

# West Sussex Clinical Governance 2007-2010

## Medical History Taking Audit

### 1.1 The topic to be Audited including Aims and Objectives

An audit into medical history taking and updating to ensure that all clinical records have the relevant information recorded and medical alerts, where present, are easily seen on the patients' notes so as to ensure best possible care of our patients.

### 1.2 The source material/references you will be using

BDA Medical history Questionnaire, Standards in Dentistry, BDA Compendium BDA Quality Assurance Manual BDA Good Practice.

### 1.3 The Proposed Standard

85% or greater of all patients attending the practice have a written medical history taken and relevant alerts noted.

10% or less have a medical history taken with minor omissions.

5% or less have no medical history recorded, or it appears inadequate.

### 1.4 How the activity will be measured and the data analysed: including data sample size

The sample size will be 80 records per dentist, taken at random over a four-month period. Patients will be asked to complete a medical history questionnaire and alterations and omissions noted. Data will be collected and analysed using spreadsheets.

### 1.5 Proposed timetable of activity

Meeting with the staff to discuss data collection, plan activity, and to inform the staff.

Collection of data and insertion into spreadsheets.

Analysis of data.

Discussions of findings.

Implement any changes necessary.

### 1.6 Total number of hours of CPD for audit:

5 hours.