

Dental Risk Prevention: Communicating and Record Keeping in the Dental Practice

Top Ten Best Practices for Record Keeping

1. **Patient records must be consistent.** If your record varies in degree of detail from one entry to the next, misleading implications may be made your quality of care.
2. **All boxes, blanks, or checklists in the record must be completed.** If this is not done, it gives the impression a task, procedure, or item was not performed or completed.
3. **Avoid words that are vague or may have several meanings.** Words such as reassured, appears, or inadvertent may misrepresent your actual objective intent and/or findings.
4. **Read and reread what you write.** This ensures your progress notes are correct and cannot be interpreted in more than one way. And most of all ensures your written word conveys your accurate intent.
5. **Be sure your handwriting is legible or that there are no typographical errors if using electronic patient records.** Illegible or poorly typed progress notes may lead to misinterpretation of the care you provided, which could impact patient safety or continuity of care.
6. **Avoid inaccurate or deliberately misleading statements.** Do not lessen the value of the care you rendered or jeopardize patient safety by not maintaining accurate, truthful records.
7. **Document complications, mishaps, or unusual occurrences in a concise, objective manner.** Subjectivity lessens the credibility of your records. In some states, complete lack of documentation in the patient record regarding patient injury or an adverse event may actually jeopardize the legal privilege.
8. **Limit your description of the event to what happened and resist the temptation to explain, rationalize, or argue your case in the records.** Remember that the primary purpose of the record is for patient care; your records should not be self-serving, even if litigation is anticipated. All subjective information and opinions may be provided to your professional liability carrier or legal representative.
9. **Avoid expressions that imply disapproval or a negative value judgment of the patient.** It is best to refrain from ridiculing the patient or expressing negative value judgments. Patient behavior or noncompliance should be recorded in an objective manner.
10. **Never destroy, rewrite or replace a prior record.** If there is an error in the record, rely upon standard acceptable practices for correcting errors. For written records, draw one line through the error and initial. Errors discovered the next day (written or electronic) should be corrected by writing a new entry. Failing to do so will lessen the credibility of the record casting suspicion.

This article is informational only and not intended as a substitute for legal advice. Please refer to the state statutes in the jurisdiction where you practice or contact your attorney for specific information regarding the laws and rules in your state governing record keeping.

For additional information on in-office training or to order a copy of Dental Risk Prevention or Dental Risk Prevention for Auxiliaries, please call 904-573-2232 or visit www.lindaharvey.net

©2008 Horizon Consulting Group, Inc. All Rights Reserved.
Permission to reprint this article is granted if you include the following text:
Copied with permission of the author, Linda Harvey. Source: www.lindaharvey.net