Compliance of Orthognathic Records With The BOS/BAOMS Minimum Dataset

A.MAQBOOL*, R.O’BRIEN, H.ABDAL, I.LEVISIANOS
UCL Eastman Dental Hospital and Institute, 256 Gray’s Inn Road, London WC1X 8LD

Introduction
Clinical records are legal documents, therefore they are required to be accurate, full, contemporaneous and confidential. Records form a fundamental component of audit, research, treatment planning and medico-legal purposes. Surgical orthodontics requires significant planning, whereby multiple clinical, photographic and radiographic records are essential. This can lead to record keeping becoming naturally incoherent and rather haphazard. Routine record collection during the orthognathic process must be justified and explained to the patient as part of the overall consent process.

Aims
The aims of this audit were:
• To establish the current practice in record keeping for orthognathic patients at Eastman Dental Hospital.
• To identify differences in our protocol to those set by the BOS/BAOMS minimum dataset.
• To revise our current protocol of orthognathic record keeping if required.

MATERIALS AND METHOD
A retrospective audit was carried out in the Orthodontic Department in Eastman Dental Hospital. 50 records were selected from the Joint Orthognathic Clinic.

Inclusion Criteria
• The orthognathic surgery and orthodontics must have been completed at the Eastman only
• The surgery must have been completed by the same surgeon
• The patient must have attended their post operative review appointments, including 2 years post-debond.

Selected records were assessed to check if they contained:
• Lateral cephalogram
• Orthopantomogram (OPT)
• Extra-oral and Intra-oral photographs
• Study Models
• Assessment sheet
• Documented Altered Sensation
• BOS patient questionnaire

All the above recordings were further analysed to investigate at what point during treatment they were taken:
• Pre-treatment (Prior to the start of orthodontic treatment)
• End of pre-surgical orthodontics (During surgical planning)
• Immediately post-surgery
• 1-3 weeks post-surgery
• Pre/circa orthodontic debond
• Retention

The BOS/BAOMS minimum dataset proforma was used to collect data.

STANDARDS
The BOS/BAOMS recommended a minimum data set (2005) that defines a list of radiographic, photographic and plaster records to be taken at set times during combined orthognathic treatment

Gold Standard = 100% COMPLIANCE

RESULTS

A Bar Chart to Illustrate the Records Kept As a Percentage at Particular Orthognathic Treatment Stages

Radiographs: Greater than 90% of the records had radiographs taken at the required stage, except only 16% of records had an OPT at the time of debond.

Study Models: Greater than 80% of the records had study models at the required stage. Only 4% of records had study models taken post-surgery.

Clinical Measurements: 82% of the records had measurements recorded pre-treatment. Only 4-6% of records had clinical measurements taken post-operatively.

Altered Sensation: Less than 36% of the records contained a measurement of sensation.

Questionnaire: No questionnaires were found in any of the records.

DISCUSSION

Radiographs were consistently present throughout the treatment stages. Although records of study models and clinical photographs require some improvement. Only professional photography within the notes were included, but many students use their own cameras. In general, less records were taken during retention in comparison to the pre-operative planning stages. There was no evidence of a patient satisfaction questionnaire, however these are still awaiting national approval. Currently at the Eastman, there are 2 sets of records for each patient, an additional departmental set on top of the standard clinical notes. This may explain why particular data such as clinical measurements were absent. This audit demonstrated that the Eastman is conforming with a good standard of clinical record keeping, although it did not meet 100% gold standard set by the BOS/BAOMS minimum dataset.

Audit Recommendations
• An Eastman Orthognathic Proforma Sheet adapted from the dataset
• Clinician’s own clinical pictures, clinical measurements and baseline/ altered sensation recorded in both the medical and departmental notes.
• Re-audit in suitable timeframe.

REFERENCES

www.eastman.ucl.ac.uk
University College London Hospitals
NHS Foundation Trust