

**QUALITY ASSURANCE INSTRUMENT FOR
DENTAL RECORD REVIEW**

**Tennessee Department of Health
Bureau of Health Services
Oral Health Services Section**

CHART NUMBER

CRITERIA										
II.A. MEDICAL/DENTAL HISTORY										
Dental Exam and Operative Record										
Current (PH-0205A), Health History for Dental Services (PH-3990) (A.1.)										
Patient Information (A.2.)										
Health Questionnaire (A.3.)										
Conditions Flagged (A.4.)										
Signed and Dated (A.5.)										
History Updated (A.6.)										
II.B. PATIENT EXAMINATION										
Consent for Treatment (B.1.)										
Blood Pressure (B.2.)										
Oral Conditions (B.3.)										
Charting Completed (B.4.)										
II.C. RADIOGRAPHS										
Diagnostic Quality (C.1.)										
BW/PA criteria (C.2.)										
Mounted and Labeled (C.3.)										
Pre-op Radiograph (C.4.)										
Anterior Radiographs (C.5.)										

GUIDELINES AND CRITERIA FOR STANDARDS OF ACCEPTABLE QUALITY PUBLIC HEALTH DENTISTRY

II. DENTAL RECORD REVIEW (20 Records must be Reviewed)

A. PERFORMANCE AND DOCUMENTATION OF THE MEDICAL/DENTAL HISTORY

1. A *Health History for Dental Services (PH-3990)* and a *Clinic Oral Health and Treatment Record (PH-0205A)* are completed for each patient seen in the dental clinic, using the most current versions.
2. Key patient identification information (address, phone number, emergency information, and source of payment) is located on PH-3990.
3. The health questionnaire (medical history) contains **no** unanswered questions. Questions that are answered yes, must be explained, i.e. Are you seeing a Physician – Yes – Why.
4. Medical conditions or medications requiring an alert are flagged. Alerts are to be flagged using appropriate stickers for Med Alerts and Allergies or by using a Red Pen. Stickers or red annotations are to be placed on the Health History for Dental Services, and on the Clinic Oral Health & Treatment Record.
5. The medical history is signed and dated by the patient or parent/guardian and the dentist.
6. The medical history is updated at each appointment, and any change is noted on the PH-3990 or in the progress notes. A new Health History must be completed annually.

B. PERFORMANCE AND DOCUMENTATION OF THE PATIENT EXAMINATION

1. Written (signed) consent for treatment is obtained for all patients. Patient's name must be written in treatment consent line.
2. Blood pressure recordings are taken at the initial visit of adult patients and prior to all surgical, invasive or stressful procedures. Blood pressures are taken at each visit on patients with a history of hypertension.
3. Oral conditions including restorations, caries, periodontal status, oral hygiene status and any other pertinent observations are recorded for each patient undergoing comprehensive or preventive care.
4. Charting of the examination findings are completed in the appropriate tooth grids on PH-0205A, using Standardized Charting.

C. RADIOGRAPHS

1. Radiographs have proper density, contrast, and detail.
2. Periapical radiographs include all of the crown, roots, and surrounding bone in the area of observation and are not distorted or overlapped (where anatomically possible). Bitewing radiographs split the contacts if possible and include the distal of the cuspids and the mesial of the last tooth in the arch. Bitewings are taken all initial exam appointments when there are close posterior contacts and updated based upon carious activity, caries risk, disease activity or specific problems.
3. Intraoral radiographs are mounted properly and labeled with the date and patient's name. Extra-oral radiographs are labeled with the date and the patient's name.
4. A periapical radiograph with diagnostic quality is taken prior to extracting any tooth (except primary teeth near exfoliation). A current panoramic radiograph of diagnostic quality can be made prior to extraction of teeth # 1, 16, 17 or 32 only. Periapical radiographs are indicated prior to an extraction because they show a view of the entire tooth and its periodontal supporting structures. Periapical radiographs also reveal the preoperative condition of the hard and soft tissues including pathology and possible surgical complications that might be encountered during treatment. Bitewing radiographs are inadequate due to the fact that they show only the crowns of the teeth and the alveolar crest in a dentition with normal to slight bone loss.
5. Anterior periapicals or panorex x-ray must be taken prior to any restorative procedures performed on anterior teeth.

D. TREATMENT

1. The treatment for each patient is based on the history, examination, and diagnosis.
2. The treatment follows a logical sequence. Normally, with minor variations, this is:
 - a. Relief of pain and discomfort
 - b. Elimination of infection and traumatic conditions
 - c. Caries control (removal of soft, deep caries)
 - d. Prophylaxis, preventive procedures, and oral hygiene instruction
 - e. Endodontic therapy
 - f. Periodontal therapy
 - g. Necessary extractions
 - h. Restoration of teeth
 - i. Replacement of teeth
 - j. Placement of the patient on an individualized recall schedule
3. *Informed Consent for Oral & Maxillofacial Surgery* (PH-3432) or *Informed Consent for Patients Taking Oral Bisphosphonates* (PH-4035) is completed for

all oral surgery procedures. If the patient has taken an Oral Bisphosphonate drug, both forms must be filled out. If the patient has no previous history of taking Oral Bisphosphonates just the Informed Consent for Oral & Maxillofacial Surgery (PH-3432) needs to be completed.

E. PROGRESS NOTES

1. All progress notes are legible, dated, and signed by the provider on the date of service in blue or black ink, using signature found on Legal Signature Page, of dentist, hygienist or assistant and credentials (DDS).
2. All progress notes are in chronological sequence.
3. Documentation of services (treatment) rendered contains the following at a minimum: (see example below)
 - a. Date of service
 - b. Tooth number, if appropriate, in tooth number block
 - c. Description of the service
 - d. Anesthetic used, if any - including quantity
 - e. Materials used, if any – i.e. shade of comp, brand of amalgam, type of base etc.
 - f. Prescriptions or medications dispensed including name of drug, quantity, and dosage
 - g. Additional comments on referrals, consultations, and instructions
4. Standardized charting of treatment is completed in the appropriate tooth grids on PH-0205A.
5. Broken appointments are documented in the progress note.
6. Copies of all referral slips, and correspondence from other providers are kept in the patient's chart.
7. A recall plan or next visit is included in the progress notes.
8. Errors should never be corrected with white out. A line should be drawn through the mistake to avoid the impression that a record may have been altered. CID (Correction in Documentation) is written immediately above the mistake, along with initials and date (if different from date of original entry).

Example of Progress Note:

**1/18/07 Pt. presents for operative #S (DO) & # T (M)
Health History reviewed. NKDA. Pt. taking no meds. OHI reviewed. Caries # S (DO), #T (M).
Tx plan: 1. Today: amalgam #S (DO), #T (M), Used ½ carp 2% Lido with epi 1:100,000. Removed all caries. #T – acid etched, 34% Caulk, bonded with Prime and bond NT, placed flowable composite,(Vivadent) shade A2. # S- placed amalgam (Tytin) checked**

margins and occlusion. 2. Findings & treatment explained to pt. Pt. dismissed in stable status. 3. Appt. made for #L (pulp & SSC).

John Doe, DDS

F. PTBMIS VERIFICATION OF ENCOUNTER One encounter/patient record reviewed

1. Correct provider numbers are listed for this DOS.
2. Correct program codes are posted for this DOS.
3. Correct services and procedure codes are posted for this DOS per PTBMIS Codes Manual and ADA.
4. The services and procedures billed for are documented in the dental chart. This would be marked no if they were coded as being done but not documented in the chart.

G. TENNCARE ADVOCACY

1. Level I – Can be done by any health department employee. Only one code may be coded on the patient encounter form per clinic visit.
2. Can be documented on the TennCare Advocacy Encounter log or put a comment in date of service.
3. Level II – Can only be done by a dentist or hygienist.
4. In order to take this code it must be documented in the chart what was done for the patient – above & beyond everything else.

**QUALITY ASSURANCE INSTRUMENT FOR THE
DIRECT OBSERVATION OF PATIENT CARE**
Tennessee Department of Health
Bureau of Health Services
Oral Health Services Section

PATIENT'S CHART NUMBER

CRITERIA											
III.A. DIAGNOSIS											
Initial Exam/Recall Exam (A.1.)											
Initial Radiographs (A.2.) (A.3.) (A.4.)											
Recall Radiographs (A.5.) (A.6.)											
Lead Apron with Thyroid Collar (A.7.)											
Film Positioners (A.8.)											
Scatter Protection (A.9.)											
Appropriate Diagnosis (A.10.)											
Use of Diagnostic Aids (A.11.)											
Periodontal Disease (A.12.)											
Appropriate Referrals (A.13.)											
Appropriate Treatment (A.14.)											
III.B. PREVENTION											
Appropriate Preventive Procedures (B.1.)											
Prophylaxis/Recall (B.2.)											
Fluoride/Sealants (B.3.)											
III.C. OPERATIVE DENTISTRY											
Work Practice Controls (C.1.)											
Water Cooling Spray (C.2.)											
Proper Sedative Fillings (C.3.)											
Appropriate Bases (C.4.)											
Complete Removal of Defective Restorations (C.5.)											
Restorations Reproduce Sound Tooth Contours (C.6.)											
Class II Restorations Performed Correctly (C.7.)											
Stainless Steel Crowns (C.8.)											
Agitator Covered (C.9.)											
Storage & Recycling of Scrap Amalgam (C.10)											
III.D. REMOVABLE PROSTHODONTICS											

GUIDELINES AND CRITERIA FOR STANDARDS OF ACCEPTABLE QUALITY PUBLIC HEALTH DENTISTRY

III. QUALITY OF PATIENT CARE SERVICES

A. DIAGNOSIS *

1. **An initial or recall examination is conducted on all patients.**
2. Initial radiographs for an adult patient consist of individualized films including bitewings with panoramic exam or bitewings and selected periapicals. A full-mouth intraoral radiographic examination is appropriate when the patient presents with clinical evidence of generalized dental disease or extensive dental treatment.
3. For children with primary teeth only, radiographs are taken if proximal surfaces of the primary teeth cannot be visualized or if there are specific problems.
4. For children with a transitional dentition, or an adolescent with permanent dentition, initial radiographs should consist of appropriate posterior bitewings with panoramic exam or posterior bitewings and selected periapical images.
5. Recall radiographs (bitewings) are taken at a frequency based on caries activity, caries risk, disease activity, or specific problems but should be taken at least once annually or more frequently if needed.
6. Recall radiographs (panoramic) for children with transitional dentition should be based on clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth & development. For adolescents with permanent dentition the recommendation is based on clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth & development.
7. Lead aprons, with thyroid collars, are used on all patients receiving radiographs.
8. Film positioners are used. Neither patient nor staff holds the film during exposure.
9. Staff is protected from scattered radiation during film exposure.
10. A proper diagnosis consists of the patient's state of oral health and the existence of any pathology or abnormal condition including the causes and type of the pathology or abnormal condition. The primary tools are the history and clinical examination.
11. The diagnosis includes the use of a variety of aids as necessary, such as, but not limited to radiographs, study casts, periodontal probing, pulp tests, percussion, palpation, transillumination, and biopsy.
12. Patients with periodontal disease are informed of their periodontal condition(s), and appropriate referrals are made for consultation and treatment.
13. The patient is referred for medical and/or dental consultation, if necessary, to reach a definite diagnosis.
14. The treatment for each patient is appropriate and is based on the history, examination, diagnosis, and discussion with the patient and/or parent (guardian).

- **Direct Observation of Patient Care QA review must include at least one patient from the following categories for the first review (conducted during the first four months of hire) for new providers. For annual reviews, Direct Observation of Patient Care QA review should include at least 1 patient from the following categories:**
 - **Operative Dentistry**
 - **Oral Surgery**
 - **Prevention**

B. PREVENTION

1. Treatment includes appropriate preventive procedures for each patient undergoing comprehensive care.
2. Professional prophylaxis, which removes plaque, extrinsic stains, and calculus, is performed at regular intervals appropriate to the individual.
3. Caries prevention in children includes, when appropriate, systemic or topical fluoride, sealants, and oral hygiene instruction.

C. OPERATIVE DENTISTRY

1. Rubber dams, high volume evacuation, and proper patient positioning are utilized to reduce formation of aerosols, droplets, and spatter.
2. A water-cooling spray must be used with high-speed tooth reduction.
3. Sedative treatment fillings are used only when gross caries have been removed.
4. Bases are used in all deep cavity preparations.
5. Defective restorations or restorations with recurrent caries are completely removed and replaced.
6. All restorations reproduce sound tooth contours, restore or achieve interproximal contact, and have flush margins.
7. Mechanical matrices and gingival wedges are used in the restoration of all class II caries with an adjacent tooth.
8. Significant interproximal carious lesions on primary teeth are restored with stainless steel crowns.
9. The agitator of the amalgamator functions under a protective cover.
10. Amalgam scrap is stored in a tightly closed container and recycled properly, to include extracted teeth with amalgam in them.

D. REMOVABLE PROSTHODONTICS

1. Partial Dentures
 - a. Partials are designed so that they do not harm the remaining teeth with undue stresses and/or create food traps.
 - b. Abutment teeth requiring restoration should be restored with a crown or onlay if areas supporting retention devices are involved.

- c. Tissue-bearing areas are covered to the physiological maximum within acceptable esthetic limits.
- d. All patients receive thorough instructions in oral hygiene procedures.

2. Complete Dentures

- a. Patients are informed of the limitations of complete dentures.
- b. Baseline radiographs (panoramic x-ray) of edentulous areas are taken before denture construction.
- c. Dentures cover the maximum areas physiologically possible.
- d. Dentures maintain vertical dimension and physiologic occlusion.
- e. Dentures are esthetic and shaped to minimize phonetic problems.
- f. All patients receive thorough instructions in oral hygiene procedures.

E. ENDODONTICS

1. An accurate periapical radiograph of the involved tooth (including apices) is taken prior to the start of endodontic therapy.
2. A rubber dam must be used for all endodontic cases.
3. Gutta percha is used in the root canal filling and is densely packed and sealed to about one millimeter of the apex.
4. Pulpotomies are not performed on primary teeth with apical involvement, intraradicular involvement, or noticeable mobility.

F. PERIODONTICS

1. Periodontal treatment is preceded by examination to include periodontal charting, diagnosis, and treatment planning.
2. All patients are instructed in home care to attain plaque control and caries prevention.
3. Mild periodontal disease is treated by scaling, root planing, and replacing or modifying defective restorations.
4. Patients with moderate or advanced periodontal disease are referred to appropriate specialists for consultation, treatment, and follow-up care.
5. Periodontal patients treated in the clinic are placed on regular recall at intervals specific to the each patient.

G. ORAL SURGERY

1. When teeth are extracted, all portions of the tooth are removed, except under circumstances where injury to the surrounding hard and/or soft tissues is likely to occur with further attempts at retrieval.
2. If it is necessary to leave a root tip, the patient is informed; treatment options including referral are discussed; and all pertinent information is documented in the patient's record.

3. A periapical radiograph with diagnostic quality is taken prior to extracting any tooth (except primary teeth near exfoliation). A current panoramic radiograph of diagnostic quality can be made prior to extraction of teeth # 1, 16, 17 or 32 only.
4. Written informed consent using form PH-3432. If the patient has taken an Oral Bisphosphonate drug, then the *Informed Consent for Patients Taking Oral Bisphosphonates* (PH-4035) must be completed as well. If the patient has no previous history of taking Oral Bisphosphonates only the Informed Consent for Oral & Maxillofacial Surgery (PH-3432) needs to be completed.
5. After extractions all patients are given oral & written post-operative instructions.

H. EMERGENCY TREATMENT

1. No patient is sent home or referred without measures taken to relieve his/her distress.
2. Patients with acute conditions that negate the ability to achieve adequate local anesthesia receive palliative treatment.
3. A sufficient number of radiographs with diagnostic quality are made, and other diagnostic aids are utilized, as needed, to reach a definitive diagnosis.
4. The emergency condition is treated by the most efficacious method.
5. If the tooth can be restored, but time does not allow for a permanent restoration, a temporary or sedative filling is placed after removal of gross caries.
6. If root canal therapy or pulpotomy is indicated, initial endodontic treatment is performed to relieve pain.
7. Appropriate antibiotics and/or analgesics are dispensed or prescribed as necessary.
8. If the emergency is complex and beyond the ability of the dentist, the dentist arranges referral to the appropriate dental specialty.

I. INFECTION CONTROL (From section 1)

1. Dental unit waterlines to all instruments (high-speed handpiece, air/water syringe, and ultrasonic scaler) are flushed for several minutes at the beginning of the each clinic day and for a minimum of 20-30 seconds after use on each patient. Dental unit waterlines must be treated with appropriate products (i.e. Sterilex), and all water monitoring recommendations must be adhered to.
2. Critical and semicritical instruments – After thorough cleaning, all heat-stable Instruments, including handpieces, are heat sterilized. Handpieces, to include low speed attachments & motors must be sterilized between patients.
3. Noncritical instruments - After thorough cleaning using the Ultrasonic cleaner, all instruments and medical devices receive intermediate or low-level disinfection.
4. Disposable covers and disposable supplies are used whenever possible. Disposable items are never reused.

5. Hands are washed thoroughly before and after treatment of each patient with antimicrobial soap or hand sanitizer.
6. Protective attire (gloves; masks; and eye, face, and long - sleeved clothing protection) is worn, by the dental staff.