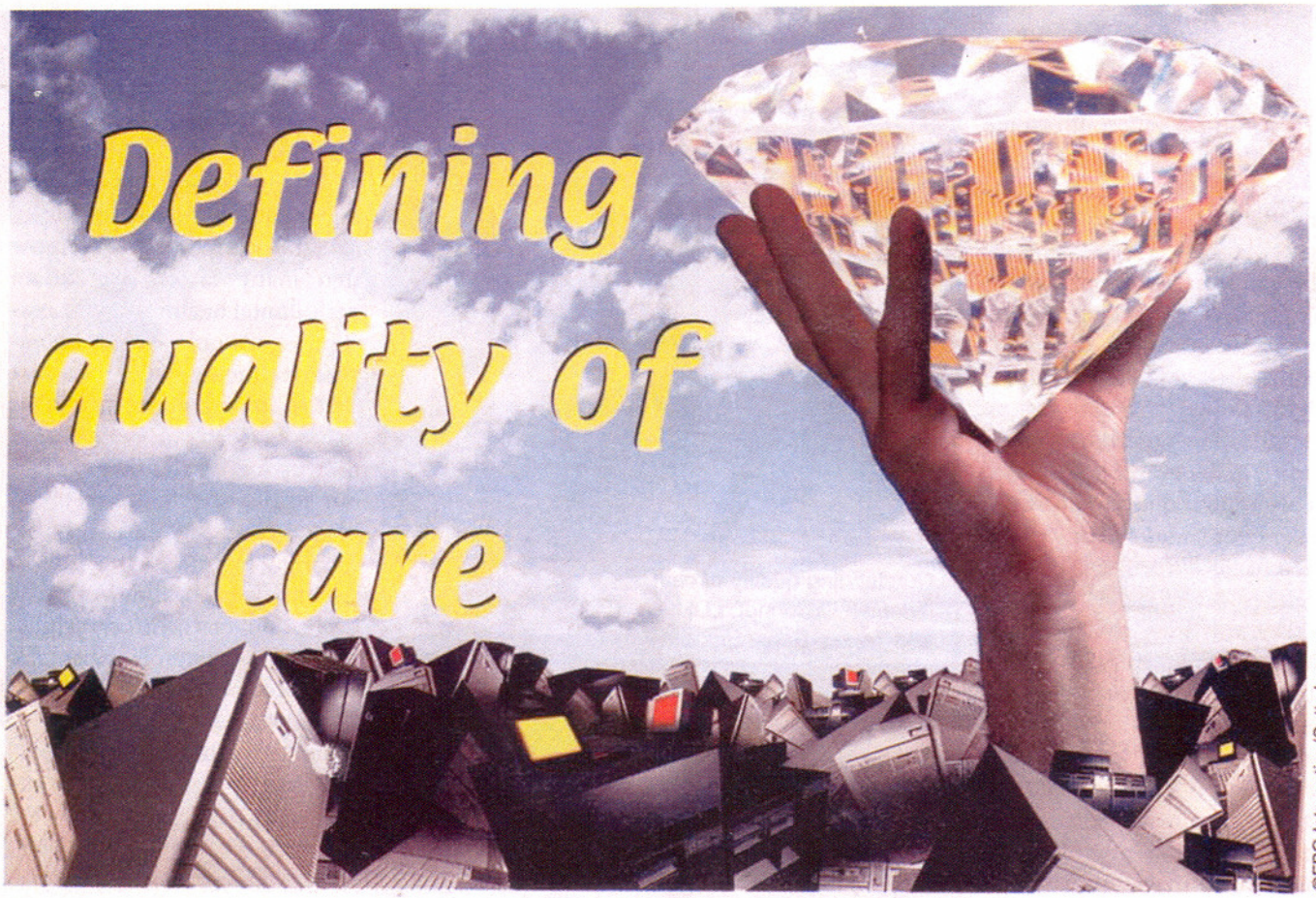
Defining quality of care



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Achieving the highest level of quality of care is like finding a D-flawless diamond — both represent the very best and both stand out above the rest!

by Teresa Barjenbruch, RDH; Lisa O'Connor, RDH; and David P. Reichwage, DDS

Quality of care. The definition of this phrase has greatly evolved in the past five years in all aspects of clinical treatment. What was once considered the standard of care now has become inadequate to meet our current definition of quality care.

In our practice, the wide range of definitions for "quality of care" always amazes us. How our established patients perceive their care — and the perception new patients have when comparing our practice to other practices where they have been patients — can vary significantly.

Our entire team took part in the development of our hygiene program as part of a total practice approach to patient care. Through ongoing continuing education, we actively treat disease, participate in treatment decisions and planning, and deliver a standard of care that makes our patients healthier and makes us proud of the dentistry we provide.

We believe it is important to share our hygiene philosophy with other practices so that others know there is a different — and, we believe, — a better way to provide dental-hygiene care. We want hygienists to experience the same enthusiasm and satisfaction from hygiene that we experience by practicing this philosophy.

Throughcontinuing education for our entire team over the last four years, we have utilized the research and technological advances in dental science to create more opportunities to deliver clinical modalities for improved periodontal health. The science and technology now available means we have a responsibility to deliver higher standards of care than ever before.

So what forms the standard of care for our patients? Our hygiene philosophy is simple: *optimal tissue health whenever possible*. This means that the tissue is pink and stippled with probing depths of 1-3mm and eight or fewer bleeding points. We believe it is our mandate from the American Dental Association to diagnose, inform, educate, and treat patients to assist them in reaching and maintaining this goal.

We treat patients with a wide range of techniques that are specifically designed for their individual needs. These include comprehensive periodontal charting utilizing six-point references, oral-cancer screening, occlusal and anterior guidance analysis, recording of bleeding on scaling and probing, recession, charting existing restorations, and taking the patient on an intraoral camera tour to facilitate co-diagnosis.

We utilize microultrasonic scalers for debridement to bridge the gap between gross and fine scaling. The thin tips available for these instruments allow easy access into the deepest pockets, as well as a thorough debridement. We have found that clinicians who are highly skilled with curettes can transfer their expertise to ultrasonic scalers and effectively debride periodontal pockets in less time and with added patient comfort. We use Dentsply's DualSelect unit.

Outstanding quality of care is the goal of, from left, Lisa O'Connor, LDH; Dr. David P. Reichwage; and Teresa Barjenbruch, RDH.

We also use chlorhexidine for irrigating. Recent studies consistently suggest that chlorhexidine irrigation enhances the reduction of gingival inflammation. These studies also note reduced plaque and gingival scores of bacteria. The studies have shown that irrigation with medicaments consistently improved the clinical and microbiologic parameters and tend to outperform irrigation with water alone.

Following chlorhexidine irrigation, we lase infected areas with the (Premier Aurora) soft-tissue diode laser on a pulse setting of 1.0, 10, and .05 to reduce or eliminate bacteria and inactivate bacterial toxins. (Studies on the diode laser indicate very favorable results with the bacterial reduction of actinobacillus actinomycetemcomitans, porphyromonas gingivalis, and prevotella intermedia.)

Soft-tissue laser therapy, in combination with scaling and microultrasonics, supports healing of the periodontal pockets. However, the diode laser does not contribute to calculus removal.

Every time patients come to our practice, we inform them about the progress of their condition, with a goal of motivating them to take an active interest in their dental health. We incorporate oral hygiene and home-care instructions specifically tailored to each patient's needs, based on the diagnosed conditions of that patient. We seek to get patients actively involved in their care by asking them these questions:

"How much infection and inflammation is too much?"

"Should we wait until there is permanent bone loss before treating your periodontal condition?"

Our philosophy is not just to watch and maintain disease, but to try to intercept the process at its earliest stage to prevent problems in the future. We feel patients *must* be informed of their condition and be given options of treating periodontal disease while it is in its earliest stage — gingivitis — before permanent bone loss has occurred. We regard this level of vigilant early diagnosis as our ethical responsibility to patients.

When disease is found, we investigate all possible causes for the condition. We know that many factors can affect periodontal health. For this reason, we not only look at home-care regimens, but we go further to look at other issues that may exacerbate periodontal destruction. In addition to obvious inadequate home care and plaque-control issues, the following factors can inhibit patients from healing properly: occlusion, bruxism/ clenching, smoking, systemic diseases, stress, medications, lack of anterior guidance, or existing old restorations.

If we can pinpoint the cause, we can help our patients to possibly correct the problem and put them on the road to optimal tissue health. We want patients to know and understand the etiological factors of periodontal health that affect their "barometer" or level of susceptibility to periodontal disease.

The rewards have been enormous for both our patients and our team. Many patients not only know the specific sites where they have had problems in the past, but they also actively follow periodontal charting and participate in reviewing their progress by comparing previous chartings. When patients attain this level of education, they can make a more informed decision regarding their treatment, instead of having it dictated to them by the dentist or hygienist. Optimal tissue health and comprehensive preventive dental care is our definition of *quality of care*. It is our goal to set a standard of care for our patients that utilizes all of the advantages offered by contemporary dental science.

Lisa O'Connor, RDH, graduated in 2000 with an associate's degree in dental hygiene from Indiana University-Purdue University of Fort Wayne, Ind. Teresa Barjenbruch, RDH, graduated in 1990 with an associate's degree in dental hygiene from Indiana University at South Bend. Both dental hygienists have attended the Pacific Esthetic Continuum and completed an advanced anterior esthetic courses and laser certification courses. Barjenbruch is a graduate of the JP consultants Institute in the advanced diagnosis and treatment of periodontal disease. David Reichwage, DDS, has practiced family dentistry in Fort Wayne, Ind. for 29 years. During the past five years, he has completed post-graduate courses in laser dentistry, and advanced cosmetic, periodontal, and restorative dentistry.