Subject: **Oral Hygiene Instructions**

Policy nr: DEN009

Effective date: 2015-01-01

Review date: 2015-09-01

POLICY:

Oral Hygiene Instructions (Code 8151) to be paid with an oral examination (Code 8101) from available benefit. No benefit if the patient is younger than 12 years. Only pay once per family per service date. Patients/members must be informed that a tariff will be charged for the procedure (SADA Guideline)

DEFINITION:

The process of informing and educating a patient in all aspects of oral care, including, but not limited to, plaque control, dietary instructions, explanation and demonstration of brushing and flossing, self-practice session by the patient under professional supervision, recording of a plaque index with or without the assistance of special aids such as plaque disclosing agents. Additional information can also be provided by distributing pamphlets or leaflets. (SADA Coding Schedule and Guidelines)

GUIDELINE:

Oral Hygiene Instructions (OHI) should be given only once a thorough examination is conducted, charting done and findings documented as per SADA Guidelines. It can therefore not be performed in isolation. OHI should not be charged to all members of the same family at a single visit. OHI can be given to a family attending the dentist/therapist/oral hygienist in a combined session.

GENERAL INFORMATION:

Oral and dental care cannot be administered before a thorough clinical examination of a patient has been done by a dentist. The information gathered at such an examination will also guide the dental practitioner in deciding an appropriate oral hygiene regime for the patient.

This information will ultimately form the basis for the decisions which will dictate the oral hygiene treatment plan, as well as the specific instructions which will be given to a patient to address his or her individualised needs.

The American Dental Hygienists Association states in a position paper: “It is therefore clear that dental hygiene diagnosis is a necessary and intrinsic part of dental hygiene education and practice.”
The most cost-effective measure to prevent tooth decay remains the fluoridation of public water supplies and certain foods. In South Africa legislation was adopted as long ago as 2002 and regulations published. This was however never implemented yet and seems to be bogged down in controversy and unanswered questions.

Several studies have been conducted all over the world, in sophisticated as well as developing countries, to determine the best way to deliver dental and oral hygiene education. Periodontal peer-reviewed literature abounds with numerous studies conducted over the past twenty years. These were done with children from pre-school to adolescence as well as adults. It was done in private and public settings as well as workplaces. Methods range from intensive supervision and physically monitored brushing and rinsing programs in pre-school classes, to the mere hand-out of self-instruction leaflets to older children and adults.

All these studies agree on one important point; dental education improves the oral and gingival health of recipients and increases their dental awareness.

However, there is little scientific evidence to support the hypothesis that repeated personal instruction by a qualified dental professional has a significantly better outcome than other more general methods such as self-education manuals, videos and leaflets, etc.

The conclusion drawn in most studies indicate that oral hygiene can be self-taught by making instruction material available to patients. More importantly, it was found in numerous studies that no significant difference could be found in the gingival health of groups receiving intensive personal instruction from a dental professional, and those instructed by any of the other ways mentioned above.

Specific studies conducted in private dental practices found no evidence that personal instruction by highly qualified professional health workers, e.g. dentists, dental therapists or oral hygienists, will deliver significantly different oral health outcomes to those achieved by means of leaflets, videos or self-instruction manuals. This type of material is freely available on the Internet, from companies marketing toothpaste and toothbrushes, etc.

It could certainly be argued that the availability of dental educational material in the public domain could actually be utilised much more cost-effectively in a medical scheme population than the funding of individual OHI sessions to a small section of the entire membership attending a private dental practice.

REFERENCES:


