Top ten tips for good record keeping

By Richard Birkin[1]

We take record keeping for granted. The dental team never wants to spend less time on treating the patient or indeed less time talking to the patient. So when we are pressed for time, what gets ignored? Record keeping.

But if there is a complaint or when the Care Quality Commission (CQC) (in England) visits, or if there is an NHS investigation, the first thing that gets examined in minute detail is the patient's clinical records. Experts will pore over them in detail using the latest standards to judge their quality and accuracy. They will not only consider the precipitating event but will examine everything in the records going back over a number of years. Here are ten top tips for good record-keeping.

1 Work as a team

Team work is essential for good record keeping. The amount of detail needed in good records means one person does not have the time to include all the essential data. The receptionist can take medical and social histories which helps reduce time pressures in the surgery. The dental nurse can record what the dentist does and the discussions had with the patient. They will need to be checked and signed by the dental care professional (DCP) but this takes less time than writing them from scratch.

2 Beware defaults and tick boxes

Much of day-to-day clinical work is repetitive and the temptation to use computer defaults or tick boxes for key phrases on paper records is strong. If a record shows you performed smoking cessation on a two-year-old patient or records that a 70-year-old man was pregnant this puts into question the accuracy and probity of the whole record and indeed all other records!

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inspectors how valid consent was arrived at. Lawyers would have you believe valid consent is just about the law; communication is equally important.

4 Patient compliance

The response of patients to advice and prevention is core to disease control and feeds decisions on whether or not to provide advanced treatments. This again personalises the record and can demonstrate why a specific care pathway was taken. A decision not to provide complex treatment can be supported by the lack of compliance to the oral hygiene advice or the patient's repeated non-attendance. 'Did not attend' appointments should all be recorded.

5 Don't try to hide mistakes

We all make mistakes and we all forget detail. Never try to hide these mistakes. If an entry is not contemporaneous because it was forgotten, make this clear. Do not obliterate words in paper records – use a single line crossing out the error. Never delete contemporaneous entries in light of subsequent events. Similarly if something is forgotten or a mistake made in a computer record do not try and delete or alter the entry and never attempt to amend the dates. A correction can be added afterwards with an explanation as to what has been omitted or what the mistake is.

A computer hard disc always records the date and time of an entry; this cannot be deleted and can be forensically retrieved. The General Dental Council (GDC) takes falsification of records extremely seriously.

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3 Personalise consent

The use of the team can be vital in providing the fine detail to demonstrate valid consent. One tip is to record what a patient's problems are, what they think of the treatment options and what they are worried about when it comes to risks of treatment *in their own words*. Direct quotes of patients' words in the records emphasises the record is individual to that patient and demonstrates respect for their opinions. It can also demonstrate to CQC and other

6 Radiography reports

Records of radiographic examinations are a legal requirement. Dentists are generally good at complying with *IRMER* but fall down when it comes to reporting on the results of the radiographic examination. They act upon what the radiograph shows but do not always report on their findings in the records. Such a record is an *IRMER* requirement. Team members can ask the dentist for a report on the radiograph and enter this on their behalf. The dentist can check this entry and initial it to say it is accurate.

7 NHS or private

The NHS/private interface needs careful recording. The records should make clear what is planned, whether it is NHS or private and, if the latter, whether the treatment is available and was offered on the NHS. Recent GDC advice gives guidance on this (*Standards 1.7.2, 1.7.3 and 1.7.5*). The NHS Regulations also demand that there should be no criticism of the quality or availability of NHS treatment (Contracts Regulations 3361 10 [3] [a] & [b]).

8 Risk status

It is best practice to record a patient's risk of developing disease. This is the subjective assessment of their clinical and social risk factors, taking into account procedures that reduce these risks. This assessment will also feed the recording of the risk assessment for the recall interval under National Institute for Health and Care Excellence (NICE) guidelines.

9 Do an audit

Doing a clinical audit of the records can demonstrate to a CQC inspector the practice's quality and your drive for improvement. Audits are key part of clinical governance and are likely to be an integral part of GDC revalidation. Pick just two or three items to audit, set benchmarks, and record actions for improvement. BDA Expert members get an audit tool as part of their membership.

10 Abbreviations and insults

Never make derogatory comments about patients under the guise of abbreviations. No matter how clever you think you have been, a lawyer or another dentist will work out the true meaning. Writing 'PIN' ['pain in the neck'] could be read by the patient and could lead to erasure!

The British Dental Association (BDA) is running a Law, ethics and record keeping course on Friday 4 July 2014 at the BDA, 64 Wimpole Street, London, W1G 8YS. For further details, please visit ***www.bda.org/training*** *or call the events booking hotline on 020 7563 4590.*

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