

Process Map for Clinical Record Audit

- 1) Select audit topic and consider reasons for examining this area. Decide what aspects of Clinical Records you wish to examine. This may be general or a particular area if a problem has been identified.
- 2) A sample size of 100 Records will show any problem areas.
- 3) Set Standard. The standard should be based on Best Practice. It would therefore be reasonable that the ultimate standard should be 100% in all areas. As the main object is to highlight areas of deficiency, an interim standard close to 100% could be set. The Audit process of Re-Audit could then be used to implement change and drive improvement with the aim of achieving best practice standards.
- 4) Make Data Capture table. Devise a scoring system. This could be : Not recorded - 0 points, Partially recorded- 1 point, Fully recorded- 2 points.
- 5) Collect Data.
- 6) Analyse Data and see what areas need to be improved. There may be problem areas, for example, soft tissue records, smoking and alcohol related areas, or Periodontal records.
- 7) Consider Re audit to ensure changes or improvements have been maintained. This should be carried out at least annually using a small sample of records.
- 8) Write up report and complete CA2 form.

Appendix A – Data Capture Sheets

Record card audits (Dentist 1)

Completeness of patient records

Patient	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Patient contact details															
Medical history up to date and signed by patient															
Medical alerts clearly indicated on record card															
Existing restorations															
Carious lesions															
Periodontal status															
Soft tissue status															
Radiographic report if appropriate															
Signed and dated notes															
Total															

Recording of mouth cancer risk factors

Patient	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Smoking habits/ alcohol use identified															
Smoking/drinking advice and mouth cancer advice given															
Total															

Consent and written financial estimates

Patient	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Treatment options explained and recorded?															
Written cost estimate and treatment plan given?															
Consent form signed?															
Total															

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