Documentation dilemma

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Dear Dianne,

I am a hygienist who works two days per week at the front desk and two days in clinical hygiene. The office where I work has three dentists and five assistants. The problem is that they are AWFUL with documentation. Their chart notes are scanty and often incomplete.

Today when I reviewed the charts, there was one new patient chart with a blank medical history and one for a patient who had not been in for the past three years with no health questions answered. Both patients received antibiotics and pain medications.

Over and over, I beg the assistants and doctors to update medical histories and be more concise with chart notes. Do you have any helpful hints to help me make my point with the doctors and assistants in our office to improve their documentation?

Trying To Avoid a Lawsuit

Dear Trying,

The dental chart is a legal document. It is the first line of defense in a malpractice suit. When a patient decides to file a lawsuit against a dentist, the dental chart becomes the single most important piece of information relative to the suit. A poorly written, inadequate narrative can be the most damaging evidence against a clinician.

The ADA questioned several of the major malpractice carriers about various record-keeping errors that they had observed in malpractice proceedings. The number one record-keeping error they identified was failure to have a treatment plan. The number two record-keeping error was failure to update the medical history. The medical history should be updated at **every** patient visit by the clinician. At least once per year, the patient should be asked to verify that his or her current medical history is correct by signing the form (or tablet in paperless offices). Most risk management experts recommend having the patient fill out a completely new history about every three years.

There have been numerous malpractice cases where patients were prescribed drugs by dental professionals that were clearly contraindicated by the patient's medical history. This brand of inattentiveness can lead to serious consequences for both the patient and clinician.

You might be interested to know that one of the top reasons clinicians lose malpractice cases is when the clinician finds out he or she is being sued for malpractice, somebody alters the chart. Why do clinicians alter the chart? The main reason is because the clinician failed to record thorough chart notes at the time of treatment, and the clinician tries to make it appear thorough after the fact.

Recently I spoke with an attorney who shared with me that he lost the biggest case of his entire career because the doctor altered the chart after he found out he was being sued. The doctor tried to insert additional comments and make them appear as contemporaneous to the original entry. An expert with the court determined that two different pens had been used and was able to state that the original entry had been altered. Of course, this revelation destroyed the doctor's credibility and ultimately caused him to lose the case.

When people write incomplete chart notes, the usual excuse is lack of time. It becomes a habit to whiz through the day without being concerned with recording details of patient visits in the practice. More often, the problem is not lack of time but rather lack of due diligence. People get sloppy with record-keeping. The fact is that in a court of law or before a state dental board, incomplete records could prove to be the most damaging factor to the clinician. Remember that in the eyes of the law or a state dental board, if something is not recorded in the chart, it never happened. Clinicians have a legal and ethical responsibility to record complete and accurate information. Dental professionals are without excuse for poor, inadequate records.

Thorough documentation includes the complete and accurate recording of all collected data, treatment planned and provided, recommendations, and other information relevant to patient care and treatment. All entries should record information objectively and comply with HIPAA regulations.

Some charting tips include:

❶ NEVER alter or add to original chart notes. If you need to amend an entry, make a new entry as an addendum to the original entry.

❷ For paper charts, do not skip lines between entries. Do not leave white space. Do not write in margins or below the last line, and always use permanent ink. Handwritten notes **must be legible**.

❸ Record events of the visit in the order they happen.

❹ Record all materials used, especially anesthetics (kind and how much).

❺ Be consistent with abbreviations. Some risk management experts advise against using the abbreviation "WNL" because it is ambiguous.

❻ Stick to the facts, and do not use unclear verbiage, such as "Patient seemed angry." Note instead, "Patient said, 'I'm sick and tired of this sore tooth.' "

❼ Do not ever record disparaging entries in a chart that you would not want a jury to see, such as "PITA patient."

According to Marcia Freeman (www.marciafreeman.com), chart entries should include the following:

- Date
- Reason for the visit
- Thorough review of health and dental history
- Patient's chief complaint in his/her own words
- Symptoms (symptomatic or asymptomatic)
- Clinician's visual findings
- Diagnostic records
- Doctor's examination
- Doctor's diagnosis
- Doctor's recommended treatment
- Discussion with patient and his/her choice of treatment
- Treatment rendered
- Items given to patient
- Next scheduled visit
- Signature

You need to sound the warning trumpet to everyone in the practice regarding the possible consequences of inadequate record-keeping, which includes updating medical histories. Those consequences include loss of a malpractice suit, suspension or revocation of license, even jail time. I suggest you conduct a staff meeting and go over the record-keeping protocol from a defensive standpoint. Let everyone know you have the best interests of patients and clinicians at the forefront of the discussion.

Unfortunately, it may take a lawsuit or board complaint to arouse some people from their sloppy record-keeping slumber. For sure, that would be an unpleasant wake-up call!

Best wishes,
Dianne