

You Asked About...

Recordkeeping

One problem we see far too often is the quality and level of record keeping by some dentists.

Detailed records are essential for continuity of care, safe treatment of your patients and your own protection. Many dentists believe that they will remember details of a patient's care if necessary and do not record sufficient detail in the patient's record. Your memory cannot be relied upon! Your memory is not a good defense!

If another dentist or healthcare professional must provide treatment to your patient, it must be clear and obvious in the patient record what treatment was provided and what drugs, including dosage, were administered to a patient.

As outlined in the Alberta Dental Association and College Guide for Patient Records and Informed Consent there are several essential components of a clinical record that include:

- accurate general patient information that is periodically updated;
- a medical history that is periodically updated and at a minimum verbally reviewed prior to each appointment and noted within the chart;
- a dental history;
- an accurate description of the conditions that are present on initial examination, including an entry such as "within normal limits (WNL)" or "no abnormalities detected (NAD)" where appropriate;
- an accurate description of ongoing dental status at subsequent appointments;
- a record of the significant findings of all supporting diagnostic aids, tests or referrals such as radiographs, diagnostic casts/models, reports from specialists;
- all clinical diagnoses and treatment options;
- a record identifying all reasonable treatment planning options including no treatment and that they were discussed with the patient;
- the proposed and accepted treatment plan;
- a notation and documentation that informed consent was obtained;
- assurance that patient consent was obtained for the release of any and all patient information to a third party;

- a description of all treatment that was performed, materials and drugs used, and where appropriate, the prognosis and outcome of the treatment;
- details about referrals;
- an accurate financial record;
- the patients, caregiver or guardians signature in most cases on the medical history, privacy policy and informed consent documentation; and
- a copy of all patient communications.

In keeping and maintaining acceptable patient records, a dentist must adhere to the following general principles as outlined in the Guide for Patient Records and Informed Consent:

- all entries should be dated and recorded by hand in permanent ink or typewritten, or be in an acceptable electronic format and be complete, clear and legible.
- all entries, including electronic entries, should be signed, initialled or otherwise attributable to the writer and if different, the treating clinician.
- radiographs and other diagnostic aids, such as diagnostic casts/models, should be properly labelled, dated and the interpretation of the findings documented by the dentist.

If you maintain handwritten records, all entries must be recorded in ink, not pencil, and dated. If an error is made or something changes in a clinical record, cross out the entry so that the previous text can continue to be read. Do not use white out in a record. Ensure your records are legible. If you maintain electronic records, the audit trail of the record is a part of the clinical record.

A dentist cannot withhold a patient's record because of an outstanding balance on account. Article A7 of the Alberta Dental Association and College Code of Ethics addresses this issue as follows:

Patient information, verbally, written or electronically acquired and kept by the dentist, shall be kept in strict confidence except as required by law or as authorized by the patient. The information in dental records or reports must be released to the patient or to whomever the patient directs, including other professionals and dental plan carriers, when authorized by the patient. This obligation exists regardless of the state of the patient's account.