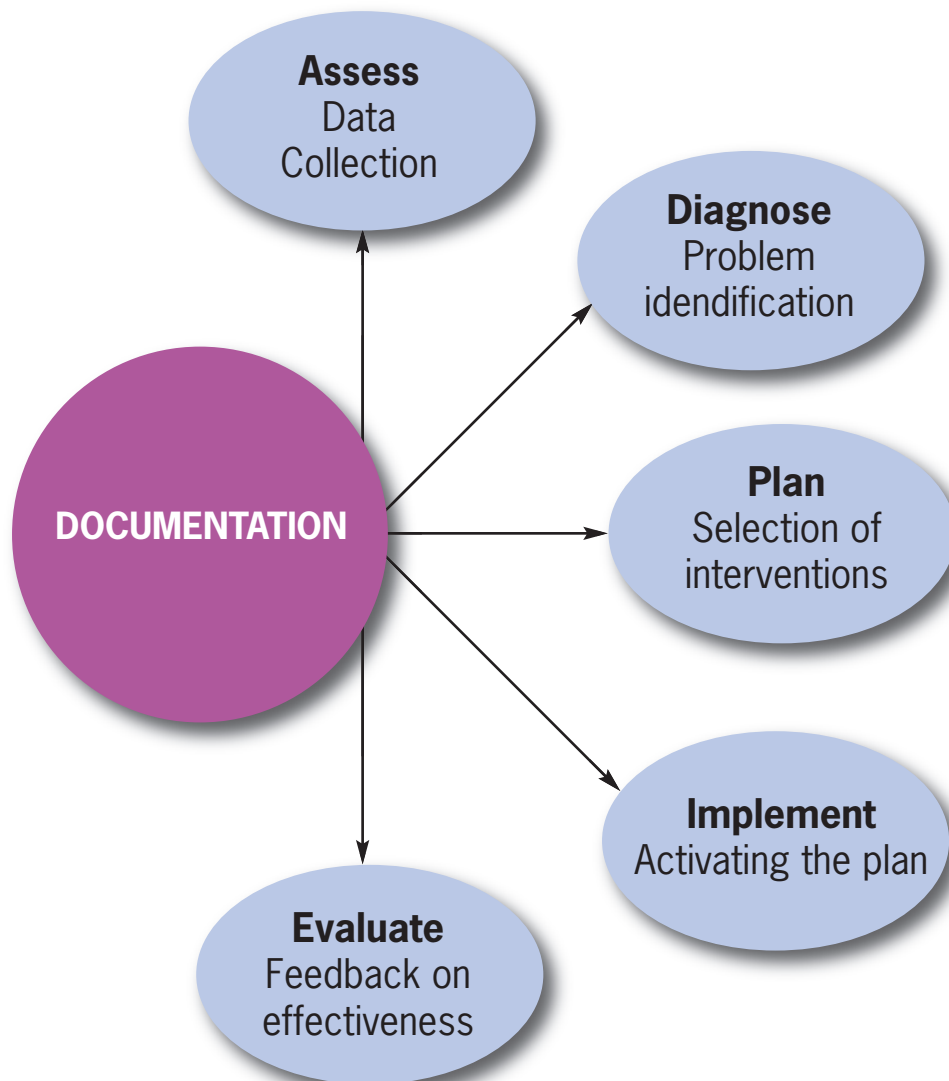
Special Care Dentistry:

<http://www.scdonline.org/>.

## Appendix A

### Dental Hygiene Process of Care

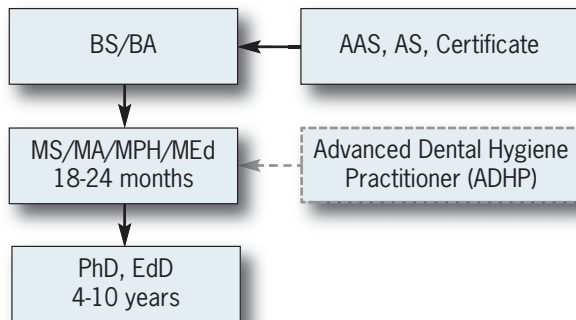
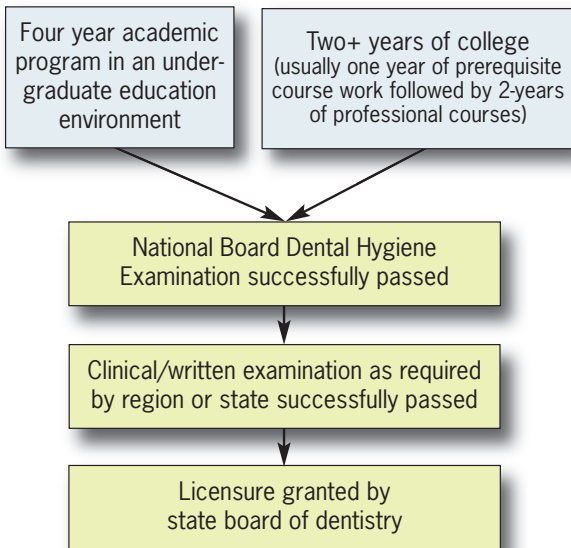
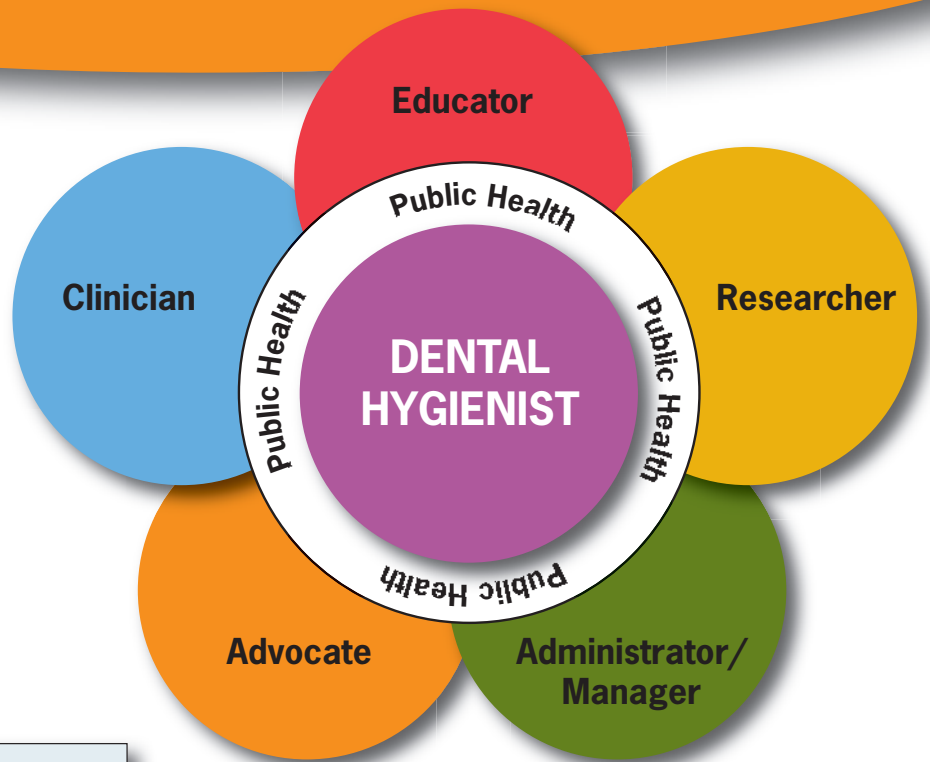
There are six components to the dental hygiene process of care. These include assessment, dental hygiene diagnosis, planning, implementation, evaluation, and documentation. The six components provide a framework for patient care activities.



Adapted from: Wilkins, E.M. (9th ed). (2005). *Clinical Practice of the Dental Hygienist*. Philadelphia, PA: Lippincott Williams & Wilkins: p. 6.

**Appendix B**

**Professional Roles of the Dental Hygienist**



**Appendix C**

**Educational Path for Entry into the Profession**

Dental hygienists must complete an accredited educational program to qualify for licensure in a particular state or region. Dental hygienists are licensed with the credential of Registered Dental Hygienist (RDH) or Licensed Dental Hygienist (LDH) following completion of an academic program that includes didactic and clinical requirements.

**Professional Specialization**

Dental hygienists can further their academic credentials after earning a certificate, associate, and/or baccalaureate degree. A dental hygienist can continue their educational advancement by enrolling in a variety of Master level programs which provides eligibility for a Doctoral level degree.

## Appendix D

### Development and Validation Process for the Standards for Clinical Dental Hygiene Practice

In 2003, the ADHA Board of Trustees approved the establishment of a task force to define and develop standards of clinical dental hygiene practice. The previous standards of practice document created by ADHA was published in 1985 and was no longer being distributed due to the significant changes in dental hygiene practice; therefore the association did not have a document accurately reflecting the nature of clinical dental hygiene practice. A series of task force meetings occurred by phone, electronically and in-person from 2004-2008 in order to create and revise the draft standards document.

As part of the validation process, in November 2005, a survey was distributed to all ADHA council members, 50 participants in the ADHA Constituent Officers Workshop, and a 50-member random selection of the ADHA membership to provide feedback regarding the draft *Standards of Practice* that had been created by the task force. The data collected from these audiences was collated, analyzed and reviewed by the task force in making subsequent modifications.

During the 2006 ADHA Annual Session, the chair of the task force presented the draft *Standards* document to the membership, responded to questions, and requested written and verbal feedback regarding the direction of the document. The *Standards* were also posted on the ADHA website prior to the annual meeting and for a period following in order to solicit feedback from the membership and other communities of interest. In the fall of 2006, the task force met and considered the comments from all respondents and made additional revisions to the document. The task force also reviewed clinical standards of practice documents from other professions as a point of comparison.

In 2007, the revised *Standards* were shared during the ADHA Annual Session with the draft document posted online and open for comments from the communities of interest. Following the annual meeting, the draft document was also broadly distributed to the broad communities of interest, which included a pool of approximately 200 organizations.

Following the collection of feedback from all interested parties, the task force considered all feedback and met by conference call in order to finalize the document. The final document was submitted to the ADHA Board of Trustees in March 2008 for their consideration and adoption.

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