

Managing Professional Risks

ADA Guidelines for Practice Success™ (GPS™)

ADA Tip Sheet on What and How to Write, or Change, in the Dental Record

Each patient's dental record should:

- Detail charting practices that are consistent in each setting and the dentist is always obligated to ensure that charting is accurate.
- Include the intake, or patient registration, form that contains the patient's basic personal and contact information, the name of the patient's employer and complete information about the patient's primary and, if available, secondary dental benefits plan.
- Include results from any physical head/neck/oral cancer exam, periodontal and endodontic findings, the diagnosis and treatment plan as well as findings from occlusal and temporomandibular joint exams.
- Be primarily of a clinical nature.
- Be objective in tone and based on facts
- Include abbreviations and acronyms only when necessary and only if they are commonly-used and understood by the staff members who will have access to the record.
 - ✓ It's a good idea to have a universal "key" readily available to all staff that provides definitions for all abbreviations and acronyms.
 - ✓ Consult [*Dental Abbreviations, Symbols and Acronyms*](#), a publication produced by the American Dental Association's (ADA) Council on Dental Practice (CDP), for guidance on commonly used shortcuts for a variety of dental terms.
- Contain progress notes that include, but are not limited to:
 - ✓ A treatment plan
 - ✓ The patient's medical and dental history
 - The medical history should be reviewed and updated at every appointment and a complete history should be completed by the patient every two years
 - The dental history is important since it provides information of past issues and current concerns
 - ✓ Diagnostic records, including charts, radiographic images, clinical photos and study models
 - ✓ Laboratory work order forms, including notes regarding the mold and shade of teeth used in partials and dentures, the shade and materials used for crowns, bridges, inlays/onlays and veneers, and appliance design and instructions
 - ✓ Findings or observations
 - ✓ The patient's chief complaint
 - ✓ Treatment you performed and what the outcome was
 - ✓ Notes regarding informed consent/informed refusal discussions and the appropriate forms signed by the patient.
 - While not required, some dentists ask a staff member to witness the signing of those forms and include their signatures on the documents.
 - ✓ Details regarding treatment performed, including:
 - Medications administered during any procedures, including the date and the dosage used and details about the brand and manufacturer
 - The patient's reactions during and post procedure

- Medications prescribed, including date of the prescription, the dosage, and the frequency and length of time the patient should take it
 - Results of oral cancer screenings
 - Post-procedure instructions that were given to the patient with an indication of whether they were provided in a paper format or if the patient was referred to information available on the practice's website.
 - It can also be helpful to provide patients with a document detailing what was done and what they can expect. Not only is this excellent customer service, it's an opportunity to close the informed consent cycle because it details what happened.
 - Any other post-procedure or follow-up plans
 - Details regarding compliance/noncompliance with home care and/or post-procedure care recommendations
 - Post-procedure follow-up by the doctor to check on the patient's status
 - Treatment outcomes
 - Information regarding whether treatment provided was due to medical necessity
 - The dates and results of any periodontal and endodontic exams and/or charting
 - Any complaints, assessments or exams to determine if the patient has a temporomandibular disorder (TMD)
 - Caries risk assessment
 - Cosmetic treatment performed or discussed
 - An indication as to whether the procedure(s) performed was done on a specific individual tooth or whether it involved multiple teeth with the appropriate tooth numbers being detailed
 - Impression and delivery dates for dental prosthetics or appliances
- ✓ Non-clinical details such as:
- The patient's next scheduled appointment
 - The patient's history of appointment status, such as whether appointments were cancelled or skipped. Some dentists make this notation in the patient's treatment record and record it in the account note.
 - An account detailing phone calls and/or emails sent to or received from the patient, including any made after hours.
 - Insurance benefit notices, insurance claims or pre-estimates and payment vouchers.

Dental records should never:

- Be so vague as to be ambiguous or open to interpretation
- Overuse template phrases or "copied and pasted" entry for recording progress notes.
 - ✓ Each chart entry should be unique and specific to that individual patient.
 - ✓ Frequent use of templates or "copied and pasted" phrases could be a red flag in the event of an audit.
- Contain information regarding a dental healthcare worker's responses or feelings about patient behavior, appearance, etc.
- Contain unnecessary, or excessive, abbreviations, acronyms, or arcane symbols.
 - ✓ While it may seem an inconsequential concern, the inappropriate use of abbreviations, acronyms, or symbols could delay identification in a forensic investigation.
- Include financial information, such as ledgers.

Special considerations relating to electronic patient records:

- Electronic Health Records (EHR) provide many potential benefits, such as cost savings and improved efficiencies, but they also create new risks.
 - ✓ It's important for dentists to make sure that contracts with their software vendors are managed in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including complying with the requirement to have a business associate agreement (BAA) with vendors.
 - Make certain that all electronic Personal Health Information (ePHI) is encrypted.

- Have a written policy for dental records that details who can access patient records, who can enter data, and how record transfers should be conducted.
- Ensure that all staff members are adequately trained and authorized to enter information into the patient record.
 - ✓ Access should be password protected.
- Validate the patient and the information entered into the record; i.e., X-ray images, referrals and treatment notes.
- Cyber security is essential for HIPAA compliance.
- Be sure to use secured methods for transmitting digital dental images and all dental records that include PHI.
- Exchanging identifiable patient information via unsecured email can risk unauthorized access and may lead to data breaches requiring notification under HIPAA and/or applicable state law.
 - The dentist is responsible for safeguarding the security and storage of electronic health records with approved back-up systems.
- ✓ Clinical photographs and full 3D (three dimensional) X-ray volumes that identify the patient or could be used to identify the patient should be considered to contain protected health information (PHI) as defined by HIPAA.
 - Guidance to safeguard the transmission of protected health information (PHI) and how to render it unusable, unreadable, or indecipherable to unauthorized individuals can be found on the [Health Information Privacy section of the HHS website](#).
- ✓ Have a written policy for the transfer of dental records.

Special considerations relating to paper patient records:

- Entries should be legible, dated, initialed and written in ink.
 - ✓ While no specific color of ink is required, any copy of the record should be easy to read. When using different colors of ink, such as in cases where a practice assigns certain ink colors to particular staff members, remember that the different colors will not appear on photocopies unless a color copier is used. Check to make sure that the ink colors your office uses photocopy well and are legible if copies are produced in black and white or grayscale.
- Each page of the treatment record should have the patient's name and date of birth at the top of page.
- Do not leave blank lines between entries with the intent to add something at a later date since that could be construed as altering the record.
- Do not later insert words or phrases without dating changes in an entry since that, too, could be construed as an alteration.
- Be careful when making corrections to the record and make sure to comply with any state laws that may apply.
 - ✓ Some state laws allow healthcare providers to simply cross out the wrong entry with a thin line and then make the appropriate change.
 - Date and initial each change or addition.
 - ✓ Never obliterate an entry.
 - Do not use markers, correction tape or liquid correction.
 - The "wrong" entry must always be readable.
- If you remember something you want to add to the record at a later date, make the entry chronologically and refer to the date of the actual visit.
 - It's a good rule of thumb to flag when the new information was added. One way to do that is to add a note that says: "Addendum to treatment date 1/10/18."
- The outside cover of the chart should only display the patient's name and/or the account number, unless your state requires additional information on the outside cover.
 - ✓ In these cases, use an abstract system, such as colors or symbols, specific to your practice to maintain confidentiality while alerting staff to look on the inside for important information regarding allergies, medications, antibiotic pre-medications, and clinical conditions that can affect dental treatment. All medical notations belong inside the chart for only authorized personnel to see.
- Should you receive notice of a malpractice claim or dental board complaint immediately store patient record in a secure location. Do not alter the record in any way or for any reason.

Resources:

- Articles from the ADA Guidelines for Practice Success™ (GPS™) module on Managing Professional Risks:
 - [Making Entries in the Dental Record](#)
 - [The Consent Process: Types of Consent](#)
 - [Practitioner Considerations on Informed Refusal](#)
 - [Consent for Minors/Emancipated Minors](#)
 - [Custody Arrangements](#)
- The ADA Council on Dental Practice's publication [Dental Abbreviations, Symbols and Acronyms](#)
- The U.S. Department of Health and Human Services' (HHS) web page on [Guidance to Render Unsecured Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals](#)

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