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Assess Your Records Management Practices

Sound risk management practices can aid dentists in two ways: first, by reducing the chances that an untoward patient care event will occur, and second, by helping protect the practitioner if a liability claim is filed.

Complete, accurate and unaltered documentation is your best defense against malpractice allegations. The following questions can help you assess your level of supportive risk management.

- ❑ Are all office record-keeping systems (including telephone, appointment and equipment maintenance logs) accessible, legible, well-organized and appropriately archived?
- ❑ Are all entries made in ink?
- ❑ Do you read and initial every entry in the record made by a staff member?
- ❑ If you have to correct an entry, do you always date and initial the change and make sure that the old entry is still readable?
- ❑ Do you record information in a patient record for all emergency treatment, even for new patients you are unlikely to see again?
- ❑ Do you schedule regular record audits to assure quality and consistency?
- ❑ Do you store patient records – including inactive ones – indefinitely?
- ❑ Are the dental terms and abbreviations in your records unambiguous, consistent and appropriate?
- ❑ If your information systems are computerized, do you back up the information every day and store the back-up data outside of the office?
- ❑ Do you write comprehensive progress notes at each visit?
- ❑ Do you ask patients for and document their chief complaints at each visit?
- ❑ Do you document all patient telephone calls (including calls received outside of the office) in the dental record?
- ❑ If you use written informed consent forms, do they contain all necessary information, including potential complications and alternative treatment methods?
- ❑ Do you always have appropriate face-to-face informed consent discussions with patients?
- ❑ Do you send only copies of radiographs, never originals?
- ❑ Do you require patients to submit a written, signed authorization form before you release any confidential information?

- ❑ Do you use a written referral form for every outside referral and keep a copy in the patient record?
- ❑ Do you keep a copy of all written consultations?
- ❑ For telephone consultations, do you document the information you receive in the patient record?
- ❑ Do you monitor and document all missed recalls and appointment cancellations?
- ❑ Do you document all attempts made to contact a patient before terminating the dentist-patient relationship?
- ❑ When it's necessary to terminate a dentist-patient relationship, do you do so in writing via certified mail?
- ❑ Do you have a written policy manual for your staff?
- ❑ Do personnel files contain up-to-date information about licenses, job descriptions and performance reviews?

Don't let the quality of patient care depend on unaided memory. If forgetting something could have a negative effect on care, write it down.