**Record card audit guidance notes**

Across health care provision there are a number of publications which indicate there is a clear correlation between quality of care and good patient records. Both regulatory bodies of Dentistry (GDC and CQC) require practitioners to keep full accurate and contemporaneous records of their patient’s treatment. The record card audit template used by HEE North West and NHS England Mersey Area Team has been developed over a number of years and its use allows an assessment to be made of the quality of patient records. The audit is based on national guidance relating to the different aspects of patient records and continues to be refined as new guidelines are published.

**Patient ID-initial and DOB:**

This column records patient data to allow individual patient records to be identified to allow a discussion to take place regarding the quality of the individual patient record audits and to allow the same records to be at a later date re-audited to demonstrate an improvement in quality of records.

**Periodontal Screening & Management:**

Delivering Better Oral Health (3rd edition 2014), Clinical examination and record keeping(FGDP 2009),Guidelines for Periodontal Screening and Management of Children and Adolescents (BSP 2012) ,Guidance documents re BPE monitoring and periodontal management of patients on the BSP website are all recognised national standards for periodontal care of children and adults. Not only is BPE (Basic Periodontal Examination) required to be recorded (1 point) but a full periodontal charting required if a BPE score is over 3 in any quadrant. The practitioner should record what periodontal maintenance/treatment is in place as a result of the BPE scores (1 point).

**Appropriate Radiography:**

The publication Selection Criteria for Dental Radiography (FGDP 2013) and the |IRMER Regulations 2000 give very clear nationally accepted guidance as to the appropriate use of radiographs in dentistry. The practitioner should record why the radiographs are being taken –justification (1 point), quality assure the radiographs (1 point) and report on the findings and action to be taken (1 point).

**Soft tissues examined:**

The publication Clinical Examination & record-Keeping (FGDP 2009) gives very clear guidance on the requirements for GDP’s to carry out an extra oral (1 point ) and intra oral (1 point) soft tissue examination when reviewing a patient. Appendix 9 of this publication identifies in detail the individual requirements of the extra and intra oral examination.

**Medical History:**

The recommendations for recording the medical history of a patient are clear. The practitioner or appropriately trained nurse should work through the medical history form with the patient. The medical history should be updated for each new course of treatment or upon learning of significant new medical events. All negative findings-as well as positive findings-should be recorded (1 point). The completed questionnaire should be dated and signed by both the patient and the dentist, and then retained as part of the record (1 point).

**Consent and estimates:**

Guidance on consent is to be found in Appendix 6 of the publication Clinical Examination & Record-Keeping (FGDP 2009). Whether written or verbal consent has been obtained the treatment plan and the substance of the discussions with the patient should be recorded in the clinical notes (1 point). In particular, explanations concerning treatment options and prognosis should be recorded, as well as warnings regarding potential complications (1 point).Written treatment plans and fee estimates signed by the patient, with a copy retained in the records is advised (1 point). For NHS patients requiring band 2 or 3 treatment the use of the form FP17DC06 is a legal requirement.

**Evidence of Patient Risk assessment:**

The publication Delivering Better Oral Health DOH June 2014 is an evidence based toolkit to support dental teams in improving their patient’s oral and general health. In order to improve oral health practioner’s are required to carry out the following risk assessments-Dental caries,periodontal, cancer, tooth surface loss and record in the records appropriate treatments required for the patient. The recall interval for the patient should also be recorded in line with NICE guidance.