NSQHS Standard 1 Governance – attachment 5

Clinical Record Audit Tool – ORAL HEALTH (Collection of Client data)

Hospital and Health Service:	Facility:
Audit date/period:	Client Medical Record Number (MRN):
Clinician for course of care:	Auditor name:

Client audit tool: collects client level data from the clinical record **for the last complete course of oral health care**, use one audit tool for each client audited. The documentation audited includes the client registration, consent and medical/dental history forms as well as the examination and treatment sheet. In addition, this audit can include the 3Cs verification checklist audit for all treatments undertaken in the last completed course of care.

Notes:

- *Each facility needs to determine those audit questions that are applicable to their facility / health service circumstances for review*
- *Some questions and responses may not be applicable (eg. at a ward/unit level) and can be adapted to suit individual requirements*
- *The measurement plan details each audit question and the action/criteria it aligns to in the standard*
- *This audit can be used prospectively or retrospectively. When used for retrospective chart audit, all questions relate to the last completed course of care (oral health) (note a course of care may involve a number of occasions of service)*
- *This tool covers oral health services delivered in a community / oral health care setting and not when oral health clients are admitted to an acute facility core a procedure*

Clinical Record Audit		Response
1.0	Is there documented evidence on commencement of the care in the client clinical record of:	
	• Unique record number? (N/A schools)	☐Yes ☐No ☐N/A
	• Name?	☐ Yes ☐ No
	• DOB?	☐ Yes ☐ No
	• Gender?	☐ Yes ☐ No
	• Residential/postal address?	☐ Yes ☐ No
	• Home phone number?	☐ Yes ☐ No
	• Marital status?	☐Yes ☐No ☐N/A
	• Medicare number?	☐Yes ☐No ☐N/A
	• Proof of eligibility (including children 4 y.o. to 10 y.o.)	☐ Yes ☐ No
	• Details of next of kin/ Emergency contact person?	☐ Yes ☐ No
	• Details of the client's general practitioner?	☐Yes ☐No ☐N/A
	• Country of birth and language spoken at home?	☐ Yes ☐ No
	• Indigenous status?	☐ Yes ☐ No
	• Dental history?	☐ Yes ☐ No
	• Medical history?	☐ Yes ☐ No
	• Signature of the patient/legal guardian?	☐ Yes ☐ No

Clinical Record Audit		Response
2.0	Is there documented evidence that the client/parent/guardian consented to relevant information regarding treatment being provided to other health professionals involved in their care? (e.g. GP, specialists, community service providers)	☐ Yes ☐ No
3.0	Is there documented evidence that the client/parent/carer received a pamphlet or spoke to a staff member about the Australian Charter of Health Care Rights?	☐Yes ☐No ☐N/A
4.0	Is there documented evidence that the client /parent/carer received a pamphlet or spoke to a staff member about how to convey their comments and concerns?	☐Yes ☐No ☐N/A
5.0	Does EACH page of ALL forms have the correct client label or client identification?	☐ Yes ☐ No
6.0	Does the client identification label or written identification used contain 3 unique client identifiers? i.e. client full name, date of birth, sex (N/A for school oral health).	☐Yes ☐No ☐N/A
7.0	Do ALL entries in the client progress notes/treatment sheet contain: • Date? • Time? • Signature/initials of the clinician making the entry? • Printed name of the clinician making the entry? • Designation of the clinician making the entry? • In chronological date order?	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
8.0	Are ALL entries in the client progress notes/treatment sheet: • Written in black pen or according to local policy? • Have ALL errors been crossed out and initialled with "written in error"? • Only use approved abbreviations? (according to facility policy) • Used whiteout? • Have gaps or lines between entries crossed through? • Legible?	 ☐ Yes ☐ No ☐Yes ☐No ☐N/A ☐ Yes ☐ No ☐Yes ☐No ☐N/A ☐Yes ☐No ☐N/A ☐ Yes ☐ No
9.0	Is there documented evidence of the ADA treatment codes in the chart for EACH occasion of service?	☐ Yes ☐ No
9.1	If yes: does the ADA code correspond to the treatment documented?	☐ Yes ☐ No
10.0	Is there evidence that the client/parental/carer concerns were documented? (N/A Where no concerns – examination appointment)	☐Yes ☐No ☐N/A
11.0	Is there documented evidence that consent for treatment was received?	☐ Yes ☐ No
12.0	Is there evidence that the medications impacting on dental treatment were noted?(N/A for no medications impacting on treatment)	☐Yes ☐No ☐N/A
13.0	Is there documented evidence of the client's medication allergies and adverse drug reaction (ADR) status (including nil known & unknown)?	☐ Yes ☐ No
14.0	Is there documented evidence that the clinical examination sheet was completed? (Tip: complete examination sheet is: For emergency examination, as a minimum, charting of the relevant teeth and recording the number of permanent teeth. For general examination, forensic charting of all teeth present in the mouth and recording the number of permanent teeth, the DMF score, the CPITN score and the Dental Prostheses Codes)	☐ Yes ☐ No

Clinical Record Audit		Response
14.1	If yes: Is there documented evidence of full charting of every tooth and condition of periodontal and oral tissues as presented? (N/A when full charting is not indicated as in the case of emergency clients)	☐Yes ☐No ☐N/A
14.2	If yes to 14.0: Is there documented evidence that the clinician has signed, printed/stamped their name and position and dated (in black ink)?	☐Yes ☐No ☐N/A
15.0	Does the tooth charting comply with the Notes for Completion of Client Records? (Tip: The charting of teeth on the odontogram complies with the requirements detailed on Pages 3, 4, and 5 of "Notes on Completion of Patient Records". All treatment performed is accurately recorded on the odontogram.)	☐ Yes ☐ No
16.0	Is there documented evidence that x-rays were taken for this client? If no x-rays were taken record NA and go to question 17.0. If x-rays were taken but no documentation, record No.	☐Yes ☐No ☐N/A
16.1	If x-rays were taken: Is there documented evidence of the type of x-rays, including specific area if relevant e.g. LHS B.W.; PA12? If x-rays were taken but no documentation, record No.	☐ Yes ☐ No
16.2	If x-rays were taken: Is there documented evidence that the x-rays were sufficient for diagnosis? If x-rays were taken but no documentation, record No.	☐ Yes ☐ No
16.3	If x-rays were taken: Is there documented evidence that the x-rays were anatomically correctly mounted? If x-rays were taken but no documentation, record No.	☐ Yes ☐ No
16.4	If x-rays were taken: Is there documented evidence that the x-rays were mounted with client's name, DOB, gender and dated? If x-rays were taken but no documentation, record No. N/A BW and Pas films	☐Yes ☐No ☐N/A
16.5	If x-rays were taken: Is there documented evidence that the x-rays have been reported and outcome noted? If x-rays were taken but no documentation, record No.	☐ Yes ☐ No
17.0	Is there documented evidence that a treatment plan/sheet for the client exists?	☐ Yes ☐ No
17.1	If treatment plan/sheet present: Does the treatment plan/sheet reflect the examination charting? (N/A if emergency procedure and no charting)	☐Yes ☐No ☐N/A
17.2	If treatment plan/sheet present: Is there evidence of the 3Cs verification checklist sticker affixed to the treatment plan/sheet for EACH occasion of service?	☐ Yes ☐ No
17.3	If treatment plan/sheet present: Does EACH 3Cs verification checklist sticker have the clinician's signature, name printed and dated?	☐ Yes ☐ No
17.4	If treatment plan/sheet present: Does EACH 3Cs verification checklist have Step 1 Identify Client completed?	☐ Yes ☐ No
17.5	If treatment plan/sheet present: Does EACH 3Cs verification checklist have Step 2 Informed Consent completed?	☐ Yes ☐ No
17.6	If treatment plan/sheet present: Does EACH 3Cs verification checklist have Step 3 Identify Site and Side completed?	☐ Yes ☐ No

Clinical Record Audit		Response
17.7	If treatment plan/sheet present: Does EACH 3Cs verification checklist have Step 4 Final Team Check completed?	☐ Yes ☐ No
18.0	If there were any documented changes to the treatment plan/sheet, was the client /parent/carer notified of/consented to changes to the treatment plan/sheet? (N/A when no changes to the treatment plan)	☐Yes ☐No ☐N/A
19.0	Is there documented evidence of sterilising batch label (piggy back label) directly under the dated clinical notes of treatment of EACH occasion of service where tracked instruments/equipment were used? N/A when disposable instruments used	☐Yes ☐No ☐N/A
20.0	Does the client have documented evidence that a local anaesthetic was used?	☐ Yes ☐ No
20.1	If yes: Is there documented evidence of the amount and type?	☐ Yes ☐ No
20.2	If no to 20.0: Is there documented evidence of no anaesthetic? (N/A for non-operative appointments e.g. radiographs, impressions, consultations, cleaning appointments, fissure sealants etc.)	☐Yes ☐No ☐N/A
21.0	Is there documented evidence that post procedure instructions have been provided? (N/A when no procedure undertaken)	☐Yes ☐No ☐N/A
22.0	Is there documented evidence on completion of course of care, that a separation letter has been completed? (N/A when separation letter not indicated e.g. emergency treatment)	☐Yes ☐No ☐N/A
23.0	Is there documented evidence that referrals to appropriate specialist health providers e.g. oral surgery, orthodontics has been organised? N/A when referrals not indicated	☐Yes ☐No ☐N/A
24.0	If referrals have been made: Is there documented evidence of a discussion with the client/parent/guardian regarding the referrals made?	☐Yes ☐No ☐N/A
25.0	On separation, is there documented evidence that the client/parent/guardian received instructions for future care? N/A when no future care is indicated (Tip: instructions include -Treatment complete, Refer to dentist/specialist for second opinion, Refer to fixed clinic)	☐Yes ☐No ☐N/A

We recognise and appreciate that there may be gaps in the scope and questions included in these tools, however, as this is a **'Work in Progress'**, future versions will build upon the existing scope and questions, and incorporate staff feedback and suggestions for improvement.

The Patient Safety and Quality Improvement Service, Clinical Excellence Division, welcomes feedback on the audit tools and the measurement plans, to ensure the tools meet the needs of Hospital and Health Services. We appreciate any feedback you can provide for the next version.

Please email Patient Safety and Quality Improvement Service on PSQIS_Comms@health.qld.gov.au for feedback or comments.