APPENDIX III

INDIRECT REVIEW OF CLINICAL QUALITY

CHART REVIEW
Indirect Review of Clinical Quality
Chart Review

GENERAL INSTRUCTIONS

General responsibilities and guidelines for conducting quality assessment reviews are included in Appendix I of this chapter and should be followed when an outside reviewer conducts a chart review.

1) This chart review tool can be used to assess the quality of an individual provider, a targeted aspect of care, or a dental clinic as a whole. The entire document can be used or individual criteria can be selected, depending on the focus of the survey.
2) When the tool is used for ongoing peer review, it is helpful to have all of the providers in the clinic participate in reviewing the charts, so that the findings can be used as a learning experience.
3) Whenever possible, the charts being reviewed should be randomly selected to eliminate bias from the review process. Medical Records or Information Technology personnel can usually develop a random selection of records.
4) As a rule of thumb, review 10 charts per provider.
5) Identify a time frame for the review (e.g., only review chart entries that were made since the previous chart review; or, for a new employee, only review chart entries made after the provider was oriented to the chart review process and review criteria).
6) All criteria must be met to score “Yes”
7) For each category, if procedures were not performed or are not applicable, mark NA

CHART REVIEW CRITERIA

A. Every Visit

1) A health questionnaire completed by the patient and signed by the provider within the past 12 months is present and documentation exists that it was reviewed at each visit with the changes or the phrase “no changes” recorded. Medical alerts are highlighted.

2) For patients with American Society of Anesthesiologists (ASA) Physical Status (PS) classifications 2-5, appropriate measures have been taken to ensure patient safety and appropriate treatment. (e.g., blood pressure, blood sugar, consultations when necessary)
   See ASA website for PS definitions: [http://www.asahq.org/clinical/physicalstatus.htm](http://www.asahq.org/clinical/physicalstatus.htm)

3) Progress notes are legible and clearly describe the treatment provided.

4) Appropriate ADA codes are recorded (including tooth number and surface when appropriate) and documentation exists in the progress note to justify all codes.

5) Dental Progress Notes include:
   a. date of treatment
   b. signature of the provider(s)
c. printed or stamped name of provider(s)
d. degree of the provider(s)

6) Progress notes indicate that dental auxiliaries initial the direct patient care procedures performed.

7) Dental progress notes include a disposition at the end of each visit. (Next appointment, further dental needs. The purpose is to demonstrate continuity of care.)

8) Documentation of informed consent is present for appropriate procedures as defined by the facility. Informed consent includes documentation of discussion of risks, benefits, and alternatives to treatment.

9) Patient’s pain has been assessed, documented, and adequately addressed and/or managed.

10) All entries in the dental record are in ink.

### B. Exam and Treatment Plan

1) All hard tissue findings (pathology, abnormalities) are recorded in the dental record.

2) Documentation that radiographs have been read exists in the patient record.

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).

4) 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.

5) Orthodontic status (for patients ages 6 to 20) is noted on the dental exam sheet.

6) Written treatment plan exists for all patients receiving initial or recall dental exams.
   a. Treatment plan is easily understood
   b. Follows a logical sequence
   c. Is revised as needed, revisions are dated and initialed

7) If a full scope of services is not available at the facility, a chart notation is made that the patient has been informed of his/her need for treatment at another facility.

8) The patient is placed in a recall program based on his/her individual risks and clinic resources, rather than arbitrary time intervals.

### C. Drugs Administered or Prescribed

1) Drugs administered 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 (including local anesthetic).

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 regimen currently recommended by the American Heart Association.

7) Sufficient documentation exists to demonstrate that the patient complied with the prescribed antibiotic regimen, was sufficient to cover the procedure, and that the dental procedure began after the recommended time interval.

**D. Radiographs**

1) Radiographs are dated and are labeled with name or chart number, and operator’s initials.

2) Radiographs are of good diagnostic quality with regard to density, contrast, and lack of overlapping, cone-cutting, or distortion. (All criteria must be met)

3) Bitewings include distal surface of erupted cuspid and mesial surface of the most posterior erupted tooth in each quadrant. (Check all radiographs taken during review date range)

4) The types and frequency of radiographs meet clinic policies and are consistent with ADA/FDA guidelines. Copies of the guidelines can be obtained at: [http://www.ada.org/prof/resources/topics/topics_radiography_chart.pdf](http://www.ada.org/prof/resources/topics/topics_radiography_chart.pdf) and [http://www.ada.org/prof/resources/topics/topics_radiography_examinations.pdf](http://www.ada.org/prof/resources/topics/topics_radiography_examinations.pdf)

**E. Dental Emergency Treatment**

1) “SOAP” or similar format is used for each dental emergency patient to document 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 and appropriate for the diagnosis.

4) Evidence of an intraoral screening exam is present for emergency patients, either by
list of abnormalities (e.g., gross caries, periodontal disease, soft tissue lesions) or “WNL” (within normal limits).

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 in the dental record.

3) Postoperative radiograph indicates complete obturation of all root canals to within 2 mm of and not beyond the radiographic apex (refers to primary filling material, not sealer).

4) Dental record indicates that a non-resorbable primary filling material and non-staining sealer are used in the endodontic treatment of a permanent tooth, a resorbable filling material is used for a primary tooth, and that formocresol is not routinely used in permanent teeth.

5) Chart entries document the following
   a. Working lengths,
   b. Reference points, and
   c. Instrument sizes are recorded in the patient record.

6) An esthetic restorative material is used to restore each lingual access preparation on anterior teeth.

7) Choice of restoration on each posterior endodontically-treated tooth meets the need for cusp protection (i.e., provision of a crown or a cusp-protecting amalgam restoration).

8) Postoperative instructions and recommended follow-up care are documented at the obturation appointment.

G. Oral Surgery

1) A preoperative radiograph showing the apex of each root is available for all teeth extracted.

2) If sutures are placed, type and number are documented.

3) All pathology reports are present in the patient record.
   a. Evidence that the patient was notified of appropriate follow-up is present in the patient record.

4) Any documented difficult surgical procedure or untoward outcome has appropriate follow-up arranged.
H. 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.

I. Pediatric Dentistry

1) An SSC is provided or planned for each primary molar with three or more carious surfaces or pulp therapy, unless contraindications are documented.

2) All primary teeth receiving pulpectomies have preoperative and post-fill periapical radiographs.

3) 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).

4) Documentation of the behavior for all children under the age of 6 is documented.
   a. Behavior management techniques used and their level of effectiveness are documented.

J. Orthodontics

1) Request for treatment (x-rays, extractions, restorative, other) from an orthodontist is documented in the patient record.

For Patients Receiving Orthodontic Care at This Facility:

2) Pretreatment full mouth or panoramic radiographs are available for each patient undergoing orthodontic treatment.

3) Pretreatment study casts are available for each patient receiving orthodontic treatment.

4) Orthodontic treatment plan and treatment provided are consistent with pretreatment findings.

K. Periodontics
1) Patients with 2 or more sextants of CPITN 4 should have a complete periodontal chart and treatment plan. This includes probing pocket depths, furca involvement, mobility, and occlusal features, with documentation. Isolated pockets may be recorded on the examination form.

2) Preoperative radiographs and record of pocket depths of areas receiving periodontal treatment are present in the dental chart.

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

4) Dental record contains evidence of patient’s OH. May include plaque score or bleeding index.

5) 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.

6) Recall visits for patients receiving perio treatment includes a CPITN score.

L. Preventive Dentistry

1) The dental record contains an individualized dental disease prevention plan.

2) Persons with one or more smooth-surface carious lesions, decalcified areas, or with other moderating factors will receive a professionally-applied topical fluoride application. A schedule of a minimum of two and up to four applications per year should 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) Sealants are placed on unrestored, non-carious or incipient carious pit and fissure surfaces of all appropriate permanent first and second molars within two years of eruption.

4) The record indicates that patients who are tobacco users are asked if they want to quit using tobacco.

5) The record indicates that tobacco cessation counseling was provided or recommended for patients who indicated that they wanted assistance in quitting tobacco.

M. 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 (i.e., Ante’s Rule for fixed bridges).

3) Pretreatment full-arch radiographs (occlusal, panographic, or FMX) are available for all full denture patients.

4) Documentation exists and is readily available that records shades, moulds, laboratory and type of metal used.

N. **Preoperative Documentation**

1) The chart contains the patient's name, chart # and age.

2) The patient's chief complaint and history of present illness, including a justification/rationale for the procedure to be performed in the operating room, are present.

3) Documentation of allergies and current medications is present.

4) Documentation of family and surgical history is present.

5) A review of systems including systemic condition, physical examination, and assessment of patient is present.

6) Planned treatment is documented.

O. **Consent**

1) A consent is present which includes the diagnosis and proposed procedure.

2) The common risks, benefits, complications and alternatives to the proposed treatment and mode of anesthesia are included.

3) The consent is dated, including time of day, and signed by the surgeon, patient or guardian as appropriate, and a witness.

P. **Operative/Postoperative Note**

1. A preoperative and postoperative diagnosis (if different from the preoperative diagnosis) are present.

2. A detailed narrative of the operative procedure(s) is present and contains the following:

   a) operative findings
b) anesthesia

c) fluids (as appropriate)

d) drains

e) specimens

f) complications

3. Documentation of the patient's condition, including any complications, upon transfer from the operating room is present.

4. Patients going from the operating room to the Intensive Care Unit or medical surgical floor have a standard admission/transfer order written.

5. The surgeon's name is included in the note.

**R. Dental Inpatient Documentation**

1) Patients admitted for overnight stays will have admission orders which include the order to admit to the dental service, the diagnosis, and current condition of the patient.

2) The admission orders will include the following as appropriate:

   a) allergies

   b) nursing orders

   c) diet

   d) medications

   e) laboratory tests

   g) IV fluids and rate

3) Patients admitted for overnight stays have a discharge summary which includes the name of the person dictating, date of admission and discharge, and a final diagnosis if different from the admitting diagnosis.
4) The discharge summary includes the pertinent admission history and physical findings, a description of the hospital course, and the patient's disposition upon discharge.

5) The discharge summary includes documentation regarding discharge medications and/or dietary instructions as appropriate, and a follow-up date and time.
## Chart Review Tool

Facility: ___________________ Provider: _____________ Reviewer: ___________________
Date Range for Review: _______________ Date of Review: ___________________

<table>
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<tr>
<th>Record Number</th>
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### CRITERIA

**Key**
- **Y-** Yes
- **N-** No
- **NA-** Not Applicable
- **I-** Insufficient information to determine

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Result</th>
<th>Note</th>
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<tbody>
<tr>
<td>A. Every Visit (Total=__)</td>
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<tr>
<td>1) Completed and Signed Medical History, Updated</td>
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<td>2) Precautions appropriate for PS</td>
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<td>3) Legible Notes</td>
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<td>4) Appropriate Codes</td>
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<td>5) Complete progress notes</td>
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<td>6) Auxiliary initials</td>
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<td>7) Disposition</td>
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<td>8) Informed Consent</td>
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<td>9) Pain Documentation</td>
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<td>10) Entries in ink</td>
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### B. Exam and Treatment plan (Total=__) | | |
| 1) Hard tissue findings recorded | | |
| 2) X-rays read | | |
| 3) Soft tissue findings recorded | | |
| 4) Periodontal status and diagnosis | | |
| 5) Orthodontic status | | |
| 6) Treatment Plan Complete | | |
| 7) Notation of needed, unavailable services | | |
| 8) Follow up/ recall consistent with patient needs | | |

### C. Drugs Administered or Prescribed (Total=__) | | |
| 1) Consistent with Written Diagnosis | | |
| 2) Within recommended Limits | | |
| 3) Entered in Progress Notes (including anesthetic) | | |
| 4) Reactions and allergies displayed | | |
| 5) Need for Prophylaxis Determined | | |
| 6) Prophylaxis Given When Needed | | |
| 7) Patient Compliance with Prophylaxis | | |
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#### D. Radiographs (Total= __)
- 1) Radiographs are Dated, labeled and initialed
- 2) Good Diagnostic Quality
- 3) Bitewings Include Proper Landmarks
- 4) Type and Frequency Meet Guidelines

#### E. Dental Emergency Treatment (Total= __)
- 1) SOAP used
- 2) Diagnosis consistent with Findings
- 3) Tx Consistent w/ Dx & appropriate
- 4) Screening Exam

#### F. Endodontics (Total= __)
- 1) Radiographs Available
- 2) Findings Conform Diagnosis
- 3) Obturation
- 4) Obturation Material and Sealer
- 5) Adequate documentation
- 6) Esthetic Restoration of Lingual Access
- 7) Cusp Protection on Posteriors
- 8) Post-Op Instructions

#### G. Oral Surgery (Total= __)
- 1) Appropriate per-op x-ray
- 2) Sutures Documented
- 3) Path Reports Present, adequate, have appropriate follow-up
- 4) Appropriate Follow-up for Difficult Procedures

#### H. Restorative (Total= __)
- 1) Materials used appropriately
- 2) No Overhangs/Open Margins
- 3) Rubber Dam documentation
### Criteria

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#### Key
- **Y**- Yes
- **N**- No
- **NA**- Not Applicable
- **I**- Insufficient information to determine

#### I. Pediatric Dentistry (Total= ___)
1. SSCs used appropriately
2. Pre and Post-op x-rays for Pulpectomies
3. Space Maintenance
4. Behavior and management documented

#### J. Orthodontics (Total= ___)
1. Request for treatment Documented

For Patients receiving Orthodontic care in the facility:
2. Pre Treatment X-rays
3. Pre Treatment Study Models
4. Treatment Consistent with Findings

#### K. Periodontics (Total= ___)
1. Perio Work-up
2. Preoperative radiographs
3. Diagnosis and treatment plan are consistent with preoperative findings
4. OH documented
5. Hygienist’s Progress Notes
6. Recall includes CPITN score

#### L. Prevention (Total= ___)
1. Individualized Prevention Plan Present
2. Appropriate Topical Fluoride received
3. Sealants Placed Appropriately
4. Tobacco Query
5. Tobacco Counseling

#### M. Prosthodontics (Total= ___)
1. Radiographs of Abutments
2. Perio Condition Adequate
3. Full Arch X-rays for Dentures
4. Adequate documentation available
### Record Number

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### Inpatient/Operating Room Care

#### N. Preoperative Documentation (Total = __)
1) Name, chart # and age documented
2) Chief complaint and history of present illness are present.
3) Allergies/current meds documented
4) Family and surgical history documented.
5) Review of systems is present.
6) Planned treatment is documented

#### O. Consent (Total = __)
2) Consent is present
3) Risks, benefits, complications and alternatives are included.
4) Dated, including time of day, and signed by the surgeon, patient or guardian, and a witness.

#### P. Operative/Postoperative Note (Total = __)
1) Preoperative/postoperative diagnosis are present.
2) A detailed narrative of the operative procedure(s) is present.
3) Patient’s condition documented
4) Admission/transfer order present
5) The surgeon’s name is included

#### Q. Inpatient Documentation (Total = __)
1) Admission orders include appropriate information
2) The admission orders will include the following as appropriate:
3) Patients admitted for overnight stays have a discharge summary
4) The discharge summary includes the pertinent information
5) The discharge summary documents meds, diet, follow-up
## Summary and Recommendations

(Within each category subtract NA and I boxes from total number available to calculate denominator.)

<table>
<thead>
<tr>
<th>Category</th>
<th>% Compliant</th>
<th>Comments</th>
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<tbody>
<tr>
<td>A. Every Visit</td>
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<td>B. Exam &amp; Tx Plan</td>
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<td>C. Drugs</td>
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<td>D. Radiographs</td>
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<td>E. Emergency Tx</td>
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<td>F. Endodontics</td>
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<td>G. Oral Surgery</td>
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<td>H. Restorative</td>
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<td>I. Pediatrics</td>
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<td>L. Prevention</td>
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<td>N. Pre-op documentation</td>
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<td>O. Consent</td>
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<td>P. Op/Post-op note</td>
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Recommendations: