The importance of high quality clinical records

Kemi Ajayi¹ provides some tips for clinical record auditing in dental practice.

Is clinical record auditing another tick-box exercise?

Far from it. In a world of increasing compliance, and regulatory scrutiny, the importance of high-quality, complete clinical

records is becoming more pertinent. The General Dental Council (GDC), Faculty of General Dental Practice (UK), and Ionising Radiation Regulations 2017 have clear, published standards,¹ good practice guidelines² and regulations³ for dental professionals regarding record keeping. Clinical records can be a crucial part of a clinician defending themselves against complaints and litigation.

The GDC's Annual Report and Accounts 2018⁴ highlights issues with patient records as being in the top two out of 33 areas of considerations in their Fitness to Practise hearings. Failure to obtain valid consent comes in at number five, inadequate treatment plans and documenting consent are at number 13 and 23 respectively.

As a clinician myself, I understand how easy it can be, when working under pressure, to forget aspects of the patient's clinical examination that are key to keeping complete clinical records. Carrying out regular audits can be incredibly useful in helping you and your colleagues to check whether the most current best practice is being followed, minimise the risk of litigation and regulatory action, and provide good care to patients.

What do the regulations say?

Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014⁵ relates to good governance. It states, in part: 'Systems or processes must be established and operated effectively to enable the registered person to:

- Assess, monitor and improve the quality and safety of the services provided
- Evaluate and improve their practice in respect of the processing of information referred to in (this regulation).'

The Care Quality Commission (independent regulator of health and social care in England) does not list clinical record keeping audits as essential,⁶ but they do refer to the Faculty of Dental Surgery's standards (2000) for clinical record keeping,⁷ which include a recommendation to audit clinical records on an annual basis. The CQC also states⁸ that: 'If records audits have been systematically undertaken, the audit findings and any subsequent action plans may provide sufficient evidence to answer the Key Lines of Enquiry and we may not need to look at individual dental care record.'

Who is responsible?

Legal responsibility for overall quality of care in your practice ultimately lies with the registered person. However, clinical records audits can be completed by competent members of staff who are independent from the audit and who are suitably experienced, or trained, in carrying out such audits. Clinicians

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should avoid auditing their own records, to avoid any unconscious bias towards scoring themselves more positively.

What does a good record keeping audit look like?

Your clinical record keeping audit should include:

1. **Aims & objectives:** what are you trying to achieve or improve on by doing the audit? Have you already identified weaknesses in record keeping and want to look into this more thoroughly? Do you want to ensure better consistency? Whatever your reasons, they should be clear and understood by all staff involved. Your aims and objectives should include any relevant published guidance and regulations, benefits for achieving the determined aims and objectives and the potential risks of not doing so.

periodontal disease, oro-mucosal health, and endodontic failure)

- Medical history
- Consent process
- Radiograph reporting (including justification and quality grading)
- Details of discussions with patients and/or their representatives, including treatment options and advice given
- Quality and comprehensiveness of treatment plans
- Recall timings.

3. **Relevant dates and signatures:** this should include the date the first cycle audit was undertaken, and the date the re-audit is due. You would be surprised at how often this is omitted. The auditor/s should sign the audit, and it should be made clear who is responsible for carrying out the re-audit.

completed a minimum of every 12 months. Keep a record of all audits for your own use and for presentation such as during regulatory inspections.

References

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2. **Method:** there should be a clear plan about how the audit will be achieved. Will it be done via hard copy or electronically? Who will carry out the audit? What data will be assessed and how will the data be collected? Will you use a score chart?

The areas covered in the audit should be decided by the practice but should as a minimum cover the following areas:

- Personal details (title, date of birth, address, contact number)
- Socio-behavioural history (including smoking and alcohol consumption)
- Reason for attendance
- Record of attendance by representatives for children and those with impaired mental capacity
- Dental history
- Data recorded from intra and extra-oral soft and hard tissue examinations (including charting, findings and diagnoses)
- Oral health risk assessments (for caries,

4. **Valuable data:** All clinicians’ records should be audited, in order to accurately assess compliance with the guidelines or regulations, and the risk level. The audit should include dental hygienists, therapists and orthodontic therapists. The Faculty of Dental Surgery recommends auditing a minimum of 20 records per clinician.

5. **Summary of findings:** Each audit should have a detailed written summary about what was good and what could be improved. These findings should be easy to understand and shared with all staff involved.

6. **Agreement and implementation of changes:** Agree with your staff what needs to be improved/implemented and by when. Ensure the necessary improvements are made by the agreed date.

7. **Re-audit:** This can be done as often as you like (within practical limits) but should be