The issue of backing-up is no longer a concern as all the data is stored securely and automatically.

The Alpha Group also benefits in other ways. Now, all essential updates to the system are handled automatically, so there is no risk of a site being left outdated. All the software is no longer on each individual site, but on the host's powerful servers. This means in the event of a technical fault, technicians can quickly resolve the issue.

There is the further benefit that the amount of computing power required to run the software isn’t dependent on the hardware in the practice, so no expensive upgrades of equipment is required.

“The issue of backing-up is no longer a concern as all the data is stored securely and automatically.”

“From a clinical perspective, there is still direct access to all the patient’s information, but now that information, including digital X-ray images, can be easily transferred between practices if required and there isn’t a paper file that can be mislaid or incorrectly filed.

“The issue of backing-up is no longer a concern as all the data is stored securely and automatically. In the event of any disaster, none of the practices’ information will be lost, preventing any downtime that would have a significant impact on patients and business alike.”

The Managed Service is available to any practice that has a suitable broadband internet connection and sufficient computer hardware. The benefits, beyond those already mentioned, include online training options that utilise either live or recorded training packages that can be accessed at whatever time is convenient for the staff.

Other advantages include an online resource centre, where members of the practice administration team can gain access to information about the system as well as other useful advice.

The latest upgrades
For Dr Gordon, having invested in one of the most advanced software packages available, there is the option to take advantage of the latest upgrades to the programme, which provides a Care Pathway function and key performance indicators, an essential part of the latest PCT contracts.

With all products, the standard of support and service that is part of the customer care is an integral element when making a decision.

“I’ve enjoyed excellent support over the past 20 years from my software provider and it’s been that continu-ity of quality service that made choosing the R4 Hosted Service from PracticeWorks the obvious choice.”

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Clinical records

Keeping proper records of the care and treatment we provide for our patients is an essential aspect of an overall duty of care, says Dental Protection

Record keeping is one of the basic principles that we are all taught at dental school, and this message is continually reinforced throughout our practising careers through lectures, publications and personal clinical experience.

Dentists often protest that they have been trained to treat patients, not to spend their professional lives writing endless notes for every patient that they see. This reaction may be understandable, but there are many reasons why it is important to keep clear, full and contemporaneous notes of the care and treatment provided. The irony of record keeping and paperwork generally is that it is the part of dentistry that most dentists actively dislike. Consequently, many dentists spend as little time as possible on it, perhaps because it is often seen as a distraction from (and less important than) the main task - the clinical work itself. This can leave the dentist exposed and vulnerable to problems on all fronts.

Every member of the dental team can play a valuable part in ensuring that the practice's record keeping is of a high standard. Poor record keeping can make it difficult or impossible to defend allegations of clinical negligence, or professional misconduct. It can also lead to disputes over money, can cause mistrust and confusion, and can lead directly to complaints. Endless hours of "fire-fighting" can be wasted in trying to resolve problems caused by poor record keeping, and it can even lead to the most serious (and fatal) consequences; on some occasions, the records we make can change the entire course of our professional career.

Why keep records?

It is a common misconception that records are simply an aide-memoire for the personal use of the dentist. In many parts of the world, patients have a legal right of access to their records, and to obtain copies of them upon request. If and when any problems arise, other bodies such as investigating bodies and statutory authorities, Dental Councils/Boards, and experts and forensic odontologists or coroners acting on behalf of the courts will often examine records. In health funds and similar payment systems, they may be inspected by officers of these agencies, or by insurance companies. If there is intended litigation or disciplinary action being contemplated against a dentist, then the records could be disclosed to patients' legal or other representatives.

Many parts of the world are becoming increasingly litigious and good record keeping can provide vital evidence of the proper level of skill, care and attention that a patient has received. Sometimes there will be a conflict of evidence between the versions of events given by the patient and the dentist respectively. In such situations, the patient's version is often preferred unless the records can provide clear evidence to support the dentist's account of events. It is often argued that the patient is much more likely to recall the events of a single dental appointment, with a given dentist on a specific occasion, than the dentist for whom this will have been one of many patients seen on that particular day, and with many more patients having been seen since the time in question.

 Adequate records will allow a clinician to reconstruct the details of a patient's dental care without having to rely upon memory alone. Excellent records go further than this, because they provide evidence of the thought processes, which lie behind the decisions that were made. They will also provide a lot more useful detail and because of this, they can anticipate and answer all the key questions that might surface in the future, arising from the treatment provided (or sometimes, not provided).

A logical approach

Knowing what details are likely to be relevant, or irrelevant, from a deno-legal perspective, comes either from hitting first-hand experience, or from developing a better awareness of risk management through publications, lectures and other sources. It is important to understand the particular risk management issues that tend to arise in relation to each of the procedures that you carry out, especially those which are carried out frequently.

Recording the warnings and explanations given prior to the removal of an impacted third molar is an example of this; keeping records which monitor the progress of a patient's peri-odontal health is another. Noting that the dentist has checked or updated a patient's medical history is a self-evident requirement – but noting the clinician’s specific recommendation that the patient should return if symptoms do not improve, may be less obvious. Either could prove pivotal in determining the outcome of a case.

A dental nurse/assistant is ideally placed to provide an additional level of backup, ensuring that all key conversations between dentist and patient, all discussions, warnings, explanations and advice are recorded in the notes. On a busy day, when the dental team is under pressure, the crucial details can so easily be overlooked.

Think records, not record cards

Many dentists fall into the trap of believing that the clinical records only consist of the written (or computerised) notes of a patient's treatment history, detailing what treatment was carried out, when it was performed, and occasionally including financial records of what fees were charged and when they were paid. Nothing could be further from the truth.

The totality of the record of a patient's dental care could include many (or all) of the following:

- The treatment notes
- The current and historical medical history
- Radiographs (and any associated tracings), prints from MRI and other imaging
- Results of other investigations (pathology or radiology reports, pulse oximeter printouts etc)
- Study models/casts
- Diagnostic records (bite registrations, stents, diagnostic wax-ups etc)
- Photographs (including intra-oral camera images)
- Correspondence
- Practice documentation of various kinds
- Other sources of information which might refer to the patient:
  - Laboratory tickets and invoices
  - Other invoices (eg for implant fixation)
  - Financial records
  - Appointment books/daylists

Many of these records may be held on paper, others in computerised/digital form. Either way, the records are only helpful if they have been preserved and remain available at the time they are subsequently required.

What should a dental record contain?

- The patient's name, and contact details (address, preferred telephone/fax/e-mail or other contact details). It is important to keep this information up to date, as it may be needed in an emergency situation

- An up to date medical history. A full medical history (including a note of any prescribed or self-administered medication) should be taken at the initial examination and updated and checked for any changes at each subsequent visit. It is also helpful to keep a note of the patient's medical practitioner. Everybody realises the importance of taking a full, written medical history at the time of the first examination of a new patient. The problem often arises, however, that at subsequent recall examinations (check-ups) the medical history is not formally updated, and no written entry is made on the notes to the effect that the clinician has confirmed that the medical history is unchanged

- Treatment information. The date, diagnosis and treatment notes every time a patient is seen, with full details of the treatment carried out. This should specify the treatment provided, materials used, and clinical findings as the treatment proceeds. An accurate record of positive findings and signs (what you can discover for yourself) and symptoms (what the patient tells you about the problem) is important, so also is the absence of them (both not tender to percussion, lymph nodes not enlarged, no swelling, no pain, no change in medical history etc). These notes should include a summary of any particular incidents, episodes or discussions (for example, if a patient declares a referral or other treatment recommend- ed for them)

- Missed appointments. The date and details of any appointment offered to a patient but declined, or a patient who fails to attend, or cancels, or when the patient arrives late and/or needs to be re-booked

- Phone contacts. Dates and details of any telephone conversations with the patient, whether the clinician or the dental team members. Similarly, any fax or e-mail contact should be retained within the records

- Investigations. A summary of each investigation carried out with a note of both positive and negative findings. This should include monitoring information

Clinical module 20.3. Financial data that is kept separate from clinical details avoids confidentiality issues when shared with others.
such as BPE scores, periodontal probing depths and other indices, tracking of oral pathology and other conditions.

- **Financial records.** Although it is sensible to keep these separate from the clinical notes themselves, a record should be kept of all fees quoted and charged and payments made by the patient. Tax authorities may request financial data from the dentist and issues of confidentiality can be avoided if the financial transactions are kept as a separate element within the record. Processes in which any unpaid fees are pursued should also be meticulously recorded.

- **Correspondence.** All correspondence to and from the patient or any third party (including specialists, medical practitioners, other dentists etc)

- **Consents obtained.** and specific warnings given of possible adverse outcomes

- **Advice.** Notes of advice (including oral hygiene, dietary and/or general health advice such as the discontinuation of smoking or attention to other risk factors)

- **Instructions** given pre- and postoperatively to the patient (or parents)

- **Drugs given**, including route, dosages, frequency and quantity ordered. Any adverse reaction to any such medication should be recorded

- **Anything else that you consider relevant.** Here, the patient’s dental history can be particularly relevant. For example, a record should contain the reason why the patient has requested a consultation or examination, and (unless a regular patient) a note of when the patient last received dental care. This is extremely important, especially in the case of a new patient since it is always helpful to be able to refer back to notes made at the initial examination to recall what signs and symptoms the patient was actually exhibiting when he or she was first seen. It is obviously equally important to have a record of what treatment the patient requested or required.

**Baseline charting**

A traditional, basic skill which is emphasised at dental school, but which is sometimes lost as a clinician passes through his or her career, is that of a baseline charting. The computerisation of records has played a part in the demise of accurate baseline chartings, since most brands of commercially-available software insert a stylised representation of a specific type of cavity or restoration, in a standard shape and format rather than attempting to create an accurate reflection of the actual situation as it appears in the patient’s mouth.

A detailed charting showing the size and extent of existing fillings, provides so much more information than a minimal charting which perhaps only indicates missing teeth and teeth needing immediate treatment. Sometimes the records are found to contain no indication at all of which teeth are present or absent, and when several posterior teeth are missing, confusion can easily arise over which teeth are being described.

**Contemporaneous records**

Serious difficulties can arise when a dentist feels the need to re-write or embellish his or her records after becoming aware that a challenge or investigation is likely. Few, if any, records are perfect in every respect and yet it can sometimes be due to embarrassment at the inadequacy of the records kept, that some dentists take the foolish step of altering or forging their records.

“Contemporaneous” means “recorded at the time”, and it is easier than one might think, to identify entries made after the event, or to recognise record cards which have been re-written or altered. The importance of an audit trail for computerised records is covered separately below.

Records should be in diary sequence with other dated entries, and no attempt should ever be made to “cover one’s tracks” by altering or “improving” an original record card entry, or by substituting a modified record card for the original. Such efforts can easily transform a small problem into a major one, or even into a criminal matter. Courts of law, and the
dental registration bodies take an extremely serious view of non-contemporaneous records being presented and stated, dishonestly, to be the originals.

**Computerised records**

Many practices now keep some (or all) patient data on computer, and this either duplicates or replaces handwritten information. Even if you keep some or most of your records on computer, you may still need some manual records eg for non-digital x-rays, correspondence etc.

It is no defence in law that your computer broke down or you lost data, for whatever reasons. It is up to you to ensure that you can always produce, whether directly or indirectly (created from computer records), all the same information that has been discussed above in respect of paper records. Being computerised is no justification for cutting corners in record keeping – indeed, quite the reverse.

There appears to be a tendency for records kept in computerised form to be less detailed, perhaps using more abbreviations and codes that are specific to the chosen software. It is worth spending time before a problem arises, evaluating the quality and quantity of the records you are keeping and the safeguards and controls (eg computer back-up) you are operating in order to protect them.

Many clinicians fail to appreciate that changes to computerised records may still be captured on, and retrievable from, the hard disk, even when the original entry is deleted or modified. Computerised records need to have a robust and secure audit trail, showing who made each entry or amendment, at what time, on what day etc. The same details should be available for each historical entry, so that the whole evolution of the final version of the records can be tracked with certainty.

Without this safeguard, the value of the records may be seriously reduced.

**Checklist**

1) Carry out a random audit on a selection of your patient records and ask a colleague to check that they are legible and comprehensible. Involve your dental team in this process.

2) Ensure that the notes you write, or type, include the kind of detail described in the text.

3) Try to avoid using ‘shorthand’ or abbreviations that others are unlikely to understand.

4) Remind your staff of the need to ensure that the patient’s details are regularly checked for accuracy and updated, and stress the confidentiality of clinical records.

5) Review the space available for the storage of old records. Rather than destroying records when a storage problem arises, consider scanning records and x-rays and retaining them on CD-ROM or DVD in digital form, together with digital photographs of study models (which may be particularly helpful for orthodontists who face special storage difficulties).

6) Check the specific legal situation which applies in the country where you practice, regarding how long records need to be kept and any requirements for disclosure of records, or a patient’s statutory right of access to their record.