CNA HealthPro

Make Patient Records Work For You

Dentists often consider record keeping as time-consuming drudgery. But effective record keeping is one of the most powerful risk management tools available. Comprehensive, thorough records reduce the likelihood of treatment errors, communication problems and patient dissatisfaction.

The primary purpose of creating a dental record is to refresh your memory about events that occurred at previous visits. Accurately documenting pertinent conversations, observations and treatment allows you or other practitioners to continue the treatment without having to re-examine and re-diagnose the patient or recreate the treatment plan. These suggestions can help you make your records more useful and complete.

Record all objective findings that are essential to your diagnosis and treatment plan.

Clinical findings to be documented include, but are not limited to: size, depth and location of caries; areas of inflammation; periodontal pocketing; furcation involvements; mobility; mucogingival defects; radiographic findings; pulp, percussion and thermal testing results; root proximity problems; and violations of the biologic width. Whatever your findings, write them down.

Fill in all blanks and boxes on the dental examination form.

A section left blank on an examination form can lead to an allegation that the structure in question was never examined. This issue has arisen in failure to diagnose cases involving oral cancer, periodontal disease and bony lesions. If you have examined a structure and your exam form has a place to document its status, record your findings, even if the anatomy is normal in appearance. The abbreviation *WNL* (Within Normal Limits) is commonly used for such purposes.

Document corrective action taken in response to treatment complications or unusual occurrences.

Adverse events and outcomes — such as separated endodontic files, post-operative infections and fractured root tips — can happen to any dentist. When-ever an unusual occurrence or adverse outcome is documented, the corrective action taken should be recorded as well. This includes informing the patient what happened and what you recommended be done about it. Examples of corrective action are incision and drainage and antibiotics in the case of a postoperative infection, or referral to an oral surgeon for a fractured root tip that cannot be retrieved.

If you do not follow a documented plan of action, note why your treatment plan changed.

For example: A patient presents with an impacted third molar that is intermittently painful. Your clinical and radiographic evaluation determines that #32 is in a distoangular position and has a slightly enlarged follicular space. You recommend that the tooth be extracted, but the patient decides to put it off. You document your findings and also write, "Patient declines to have extraction at this time. Will reevaluate follicular enlargement #32 in six months."

You have now created for yourself a specific obligation within a set time frame. If you postpone your re-evaluation of this problem at the six-month recall without explaining the change, you have failed to follow

your own stated standard for treating the patient's condition. If you have documented that you will take further action, do so. If you are not sure about following up, do not state that you will.

Refrain from making disparaging or judgmental comments in the record.

Even though a patient may seem a jerk, an idiot or worse, *do not* write such thoughts in the dental record. Remember that patients are legally entitled to a copy of their record, as it is written. If you do not want your patient to see disparaging comments, do not write them down!

Record enough information for your records to pass the "amnesia test."

The amnesia test forces you to consider how much you really need to write down in the record. Simply stated, the test works this way: If you were to *forget* everything you ever knew about each and every one of your patients — their names, faces, treatment history and current needs — but still *remembered* everything you know about practicing dentistry, would your patient charts allow you to:

1. know exactly what treatment the patient has had and why?

2. perform whatever treatment is next for that individual and know why the treatment is necessary?

By keeping the amnesia test in mind, you should be able to create dental records with enough information to let you or any other dentist determine what treatment has already taken place, the reasons for past treatment and the patient's current and future needs.