



Standardizing Clinical Documentation in Pediatric Dentistry: A Quality Improvement Initiative

Jamekia T. Bailey, DDS, Lilliani Vieira, DDS, MSC, PhD, Timothy B. Followell, DMD, MS, MSHPE, FAAPD
University of Louisville School Of Dentistry

Introduction

Accurate pediatric dental documentation is essential for patient safety, communication, informed consent, and legal protection. The American Academy of Pediatric Dentistry (AAPD) "Best Practices" outline key required elements¹, yet studies^{3,4,5,7} consistently show incomplete and inconsistent documentation, particularly in behavior assessment, radiographic interpretation, and consent. Contributing factors include reliance on free-text charting, workflow challenges, and lack of standardized templates.

A local chart review in our pediatric dental clinic demonstrated similar deficiencies, including missing Frankl scores, pain assessments, caries risk, radiographic interpretations, and counseling documentation. These findings support the need for a standardized documentation system aligned with AAPD Best Practices to improve completeness, consistency, and quality of care.

Objective

The objective of this study was to design, implement, and evaluate a standardized pediatric dental charting template to improve documentation completeness and consistency across common clinical procedures, with a goal of achieving $\geq 90\%$ compliance with 15 essential AAPD-aligned documentation elements.

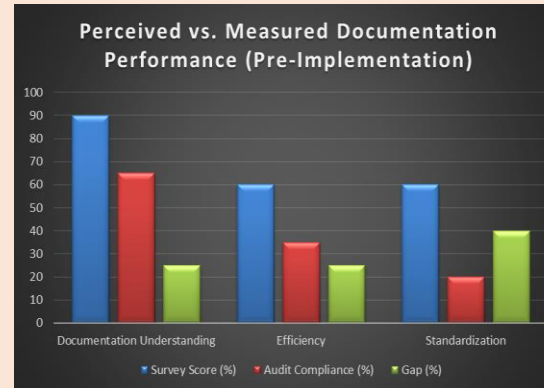
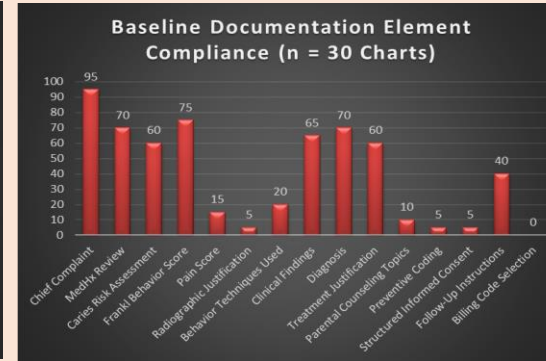
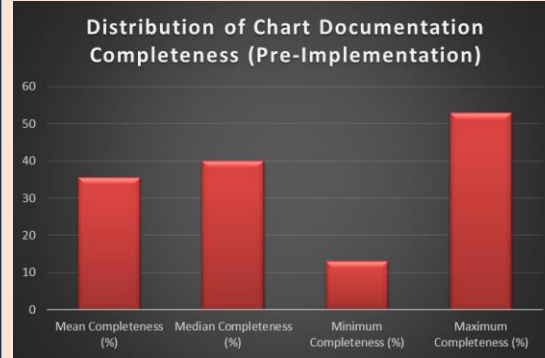
Methods

This cross-sectional study represents the baseline phase of a larger prospective Quality Improvement (QI) project using a Plan-Do-Study-Act framework. Data collection included chart audits and anonymous resident and faculty surveys.

Thirty patient charts from common pediatric dental procedures were reviewed and scored for the presence of 15 AAPD-recommended documentation elements. Concurrent surveys assessed perceived documentation completeness, clarity, and workflow barriers using Likert scales.

Descriptive statistics were calculated. Survey responses were converted to percent agreement (scores 4–5) and compared to chart audit findings. Gap scores (resident perception minus audit) were used to

Tables



Results

Thirty charts were analyzed. Mean documentation completeness was **35.6%**, with a median of **40%** (range: 13%–53%). No chart met full compliance with all 15 required elements.

Element-level compliance demonstrated marked variability. Most frequently documented elements included Chief Complaint (95%), Frankl Behavior Score (75%), Diagnosis (70%), and Medical History Review (70%). Moderately documented elements included Clinical Findings (65%), Caries Risk Assessment (60%), and Treatment Justification (60%).

Follow-up Instructions were present in 40% of charts. The least documented elements were Billing Code Selection (0%), Radiographic Justification (5%), Structured Informed Consent (5%), Preventive Coding (5%), and Parental Counseling Documentation

Discussion

Baseline analysis revealed low overall documentation completeness despite high resident-reported confidence and perceived understanding of documentation requirements.

While core clinical elements such as chief complaint, diagnosis, and behavior assessment were frequently documented, critical structural elements—including structured informed consent, radiographic justification, preventive coding, and billing justification—were consistently absent.

A significant perception–performance gap was identified, particularly in documentation standardization and workflow efficiency.

Conclusion

These findings support the implementation of a structured documentation template and standardized workflow prompts to improve completeness, reduce variability, and enhance medico-legal protection.

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