

INDIRECT REVIEW OF DENTAL CLINICAL QUALITY (CHART REVIEW)

Dentists directly employed, or who contract care for the Community Dental Center, are expected to provide that care in accordance with the following Guidelines. These standards have been written to allow dentists flexibility with which to provide care, and do so in a manner that has been determined to be appropriate and of high quality. Dentists providing care for the Community Dental Center do so recognizing that their performance may be judged by any of the following evaluation criteria, which are directly related to the Guidelines. This judgment being an integral part of the quality assurance / quality improvement program.

CHART REVIEW

Evaluator

Date

Chart Number:

Yes

No

A. Health Questionnaire, Exam, Treatment Plan

- 2) A health questionnaire has been completed and signed by the patient or legal guardian within the last 12 months.

- 2) Medical history is updated and so noted at each visit. This is documented with the reviewer's initials, date, and changes or no change in medical status.

- 3) Evidence of soft tissue exam is present, either by listing of abnormalities or designation of "STN" (Soft Tissues Normal) or "WNL" (Within Normal Limits).

Yes

No

- 4) All hard tissue pathology observable on available radiographs is recorded in the dental records. Documentation that radiographs have been read exists in the patient record.
- 5) Periodontal status (for patients age 15 and older) and orthodontic status (for patients ages 6 to 20) are noted on the dental exam sheet.
- 6) Written treatment plan exists for all patients receiving initial or recall dental exams.
- 7) Treatment plan is easily understood, follows a logical sequence, and includes an exit exam.
- 8) All entries in the dental record are written in ink (preferably black ink).

Comments, Section A: Total # Yes

Total # No

% Yes

Yes

No

B. Dental Progress Notes

- 1) Progress notes are legible and clearly describe the treatment provided.
- 2) Appropriate and legible procedure codes are used for all treatment provided.
- 3) Each initial patient visit during the fiscal year is coded 0000 and each revisit during that fiscal year is coded 0190.
- 4) Dental Progress Notes include date of treatment, age and sex of patient, and signature and degree of the provider(s).

Yes No

- 5) Progress notes indicate that dental auxiliaries routinely initial the procedures they perform.
- 6) Dental Progress Notes include a disposition at the end of each visit.
- 7) Documentation of informed consent is present when physical constraints (including hand-over-mouth, mouth props, or wraps) are used.

Comments, Section B: Total # Yes
Total # No
% Yes

Yes No

C. Drugs Administered or Prescribed

- 1) Drugs administer or prescribed are consistent with the written diagnosis.
- 2) Drug dosages are within limits recommended by the *Physician's Desk Reference* or *American Hospital Formulary Service*.
- 3) All drugs and dosages are entered in the medical and/or dental progress notes.
- 4) Reactions and allergies to drugs are prominently displayed in dental record and on outside of medical chart.
- 5) If the medical history suggests that prophylactic antibiotics may be necessary, determination of need or lack of the need is documented.
- 6) Patients who need prophylactic antibiotics receive the prophylactic antibiotic regiment

of posterior bitewings supplemented with anterior and/or posterior films and/or panoramic radio-graphs, as required by oral conditions, is recommended for all individuals

Yes

No

15 years old and older. Panoramic or full-mouth intraoral radiographic films are appropriate when the patient presents with clinical evidence of generalized dental disease or history of extensive dental treatment.

b. *Initial Child (age 1-14)*

Prior to the eruption of the first permanent tooth, bitewing films (if interproximal surfaces cannot be visually inspected) are supplemented with anterior and posterior periapical films, as required by oral conditions. Individualized radiographic examinations consist of a periapical/occlusal or panoramic examination when clinical evidence or history indicate the need for additional radiographic examination. A full-mouth radiographic exam (panoramic or intraoral periapical) is performed *beginning at age 9.*

c. *Recall*

1. Bitewings and/or periapical radiographs are taken at intervals as required by the patient's general condition.
2. In the absence of specific indications for more frequent radiographs, a panoramic radiograph or full-mouth intraoral periapical series is not taken more often than once every five years.

d. *Emergency Examination*

An appropriate diagnostic radiographic examination of the area in question is performed for emergency patients.

Comments, Section D:

Total # Yes

Total # No

% Yes _____

Yes No

E. Dental Emergency Treatment

- 1) "SOAP" or similar format is used for each dental emergency patient to document

Yes No

chief complaint, objective findings, diagnosis, and treatment plan in the patient record.

- 2) Diagnosis is consistent with subjective and objective findings.
- 3) Treatment is consistent with the diagnosis and is definitive in nature.
- 4) Evidence of an intraoral screening exam is present for emergency patients, either by listing of abnormalities (e.g., gross caries, periodontal disease, soft tissue lesions) or "WNL" (within normal limits).

Comments, Section E:

Total # Yes

Total # No

% Yes _____

Yes No

F. Endodontics

- 1) Preoperative and postoperative radiographs are available for each tooth receiving endodontic treatment.
- 2) Findings confirming the diagnosis and ruling out competing diagnoses are entered

other surgical procedure is written in the dental record.

- 2) The chosen surgical procedure is consistent with the diagnosis.
- 3) A preoperative radiograph showing the apex of each root is available for all teeth extracted.
- 4) In the event of untoward outcome or postoperative complications, the dental record indicates appropriate treatment of these complications and arrangements for follow-up treatment.
- 5) If sutures are placed, type and number are documented.
- 6) Informed consent includes documentation of discussion of risks, benefits, and alternatives to treatment.
- 7) All pathology reports and evidence that the patient was notified of appropriate follow-up are present in the patient record.
- 8) Any documented difficult surgical procedure or untoward outcome has appropriate follow-up arranged.

Yes No

Comments, Section G: Total # Yes
Total # No
% Yes

Yes No

H. Pediatric Dentistry/Orthodontics

- 1) All carious teeth are addressed in the treatment plan.
- 2) An SSC is provided or planned for each primary molar with three or more carious surfaces or pulp therapy, unless contraindications are documented.
- 3) When an indirect pulp cap is performed, there is

documentation present to support a diagnosis of reversible pulpitis.

- 4) All primary teeth receiving pulpectomies have preoperative and post-fill periapical radiographs.
- 5) In cases where rubber dam is not used for restorative procedures, the reason for non-use is documented. (In clinics where there is no evidence of documentation of non-use of the rubber dam, the provider(s) should be questioned as to whether the rubber dam is used for all restorations.)
- 6) The dental record indicates that space maintenance is provided or planned for each prematurely lost primary molar, or reason for non-provision is documented, and there is provision for appropriate recall (6 months or less).
- 7) Documentation of the behavior for all children under the age of 6 is included in the progress notes, as well as behavior management techniques used and their level of effectiveness.
- 8) Use of sedation is documented in the progress notes
- 9) Documentation that patients are informed of need for orthodontic treatment is present.
- 10) Request for extraction from an orthodontist is documented in the patient record.
- 11) Pretreatment full mouth or panoramic radiographs are available for each patient undergoing orthodontic treatment.
- 12) Pretreatment study casts are available for each patient receiving orthodontic treatment.
- 13) Orthodontic treatment plan and treatment provided are consistent with pretreatment findings.

Yes

No

Comments, Section H: Total # Yes

Total # No

% Yes

Yes

No

I. Periodontics

1) The record of patients receiving a complete dental exam contains CPITN/PSR scores and a written diagnosis by ADA-Case Type (Gingivitis, Early Periodontitis, Moderate Periodontitis, or Advanced Periodontitis), based on probing and radiographic evidence.

Yes

No

2) When definitive periodontal therapy is planned for patients with CPITN/PSR of 3 or greater, a periodontal work-up is conducted. This includes probing pocket depths, furca involvement, mobility, and occlusal features, with documentation in the progress notes

3) Preoperative radiographs of areas receiving periodontal treatment are present in the dental chart.

4) Diagnosis and treatment plan are consistent with preoperative findings.

5) Dental record contains evidence of patient counseling in home care procedures for all patients receiving periodontal treatment.

6) The hygienist's progress notes and referrals are countersigned by a dentist. The hygienist's signature alone is adequate only if covered by standing orders in the clinic policy and procedure manual.

- 7) A screening exit exam for patients receiving perio treatment includes a CPITN score.
- 8) The record indicates that each patient has been placed on a recall which is based on that patient's periodontal disease status and the clinic recall policy.
- 9) All dentate patients 15 years or older being provided routine dental care are informed of the periodontal status, treatment needs, opportunities for self-care, and have a description of periodontal treatment planned. If a full scope of periodontal services is not available at the particular clinic, a chart notation should be made that the patient has been informed of his/her need for treatment at another facility.

Comments, Section I:

Total # Yes

Total # No

% Yes _____

Yes

No

J. Preventive Dentistry

- 1) The dental record contains an individualized dental disease prevention plan, including assessment of the following needs:
 - a. Systemic fluoride
 - b. Professionally-applied topical fluoride
 - c. Self-applied topical fluoride
 - d. Fluoride toothpaste
 - e. Pit and fissure sealants
 - f. Preventive periodontal treatment
 - g. Tobacco counseling
 - h. OHI and other health education
 - i. Recall
- 2) Persons with one or more smooth-surface carious lesions will receive a professionally-applied topical fluoride application. A schedule of up to four applications per year may be followed, based

on the presence of moderating factors documented for the patient. Moderating factors include: age, present caries activity, past caries activity, exposure to other sources of fluoride, sugar intake and frequency, amount of plaque, dental anatomy, and family history.

- 3) Fluoride supplements are offered for each patient under age 16 who does not have access to drinking water containing adequate levels of fluoride.
- 4) Sealants are placed on unrestored, non-carious or incipient carious pit and fissure surfaces of all permanent first and second molars within two years of eruption.
- 5) The record indicates that patients who are tobacco users are asked if they want to quit using tobacco.
- 6) The record indicates that tobacco cessation counseling was provided or recommended for patients who indicated that they wanted assistance in quitting tobacco.
- 7) The patient is placed in a recall program based on his/her individual risks, rather than arbitrary time intervals. The patient's recall category is consistent with the diagnosis, treatment received, and medical condition, e.g., diabetes, rampant caries, pregnancy, and perio status.

Comments, Section J:

Total # Yes

Total # No

% Yes

Yes

No

K. Prosthodontics

- 1) Preoperative periapical radiographs of fixed bridge or partial denture abutment teeth

are present in the dental record.

- 2) Radiographic and other diagnostic findings indicate that the periodontal condition of the abutment teeth is adequate to support the prosthesis, e.g., Ante's Rule for fixed bridges.
- 3) Pretreatment full-arch radiographs (occlusal, panoramic, or FMX) are available for all full denture patients.
- 4) Prosthetic treatment plan exists and is consistent with preoperative findings.
- 5) Shades, moulds, laboratory, and type of metal used for the prosthesis are recorded in the dental chart for future reference.
- 6) Laboratory Rx slips are stored for future reference.

Comments, Section K:

Total # Yes

Total # No

% Yes _____

Yes

No

L. Restorative Dentistry

- 1) Restorative materials are used appropriately for satisfactory esthetic results and as accepted for use by the ADA.
- 2) Recent bitewing radiographs (no older than two years) show absence of obvious overhangs, open margins, or open contacts on restorations previously placed by the dental staff being evaluated.
- 3) In cases where rubber dam is not used, the

reason for non-use is documented. In clinics where there is no evidence of documentation of non-use of the rubber dam, the provider(s) should be questioned as to whether the rubber dam is used for all restorations.

Comments, Section L: Total # Yes

Total # No

% Yes

SUMMARY OF DENTAL CHART REVIEW

% Yes or "NA" _____

- A. Health Questionnaire, Exam, Tx Plan _____
- B. Dental Progress Notes
- C. Drugs Administered or Prescribed
- D. Radiographs
- E. Dental Emergency Treatment
- F. Endodontics
- G. Oral Surgery
- H. Pedodontics/Orthodontics
- I. Periodontics
- J. Preventive Dentistry
- K. Prosthodontics
- L. Restorative Dentistry

(80% is considered satisfactory for each category)

Recommendations from Chart Review:

- 1.
- 2.
- 3.
- 4.

Signatures:

Evaluator

Evaluee