

Quality Assurance for Patient Care

The Department of Dental Hygiene strives to provide the highest quality of care to our patients. For this reason, a quality assurance program has been implemented.

“**Quality Assurance**” is the assessment or measurement of the quality of care provided and the implementation of any changes necessary to either maintain or improve the quality of care rendered. The program is continuous and involves three key components: assessment, evaluation, and correction.

Quality Assessment

In order to evaluate the quality of care provided in the UAMS Dental Hygiene Clinic and Mountain Home Dental Clinic, assessment of quality is considered at two levels: satisfaction of the patient with the care received and quality of care provided by the practitioner.

I. Patient Satisfaction

Patient surveys are used to measure patient satisfaction as well as observations of and opinions toward the care received. Students or the receptionist distribute surveys to patients when treatment is completed. This data is tabulated and reviewed by the program director and faculty to determine if changes are needed.

II. Quality of Care

Charting Auditing - Clinical faculty members are responsible for reviewing each patient's treatment record for appropriateness of documentation and care provided before co-signing the computer record. Therefore, computer chart audits are to be conducted at the completion of patient care. However, students must also maintain a “patient treatment log” that contains the name of each patient treated in the UAMS/Mountain Home Dental Clinics, date of treatment, description of care provided, and treatment status (complete/incomplete). Each student is assigned to a faculty advisor who meets with him/her at the middle of the first clinical semester (Clinic I) to review the treatment log. Faculty advisors review each student's treatment log for appropriateness of care and to make sure all treatment initiated in the Dental Clinic is completed. Every effort must be exercised to make sure that treatment initiated in the clinic is completed. Students have a professional, ethical, and potentially legal obligation not to abandon the care of a patient. During this time, faculty advisors utilize a Treatment Log Review Guide to assist students in reviewing patient records for completeness of documentation. Faculty advisors determine if the patient's periodontal classification is correct, appropriateness of diagnoses and treatment decisions, and the outcomes of care.

In addition to instructor evaluation, students must also be able to critically evaluate their own clinical proficiency. A list of goals and objectives for each clinical skill to be evaluated is available in the clinic. Using the provided criteria, students must be able to judiciously assess their own performance.

Evidence-Based Practice - The UAMS Dental Hygiene Clinic and Mountain Home Dental Clinic promotes an evidence-based practice of dental hygiene care. Treatment options must be based on assessment of the patient's needs and expectations and sound scientific evidence based on successful treatment outcomes. Evidence-based protocols require the use of rapidly changing technology and products through the evaluation of literature and continued professional education. Through the dental hygiene curriculum, continuing education courses, scientific journals, professional meetings, and guest speakers, faculty and students keep abreast of current technology, research, and literature in order to practice evidence-based decision making in providing dental hygiene care and education.

Standards of Care - The faculty assesses the degree to which the standards of clinical care are met by students in the dental hygiene clinic through clinical competency examinations and faculty observation. The department's quality assurance (QA) program also monitors these standards to ensure compliance. Patients will be provided comprehensive assessments and a dental hygiene diagnosis and appropriate treatment plan to include preventive and therapeutic care and patient education. Students will use measurable assessment criteria to evaluate and communicate the outcomes of dental hygiene care and document all components of the dental hygiene process of care (assessment, dental hygiene diagnosis, planning, implementation, and evaluation).

Evaluation

The data from the patient surveys, treatment record audits, and the student self-assessments are collected and analyzed. Patient surveys and student self-evaluations are forwarded to the Department Chairman. Summaries of the treatment record audits for each student are forwarded by the faculty advisor to the Department Chairman. The Department Chairman evaluates the data and provides feedback to the faculty.

Correction

If the quality of treatment provided or patient opinion of the quality of care received in the clinic is inadequate, the appropriate corrective action will be taken to bring care back into line with expected standards. Faculty advisors may counsel or provide remedial education for individual students or the clinic coordinators may discuss inadequacies with entire classes of students. If an inadequacy is identified, the situation will be monitored and reassessed on a continual basis until it is resolved.

Records Management

The treatment record is a critically important part of the patient's record. It is a *legal document*. It includes all treatment provided to the patient and also provides historical insight into the patient's past treatment. The top portion of the medical history form should be filled in completely with the patient (name, address, DOB, phone number) and scanned into the computer under smart docs. The student must document exactly which services were provided, what recommendations or observations were made, and any medication given to or prescribe for the patient in the electronic clinical notes. The clinical notes must be filled out after the student has completed all treatment for that appointment and before the instructor arrives for check-out. The instructor must review the student's entry, make corrections/additions as needed, and co-sign the treatment record/clinical notes on the computer.

Documentation in Treatment Record/Clinical Notes:

Must be dated and signed by the provider and supervising faculty

Items to Document

Anything given to the patient: toothbrush and auxiliary items, x-rays, etc.

Anything told to the patient: recommendations, referrals, recall interval, oral hygiene instructions, post-treatment care instructions, etc.

Prescriptions: what, how much, directions, refills

Premedication: what, how much, when taken, specific directions given to patient

Local anesthesia: type used, vasoconstrictor, amount, injection site

Antecedotal notes

Radiographs taken: type, area, reason for individual PAs

In case of an error:

Place the date, "Correction", and provider's or faculty initials.