Clinical Records Audit

This page contains a self-audit of patient records for you to complete using the table provided. Guidance for its use is set out below. You can recall this guidance at any time using the **?** symbol at the bottom right of the screen.

The Training Programme Director will verify the audit at your meeting.
Please have the records used in the audit easily available for the meeting.

You are asked to audit the treatment records for the first ten suitable patients seen on and after a nominated starting date. All of the patients included in the audit need to have been treated as NHS patients, so patients not treated within the NHS must be excluded. No more than five of the courses of treatment to be audited should be examinations only, thus you may need to move sequentially to the next patient seen, if this is the case. Similarly there need to be five cases including items of treatment such as restorative, endodontic, prosthodontic or paedodontic work. The audit refers to work done in that course of treatment. Thus, a patient contact for a simple restoration may be part of a course of treatment started several weeks earlier, and the audit refers to the entire course of treatment for that patient over that period.

The audit form in this portal allows easy addition of data. After setting the Start Date of the audit to the nominated date, you can set each audit item cell to show a **Y** for Yes by clicking on the empty cell. A further click sets it to **N** for No, and another click sets it to **n/a** for Not applicable. One more click returns the cell back to blank.

You should click on the **Save** button to save your progress before leaving the screen via the Home or the Exit buttons, otherwise all your work may be lost. When you have competed the audit, click on the **Submit** button and the form will become locked. You can start another audit when you return to the screen. When you have more than one audit completed, buttons will appear at the top of the screen allowing you to navigate between the audits sequentially. Audits will remain in your account, so you will be able to compare current audits with your future audits in years to come.

You have the ability to print a blank audit page if you would like to work this way. First set the audit start date before pressing the button on the right hand side of the screen. You can print the form and then transcribe results to the portal later.

The items that you are required to audit are explained here. In each case if the item is present, please insert a **Y**, if not then please insert a **N**:

Patient Identifier.	Please insert a unique code or number *(five characters, numbers and/or letters, maximum)* so that you can identify the patient for retrieving the records and yet maintain anonymity.

Is there a relevant Medical History completed and signed by the patient in the last year present?	There needs to be present a signed Medical History *pro-forma* dated within the last year.
Has the Medical History been recently updated?	There needs to be evidence that the medical history has been checked in this course of treatment and before invasive treatment is carried out.
Is there a full baseline charting recorded?	There should be available a full baseline charting of the patient.
Is there charting / listing present of treatment proposed and provided?	There should be a listed or charted representation present of the treatment proposed for this course and the treatment carried out.
Has an extra-oral soft tissue examination been recorded? **Has an intra-oral soft tissue examination been recorded?**	There should be record of both extra-oral and intra-oral examinations recorded.
Has a diagnosis or a rationale for the treatment carried out been recorded?	There must be a description of the pathological process recognised: e.g. pericoronitis, acute pulpitis, caries etc., or a reason for carrying out the particular treatment?
Is the periodontal status recorded in the last year with BPE scores or similar?	This requires the presence of a BPE score within the last year. If it is not applicable, for example with edentulous patients or child patients, then **n/a** requires to be written.
Is relevant periodontal care recorded or diagnosed?	There needs to be evidence that the periodontal care diagnosed and carried out meets with the BPE scores that have been recorded.
Has tooth surface loss been recorded?	There needs to be evidence that any tooth surface loss has been recorded and appropriate management defined.
Have treatment options been recorded?	There needs to be a record of the appropriate options offered the patient.

Has the caries risk status been recorded? **Has the periodontal risk status been recorded?** **Has the cancer risk status been recorded?**	There should be caries, periodontal and cancer risk assessments recorded.
Are relevant recent radiographs present?	Normally one would expect bitewing radiographs taken in the last two years to be present. For cases involving endodontic treatment there should be suitable radiographs present. If the case is edentulous or a young child then **n/a** may be applicable. FGDP guidance is the normal standard.
Is a clinical reason for the radiographs recorded?	If radiographs are taken there MUST be a clinical reason; e.g. for bitewings it could state *'to monitor bone and caries'*. If none have been taken then **n/a** should be inserted.
Is a radiographic report recorded?	There must be evidence of a report of the radiograph, usually related to the clinical reason for it being taken. If none have been taken then **n/a** should be inserted.
Is there a record of the radiographic QA?	Is there a grading present for the quality of the radiograph? If not this may be because it is recorded elsewhere, but this will need to be explained. We would expect the NRPB grading guidelines to be followed.
Does the recall interval recorded follow NICE guidelines?	There should be evidence recorded of reasons for the recorded recall interval commensurate with the NICE guidelines?

References

1. Faculty of General Dental Practitioners (UK) Clinical examination and record keeping. Good practice guidelines. London. FGDP(UK), 3rd Edition, 2016
2. Faculty of General Dental Practitioners (UK) Selection Criteria for Dental Radiography. London. FGDP(UK),3rd Edition, 2013 (updated 2018)
3. Dental Recall - Recall Interval Between Routine Dental Examinations - Clinical Guidance NICE 2004
4. Delivering Better Oral Health - an evidence-based toolkit for prevention - 3rd Edition DOH 2014
5. Guidelines for Periodontal screening and Management of Children and Adolescents under 18 years of age - British Society of Periodontology 2012

6. Standards for Dental Professionals 2013. (Medical history standard 4) - General Dental Council

7. Antimicrobial prescribing for general dental practitioners FGDP (UK) May 2012 Updated 2016