Record Keeping: Friend or Foe?

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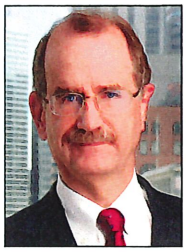

Academy Award winning actor and director Grant Heslov is quoted as saying, "I find writing really difficult – definitely the most difficult of all the things I do." Are you nodding in agreement?

You might avoid good record keeping because it's hard work, but written treatment records are required by statue, administrative regulation, and Colorado Dental Board ("CDB") policy. Charting should not be the foe. Make good records your friend and a sturdy shield against patient complaints, lawsuits, and CDB discipline. You'll sleep better at night.

Overview

Good records must include information mandated by law but should also capture the "story" of a patient's care from beginning to end, written in a way that allows you to reconstruct the course of care, if called upon to do so. The story should include the important decisions made by you and the patient, reflect discussions about the risks and benefits of treatment, document consent to treatment, and address complications or problems that arise and the steps taken to address them.

Complete records involve communications that today include not just your verbal discussions with patients, but letters, emails, texts, and voice messaging. If you use this range of communication, your office system must be capable of saving and storing them.

To facilitate charting, many practitioners now utilize digital record templates. These are convenient for many cases, such as where common procedures and steps are used for restorations. The Dentists Professional Liability Trust has examples of Patient Record Notes Templates on its website. Remember, however, a template is just a guide for routine care. It may need to be individualized with pertinent comments or observations, specific advice, or deviations from usual treatment steps. Overuse of templates to document what happened can look contrived and disingenuous.

Consent forms and pre-printed educational materials are great resources – but don't use them blindly. They should fit the circumstances and should be modified, perhaps in handwriting, as needed, before being signed by the patient. Save these documents physically or scan them to the electronic chart.

Legal Requirements

The Dental Practice Act (Colorado statutes) allows the CDB to discipline a dentist for falsifying chart entries, repeatedly making incorrect entries, or repeatedly failing to make "essential entries." What are essential entries? Probably what CDB policy, which tracks regulations, mandate. As a summary:

- CDB Policy Rule IX, which tracks requirements in the Colorado Code of Regulations and can be found on the CDB website, requires documenting the identity of the provider or supervisor of care.
- Rule IX requires (1) for comprehensive exams and periodic exams: documenting the reason for the exam, a medical history, clinical and radiographic exam results, oral cancer screening, prosthesis assessment, and periodontal charting for adults; (2) for limited or emergency exams:

patient history, clinical and radiographic exam of the area of concern, prostheses assessment and perio charting for the area of concern; and (3) for periodontal evaluations and diagnoses: measurements, radiographs (including crestal bone), and bleeding upon probing.

- Rule IX requires documentation of the recommended treatment and its risks and benefits. Patient declination of treatment and their decision to deviate from recommendations must be charted, as well as consent to treatment. Timely referrals require documentation.
- In root canal therapy, the use of a rubber dam must be documented.
- Changes to records must include date/time of change, reason for change, and be signed. Electronic records must be time stamped and unalterable.

Drugs

Per Rule IX, prescriptions must bear the patient name, date of birth, drug name, strength, dose, quantity, directions for use, refills allowed, and prescribing dentist's name. Controlled substance prescriptions and dispensing have the same requirements, plus the prescriber's DEA number, name and address of patient, and the medical purpose, diagnosis and condition treated.

Electronic controlled substances prescriptions must have an unalterable electronic signature and allow auditing under applicable DEA regulations. Such records must be maintained for at least two years regarding the dispensing and administration of controlled substances, including the authorizing prescriber name and inventory control records. You are also required to comply with any other DEA regulations for controlled substances.

Patient Records ("Rules of 7")

- Patient records must be provided when requested within seven days.
- Records from the date of the last treatment must be retained for seven years.
- The seven-year retention period for minors runs from when they turn 18 years of age (age of majority).

The patient chart is confidential. Patients are by regulation and policy allowed to access their charts without charge. Such access must be documented.

Estimated Costs

There is growing legal attention to cost and insurance, and Colorado has recently enacted "no surprise billing" laws. Written estimates for care are a good practice and are required in certain situations where care is rendered as an "out-of-network" provider. This article does not address all of the issues in this area. In general, however, the patient should have a good faith estimate of the cost of care. Signed financial agreements are helpful in fee disputes.

More about the Story

Sometimes, patients say important things: a phrase, an admission, a criticism, a disparaging word. Sometimes, they express great appreciation for your work. A patient comment placed in quotation marks can be a powerful element in telling the story. A quote is better than an interpretation, generalization, or mere recollection.

Your Confidentiality

Your communications with your attorney or your professional liability insurance carrier about patient care or concerns or CDB matters should be maintained as confidential. Do not document these in the patient chart and do not disclose them inadvertently if the patient requests his or her records.

Conclusion

Keep records that satisfy your legal obligations and allow you to recreate the story of a patient's care by addressing the patient's dental condition, the treatment rendered, and the reasons and consent for it. Objectively chart complications and the strategy for addressing them. Good record keeping will show the pride you take in your work and defend against unwarranted criticism. If your chart allows you to reasonably recreate the patient care, you are likely to pass muster.

Record keeping is not the enemy. Don't be paralyzed or frustrated by the legal requirements. Make your records your best friend. And sleep at night.

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