**Dental Hospitals National Audit**

**Outpatient therapeutic (treat infection) antibacterial prescribing**

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| Please fill this audit tool when you prescribe antibacterial agent/s (systemic and topical) to treat any oral infection. We recommend doing this prospective audit over one month period every year. We recommend doing this prospective audit over one month period every year. The prescribing pattern should be assessed locally against one of the national guidelines and action plan should be designed to address identified deviation from the gold standard. We recommend using the below standards:   1. Recommended: Antimicrobial Prescribing in Dentistry- Good Practice Guidelines ([FGDP(UK) and FDS publish antimicrobial prescribing guidelines for all dentists — Royal College of Surgeons (rcseng.ac.uk)](https://www.rcseng.ac.uk/dental-faculties/fds/faculty/news/archive/antimicrobial-prescribing-guidelines/) 2. Scottish Dental Clinical Effectiveness Programme prescribing guidance ([Drug prescribing | Scottish Dental Clinical Effectiveness Pr (sdcep.org.uk)](https://www.sdcep.org.uk/published-guidance/drug-prescribing/)) |

1. **Code of the Dental Hospital:**
2. **Please tick your speciality or clinic (tick one only).**

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| **Speciality/Clinic** | **Tick one only** | **Speciality/Clinic** | **Tick one only** |
| Dental Emergency Clinic |  | Paediatric Dentistry |  |
| Dental and Maxillofacial Radiology |  | Periodontics |  |
| Endodontics |  | Prosthodontics |  |
| Oral Medicine |  | Restorative Dentistry |  |
| Oral Microbiology |  | Special Care Dentistry |  |
| Orthodontics |  | Primary Care Clinic |  |
| Oral Surgery |  | Cleft Clinic |  |
| Maxillofacial Surgery |  | Other (specify) |  |

1. **Please tick patient age (tick one only).**

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| **Age (years)** | | | | | | | | | |
| 0-4 |  | 5-8 |  | 9-12 |  | 13-16 |  | >16 |  |

1. **Does the patient report history of penicillin allergy? (circle yes or no) Yes/No**
2. **Which factor influenced antibacterial prescribing for this patient? (tick all that apply)**

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| --- | --- | --- | --- | --- | --- |
| **Reason** | **Tick** | **Reason** | **Tick** | **Reason** | **Tick** |
| Elevated temperature |  | Cellulitis |  | Time constraints |  |
| Malaise |  | Swallowing or breathing difficulty |  | Patient demands prescription |  |
| Lymph node enlargement |  | Mucosal ulceration |  | Advised by other speciality |  |
| Pain |  | Uncertainty of the diagnosis |  | Others |  |
| Evidence of spread of infection |  | Treatment has to be delayed |  |  |  |
| Localized fluctuant swelling |  | Failure of local intervention |  |  |  |

1. **If you have selected "others”, please specify any other factor/s:**
2. **Which conditions (if any) influenced the decision of antibacterial prescribing for this patient? (tick all that apply)**

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| --- | --- | --- | --- |
| **Condition** | **Tick** | **Condition** | **Tick** |
| Poorly controlled diabetes |  | Recent myocardial infarction |  |
| Patient with neutropenia |  | History of infective endocarditis |  |
| End stage renal failure |  | Prosthetic heart valve |  |
| Immunodeficiency |  | Congenital heart disease (cyanotic) |  |
| Immunosuppression |  | Patients who illegally use intravenous drug (IVDU) |  |
| Frail elderly |  | Others |  |

1. **If you have selected "others”, please specify any other condition/s:**
2. **Did the patient receive the relevant intervention to treat their dental infection? Yes/No**
3. **If yes, please specify the procedure/s undertaken:**

Please Turn Over (PTO)

1. **Please tick the diagnosis and indicate if you have sent microbiology sample. (tick one only and tick the relevant microbiology sample if you have sent one)**

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| --- | --- | --- | --- |
| **Diagnosis** | | **Microbiology sample** | |
| **Condition** | **Tick** | **Swab** | **Pus** |
| Pericoronitis |  |  |  |
| Alveolar osteitis (dry socket) |  |  |  |
| Periapical abscess |  |  |  |
| Periodontal abscess |  |  |  |
| Necrotizing periodontal diseases |  |  |  |
| Periodontitis in patient aged less than 40 |  |  |  |
| Peri-implant disease |  |  |  |
| Osteomyelitis |  |  |  |
| Salivary gland infection |  |  |  |
| Post-surgical infection |  |  |  |
| Others |  |  |  |

1. **If you have selected "others”, please specify and indicate if you sent a microbiology sample:**
2. **Please indicate the used antibacterial agent/s, mode of delivery, dose, frequency and course duration. (tick all apply)**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Antibiotic name** | **Mode of delivery** | | | **Dose (mg unless [g] gram)** | | | | | | | | | **Frequency (how many time per day?)** | | | | **Duration (how many days?)** | | | | |
|  | Topical | Oral | IV | 100 | 125 | 150 | 200 | 250 | 400 | 500 | 625 | 1g | 1 | 2 | 3 | 4 | 1 | 3 | 5 | 7 | >7 |
| Phenoxy-methylpenicillin |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Amoxicillin |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Metronidazole |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Erythromycin |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Clarithromycin |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Co-amoxiclav |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Clindamycin |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Doxycycline |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

1. **If you used any other antibacterial agent/s, please specify its name, mode of delivery, dose, frequency, and duration:**

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| --- | --- | --- | --- | --- |
| **Antibiotic** | **Mode of delivery** | **Dose** | **Frequency** | **Duration** |
|  |  |  |  |  |

1. **How long after prescribing antibacterial agent, did you schedule a review for this patient?**

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| --- | --- |
| **Duration** | **Tick only one** |
| Not for review |  |
| 1 day |  |
| 2 days |  |
| 3 days |  |
| 4 days |  |
| 5 days |  |
| 1 week |  |
| Refer to General Dental Practitioner (GDP)/ other specialist service who will review |  |
| Others |  |

1. **If you have selected "others”, please detail any other strategy for including delayed prescription if used:**

**Thank you for completing the therapeutic antibacterial prescribing data collection sheet.**

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| **Acknowledgement**  This audit tool was developed as part of a collaborative work between all members of the Association of Dental Hospitals (ADH), the Association of Clinical Oral Microbiologists (ACOM), and the English Surveillance Programme for Antimicrobial Utilisation and Resistance (ESPAUR) Dental Subgroup. Thanks to many who have contributed to the development of this audit tool including Michael Lewis, Michael Pemberton, Melanie Wilson and Noha Seoudi. |