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Take Time to Audit Your Patient Records

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The dental record is your best defense when faced with an allegation of negligence, state board complaint, or other claims, actions, or requests made by various local, state, or federal entities. The value of your records is measured by the accuracy, objectivity, legibility, and comprehensiveness of each item documented about your patients.

To ensure the value of your records is the best it can be, establish a protocol to *routinely* and effectively audit your patient dental records. A sound audit protocol will ensure your patient records are properly kept, and your patients are getting timely and necessary care. An audit may also uncover correctable deficiencies, offsetting the potential for material harm if your record is incomplete or inaccurate with respect to an allegation of malpractice.

Getting started

Establishing a protocol for auditing your patient charts might seem overwhelming. The following list provides a good starting point. While not all encompassing, this list itemizes key information for documenting different phases of patient care, providing a baseline for keeping and maintaining comprehensive records.

Any amendments and/or corrections that are uncovered in the audit process should be made in a separate dated entry that identifies the prior entry it amends, and that explains why the amendment and/or correction is needed. Amendments should never be made in the margins.

When developing protocol, remember that a third party reading a patient chart or record should have a clear picture of the patient's treatment and why it was necessary/desired.

Diagnostics/Initial Exam: Things to Note

- *An exhaustive* medical/dental history
- Patient identity, including correctly spelled name, DOB, gender
- Pre-existing conditions and their effect on patient care
- Items or findings of the initial clinical examination, including existing restorations and their condition, missing teeth, decayed teeth, existing fixed and removable prosthetics and their condition, periodontal charting, comprehensive and screening exams, soft tissue condition, TMJ, occlusion, oral cancer screening, and any other findings
- Appropriate radiographs taken
- Findings from the periodontal examination including areas of inflammation, mobility, pocketing, furcation, mucogingival defects, violations of biologic width, and radiograph review
- Vital signs recorded
- Diagnoses and treatment plan
- Fully vetted and completed medical history, including alerts where appropriate
- Emergency contact information
- Documentation of guardianship for minors

Treatment and Progress Notes: Items to Document

- Indications that the patient's medical history is reviewed before each treatment visit, especially when the patient is treated by multiple doctors
- Patient's chief complaint(s)
- Changes to the treatment plan
- List of treatment alternatives
- Consent forms and discussion notes
- Informed refusal forms and discussion notes
- Notes that the treating dentist discussed consent forms with the patient, and that the patient was allowed adequate time to ask and have their questions answered
- Documentation that complications or unusual occurrences during treatment are discussed with the patient
- Patient satisfaction and/or dissatisfaction
- Appropriate radiographs of diagnostic quality are clearly identified with the patient name, date taken, and form of protection used
- Patient "no shows" and/or "lack of compliance"
- Study models included, if applicable
- Post-operative instructions
- Referral forms
- Photographs
- Problem lists completed
- Dental laboratory Rx
- Medication Rx and instructions
- Reports and correspondence from specialists
- Treatment notes audited, approved, initialed, and written legibly
- A diagnosis is associated with all treatments
- Medical consultation and laboratory test results included
- Corrections are *not entered* by obliterating the incorrect information
- All entries are factually accurate, objective, clear, and comprehensive (for example, notes on anesthesia and the amount administered)

General Recordkeeping: Items to Document

- Recall schedule
- Follow-up calls to referrals
- Phone calls and other correspondence related to patient care
- Affirmation that the patient has followed your referral advise or not
- Correspondence from the patient or third-party payors
- Financial arrangements
- Copies of dental laboratory correspondence
- Privacy documentation (HIPAA)
- Insurance submission forms are reviewed for accuracy
- Insurance EOB and related documentation
- Medical/dental history updates
- Changes to financial arrangements
- All necessary patient follow-up visits or correspondence completed
- *A third party reading the record has a clear picture of what treatment the patient had and why it was necessary and/or desired*

General Recordkeeping: Overall guidelines

- Confidential information is protected. For example, health alert stickers are not on the face of the chart.
- Clear alert visible for relevant medical conditions or other complications
- The patient's name is on every page of the record
- Every patient visit is noted in the record
- Entries are clearly dated with the day, month and year
- Information regarding each patient visit is entered promptly afterward
- There are no open lines between entries
- Patient comments and complaints are noted within quotation marks
- Completed confirmation of the secure backup of electronic records
- Confirmation of the security of all forms of patient records
- No disparaging remarks, abbreviations, and/or subjective comments about the patient are entered in the record
- A procedure and process should be in place to prevent and/or deter staff from making any unauthorized entries in a patient record.

As a final note, keep chart review notes and list any additional, relevant comments on the audit document record.

Putting It All Together

The previous list is not intended as a complete rendition of the items your office should adopt when reviewing your patient charts; rather the intent is to stimulate further thought and personal investigation into what parameters you need to complete a thorough audit. The purpose of an audit should be to identify correctable deficiencies, patterns of poor documentation practices, and potentially compensable events. A consistent and routine audit program is a good risk management tool and can also protect patients from falling through the cracks.

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