Barry.Nilsson.
INSURANCE & HEALTH LAW

REFRESHER GUIDE TO RECORD KEEPING

All practitioners are aware of the importance of keeping complete and accurate dental records. Time pressures and patient demands, however, can mean that in reality some notes are lacking.

In the unfortunate event that a patient makes a complaint, or if challenged about the nature and type of treatment provided, complete and accurate dental records are your best defence.

Good dental records are also important to ensure the safety and continuity of patient care. That is, to record the patient's treatment from start to finish. Carefully recording the sequence of events allows the treating practitioner, or someone else should care be transferred, to return to the records at any point in time to clarify the facts behind decision making.

The following is intended to refresh your knowledge on best practice for dental record keeping.

GENERAL PRINCIPLES

The Dental Board of Australia has produced a Guideline on Dental Records which sets out the information that should be recorded.

The following information must form part of the dental record (where relevant):

- Patient contact details (or guardian where appropriate);
- Medical history and any adverse drug interactions, etc;
- Reason for the appointment – presenting complaint;
- Information about the type of examination conducted (eg extra oral, intra oral, soft tissue, dental and periodontal findings) and findings;
- Diagnosis and any treatment proposed;
- What was discussed with the patient and whether consent is written or oral;
- The treatment plan must indicate what has been agreed with the patient (after discussing alternative treatment options and associated pros/cons) and outline the treatment to be completed.
- Type and dosages of anaesthetic and any scripts, post op instructions, etc.;
- Radiographs and other relevant diagnostic data. Digital radiographs must be readily transferable and available in high definition digital. Include other digital information including CAD-CAM restoration files and instructions to and communications with laboratories;
- Include other relevant details including:
    - All referrals to and from other practitioners;
    - Any relevant communication with or about the patient;
    - Details of anyone contributing to the dental record;
    - Estimates or quotations of fees.

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WHAT NOT TO DO

Below are "real life" examples of dental records which are clearly inadequate.

"fils as per tx plan. No la. Rebook for further tx"

"2 x fill cr 46 47 occ. 36 37 sealers. Rebook to insert ortho retainers"

"dry socket. Reassure given no tx required"

"simple check and clean. Small fill replaced 23 no la cr shade a3. Clean of denture. Review in 6m"

- Try not to use uncommon abbreviations in clinical notes. Keep in mind that other practitioners may need to rely on your notes in treating the patient.
- Simply recording that "risks and warnings were given" is not enough. Record the specific risks and warnings discussed with the patient and clearly detail their consent.
- Do not delay. Records must be completed on the day of the consultation.
- Do not retrospectively alter notes. Any retrospective changes must be clearly identifiable.
- Do not solely rely on shortcuts (i.e. quick notes, notes recorded by dental assistant, digital dictation, abbreviations). While they can be a valuable time saver, use with care to ensure they are beneficial rather than prejudicial.

KEY TIPS

1. Dental records should contain the information you would need if you were taking over the patient's care.
2. Always assume someone else (including the patient) will see your records.
3. Remember the minimum standards: history, patient information provided, examination, diagnosis, treatment options/ plan, consent.
4. Make sure you document advice or information you routinely provide.
5. Document your clinical reasoning and why you suggested the treatment plan, referred for imaging, to a specialist or wrote a script.
6. Avoid the cut and paste function.
7. Use patient records as a teaching tool or conduct self audits.

In practice, it may be helpful to use the acronym **SOAP** as a reminder to ensure you have recorded the key information in patient records.

Subjective	information the patient (or others) provide
Objective	information the practitioner finds on examination/imaging
Assessment	practitioner's diagnostic formulation
Plan	treatment plan

If you require any further information, contact Experien for advice.

In the event that you receive correspondence from your state regulator or AHPRA ensure that you notify Experien as soon as possible.

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