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Research Article

CLINICAL AUDIT IN THIRD MOLAR SURGERY FOR IMPROVING PATIENT'S CARE

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ABSTRACT

Certainly there are recommendations, but little evidence about the rationale for maintaining opd, follow-up records and review appointments for patients especially in a dental setup.

Materials and methods: Third molar surgery was analyzed by prospectively maintained database, which underwent surgical removal of impacted third molar teeth. Follow up records and reviews of all the patients were evaluated.

Results: All patients were reviewed .Just over a quarter (29%) visited prior to the appointment to obtain further analgesia. 17 complications were recorded at the initial review appointment; 5 patients had lingual paresthesia, 9 with inferior alveolar nerve paresthesia, and 3 with swelling.

Conclusion: It is recommended that more efforts should be made by the Institute/ hospital management, clinicians to improve the state of maintenance of patient records, which will help in the modification of the treatment protocol so as to give better patient care.

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INTRODUCTION

Medical record maintenance is an important step in patient management, with time and constant upgradation it has evolved into a science. Detailed records help in every aspect of treatment planning. Despite improvement in health care infrastructure in recent years in India and other developing countries, proper documentation still presents a gloomy picture. Healthcare institutes commonly see large flow of patients, undergoing variety of surgical procedures, which seldom experiences serious postoperative complications and hence negligence in the aspect of maintaining proper records. The benefit of the traditional follow-up & review appointment in modern day scenario is therefore a matter for debate. Records form most important aspect in both patient care and medico-legal purposes in modern dental care scenario and especially in oral and maxillofacial setup. Patients are normally followed up in outpatient clinics, but there is no consensus about maintain opd details, number of appointments, extent of the consultation, or the type of any investigations used etc. Literature shows that, despite the best intentions, improper record maintenance has shown detrimental effects. In our institute we maintained all the records using a well-planned perfoma, pattern of follow-up for review of patients who were treated and looked for potential associations and links with variables such as complications and their management, patient satisfaction and outcomes. To do this we recorded the number of consultations, review of patient postoperatively and final outcome. To show the practicality of maintaining documentation we retrospectively analyzed the patients who underwent Third molar surgery. The aim was to find out the importance of patient record maintenance and to see whether all patients need to be reviewed after routine third molar exodontia and to assess patient's satisfaction with their management. It also highlighted the incidence of postoperative complications and its prognosis with timely diagnosis and management.

Documentary evidence is one of the main legal proofs deciding, in cases of medical negligence.[1] The advantage of maintaining dental records is that it delivers quality patient care and follow-up.[2]It is wise to remember that "poor records mean poor defense; no records mean, no defense."[3]Thus, Clinical audit[4] is a quality improvement process.

PATIENTS AND METHODS

A total of 264 patients who underwent surgical removal of impacted third molars under local anesthesia at KAHE's KLE VK Institute of Dental Sciences from January to December 2015 were included. Pre and post-operatively all the records were analyzed and they were asked to complete a satisfaction questionnaire, details such as the waiting time, consultation time, staff conducting the appointment, associated complications, treatment were all recorded. Data was recorded in the given format, which ensured a follow-up of at least 1

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month for all patients. Audit of pre-operative and post-operative records of all the patients was done, to check for completeness of the records. Otherwise the analysis is descriptive and observational over time.

RESULTS

A total of 236 subjects attended for follow-up and review appointment, and 28 patients did not reported for follow up. The mean age of the participants was 34 years (range 15-63).

Over three-quarters (81%) of the patients who were reviewed said that they preferred the reassurance of a follow-up appointment. Eight would rather not have attended for review, but would have preferred consultation with contact number in case of problems. None of the patients felt that their care could have been improved on in any way. The mean time period between operation and review, the mean waiting time at the review appointment, and the mean consultation time are shown below :-

Variables recorded at postoperative review appointment (n = 236)

Mean Range Time period between surgery and review (days)	7-12 days
Waiting time at review appointment	16 -45 minutes
Consultation time (min)	3- 5 minute

All patients were initially reviewed by a resident, followed by a consultant if any complication or dissatisfaction was reported. Just over a quarter (29%) visited prior to the appointment to obtain further analgesia. One patient required re-exploration for decompression of the swelling. 17 complications were recorded at the initial review appointment; five patients had lingual paresthesia, nine with inferior alveolar nerve paresthesia, and three with swelling. Further appointments were arranged with consultant staff, and all except two resolved spontaneously.

Appropriate auditing was done to evaluate the quality of care provided. Basic procedure involved in the standard auditing process[5] was followed in our study.

DISCUSSION

Patient record maintenance is always tedious, burdening the workload of surgeon and the supporting staff, which often overshadows its importance. It is a routine practice in developed countries but is still lagging in developing countries like India. Studies have shown that medical records plays an important part in patient management and serves as an important tool in a negligence claim as only proof. It is important to maintain records in both legal perspective and for planning and justifying the treatment.

The audits are useful to assess whether the change was productive or not. Its results show areas of excellent, which should be recognized or it may also identify 'areas for improvement'.[7]Audit facilitates self-referencing and reflective learning.[8]

In the present study, all the patients seemed satisfied with the care and treatment that they received. This in turn can be attributed to perfect treatment planning based on thoroughly obtained record of the patient. On assessing the post-operative records and patient questionnaire we observed that over three-quarters of patients who were followed up, preferred the method of follow-up routinely followed in our institute. A healthcare institute serving large area/ population, patients may have to travel appreciable distances to attend a brief appointment. We found policy of selective review to be extremely appropriate and useful, whereby arrangements for further consultation are made only if there are complications or if there is gross pain or swelling or altered sensation postoperatively. By using clinical experience and judgment, it is likely that an unnecessary and inconvenient review appointment can be avoided for most patients, who recover uneventfully. We found the review process to have series of advantages, which include practical aspects to ensure that patients understand and comply with a specific treatment regimen. It also enables clinicians to monitor the clinical progress (physically, emotionally, and psychologically), and to look for evidence of any complication, providing valuable insight to reduce its number.

In the study we found overall complication rates of about 10% after third molar surgery, implying that 90% of recall appointments are unnecessary, which cannot be held in view that prevention is better than cure.

On retrospectively analyzing the records of Third molar surgery we found, 8 patients were dissatisfied by the follow up protocol and said it was time consuming. Review appointments were short (mean 3 min), whereas the waiting time was long, in some cases up to an hour. When waiting time is combined with travelling time to attend the appointment, and when one considers inconveniences such as time away from home or work, it becomes increasingly difficult to justify follow-up appointments for all patients. To reduce this we followed an arrangement of review with a resident first and consultants review if there is any complication or patient is dissatisfied. Analyzing the patient records thus helped in modifying the review protocol in our institute and thus achieving patient satisfaction.

Records showed that at least a quarter of the patients visited before their appointment for further analgesia. All had been prescribed an analgesic regimen that has previously been shown to be effective in controlling pain after removal of wisdom teeth. It is likely that most of these patients felt that their doctor was more approachable because of the appointments given and giving at most importance to patient satisfaction. Nevertheless, it gave an insight to review the analgesic advice that patients are given on discharge to reduce the number who subsequently visit their doctor. The fact that patients who were not reviewed did not seek help from their doctor more often than those who were has also been reported in a similar study that investigated the need for postoperative review after uncomplicated minor oral surgery.

Clinical audit of all the records was done time to time, to ensure that quality is maintained, and in a teaching hospital it is important that junior trainees have the opportunity to review the results of routine surgery. This not only helps in enhancing their skills but also in inculcating a habit of maintaining records. With the advent of scientific culture this record keeping has got an additional advantage in the field of emerging branch of forensic dentistry. In a nutshell we can say that medical record maintenance not only helps in patient care and education, but also helps in research and medico-legal purposes.

"Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity "as defined by the World Health Organization. There have been vast improvements in the field of Oral and Maxillofacial Surgery and Dental treatment, which have lead to a demand in quality of clinical care.[9]

Medical records help in proper evaluation of the patient and to plan treatment protocol and documentary evidence in cases of medical negligence. Thus, medical records should be properly written and preserved to serve the purpose of doctor as well as his patient.[6, 10]

A good medical record serves the interest of the medical practitioner as well as his patients. It is very important for the treating doctor to properly document the management of the patient under his care. Medical record keeping has evolved into a science. The key to dispensability of most of the medical negligence claim rest with the quality of the medical records. Record maintenance is the only way for the doctor to prove that the treatment was carried out properly. Medical records are often the only source of the truth. They are likely to be far more reliable than memory.[10]

In our study the record was maintained through paper work. But nowadays automated hospital information systems can help improve quality of care because of their far-reaching capabilities. Computers allow the use of a paperless, electronic system. Computers provide an easier way to look up a patient's information if they ask for it. The alternative to that would be through papers that could misplace.[11]

CONCLUSION

It is recommended that more efforts should be made by the Institute/ hospital management, clinicians to improve the state of maintenance of patient records.

In this era when medico-legal issues are increasing day by day, poor records imply poor defense. While concluding, we strongly recommend that it is the responsibility of the central authorities (DCI), institute to issue the guidelines to be followed at all times and inculcate such habits from the beginning.

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