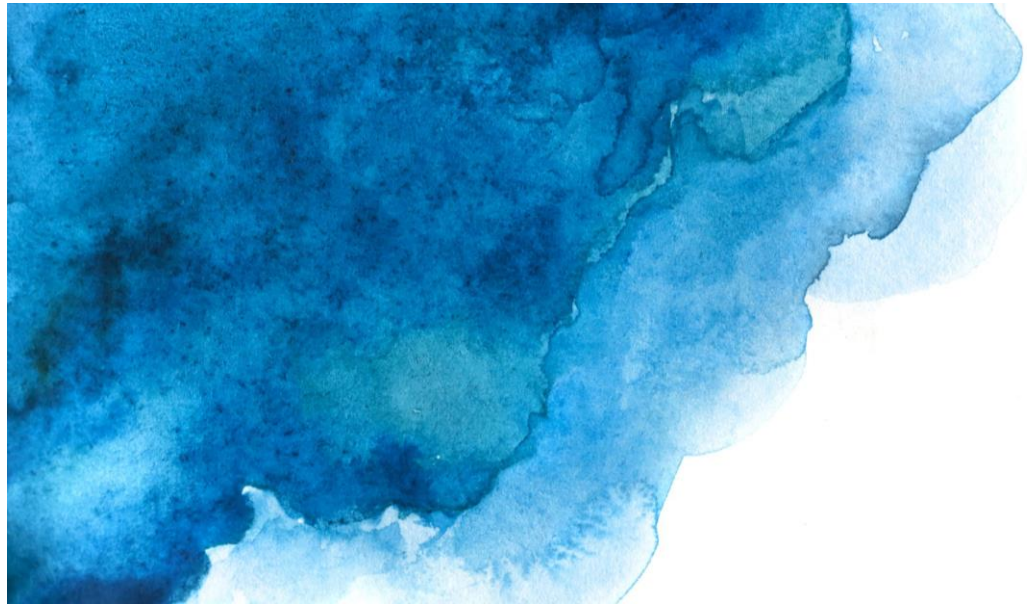
Changes to Your Dental Record Keeping Obligations



Presented by Dental Compliance Australia

Dr Kate Amos & Dr Dominic Aouad

By the end of this session…

Recognise	Recognise recent changes implemented by AHPRA and the Dental Board of Australia pertaining to dental records
Locate	Locate the key documents that now guide practice
Learn	Learn what tends to go wrong with dental record keeping
Identify	Identify the features of a complete dental record
Create	Create a plan for how you will use dental records to improve patient care

Dental Compliance ADPA Course

Evidence-based approach to dental records training

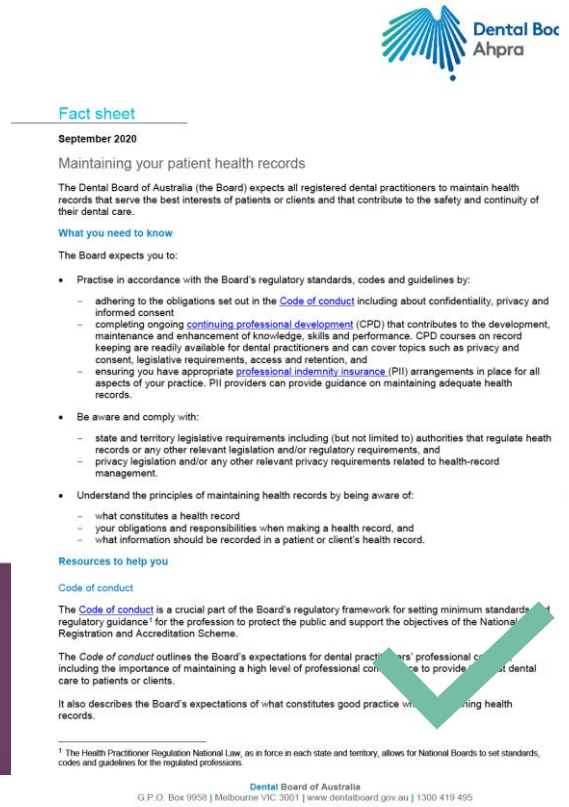
E-learning program based on Delphi consensus-building process

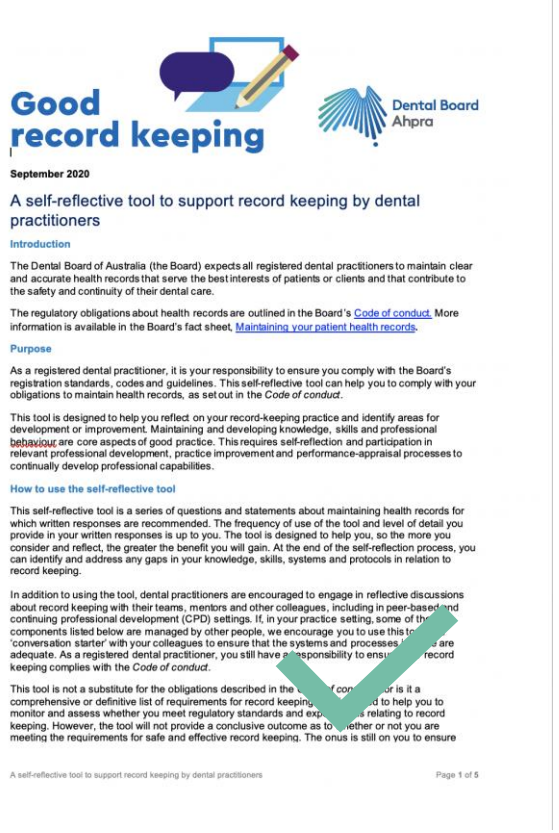
Update to the course including review by experts in dento-legal/complaints considerations in 2020

Our ‘why’

Reference: Attributes of the Complete Dental Record. Australian Dental Journal 2017; 62: 426–432

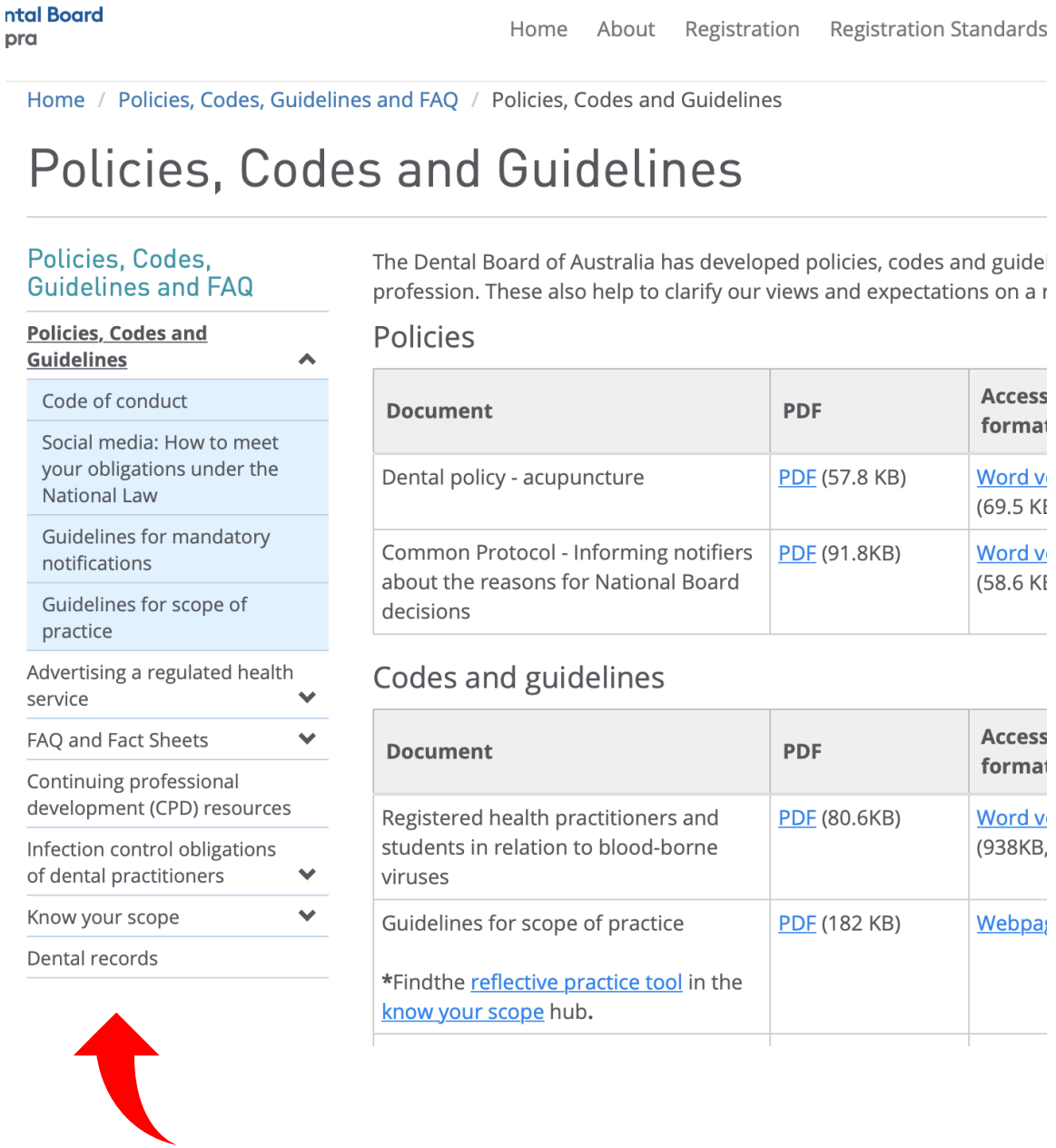
As of Oct 1st 2020





Reference: Dental Board of Australia Website available from https://www.dentalboard.gov.au/Codes-Guidelines/Dental-records.aspx

Where to find these…



The Guidelines have been retired, so what are the key references now?

The Code of Conduct

Maintaining clear and accurate health records is essential for the continuing good care of patients or clients. Practitioners should be aware that some National Boards have specific guidelines in relation to records. Good practice involves:

a) keeping accurate, up-to-date, factual, objective and legible records that report relevant details of clinical history, clinical findings, investigations, information given to patients or clients, medication and other management in a form that can be understood by other health practitioners

b) ensuring that records are held securely and are not subject to unauthorised access, regardless of whether they are held electronically and/or in hard

c) ensuring that records show respect for patients or clients and do not include demeaning or derogatory remarks

d) ensuring that records are sufficient to facilitate continuity of care

e) making records at the time of events or as soon as possible afterwards

f) recognising the right of patients or clients to access information contained in their health records and facilitating that access, and

g) promptly facilitating the transfer of health information when requested by patients or clients.

Reference: https://www.dentalboard.gov.au/Codes-Guidelines/Policies-Codes-Guidelines/Code-of-conduct.aspx

Alignment of old and new

DBA CODE	PRIOR GUIDELINES ON DENTAL RECORDS
Clinical history	Identifying details of the patient, complete and current medical history, date of visit, details of practitioner providing treatment, presenting complaint, relevant history
Clinical findings	Type of exam conducted, clinical findings and observations
Investigations	Radiographs and other relevant diagnostic data, other digital information including CAD-CAM files
Information given to patients or clients	Diagnosis, treatment plan and alternatives, consent process, estimates or quotations of fees, any relevant communication with the patient
Medication and other management	All procedures conducted, instrument batch (tracking) control, any medicine/drug prescribed, administered or supplied or therapeutic agent, details of advice provided (as part of management), instructions to and communication with laboratories, all referrals to and from other practitioners,

What does the DBA Fact Sheet contribute?

- Reinforces it is the Code of Conduct that will be the primary tool
- Clarifies the expectation from the DBA that practitioners will undertake CPD relating to dental record keeping
- Points out the sections of the Code of Conduct that are relevant: 2.2, 2.2, 3.3, 3.4, 3.5, 3.13, 3.14, 3.16, 8.4.
- Recognises the role of professional associations, insurers (including professional indemnity providers) and government health departments to give '*more detailed guidance and advice on health record management'*

Reference: https://www.dentalboard.gov.au/Codes-Guidelines/Dental-records.aspx

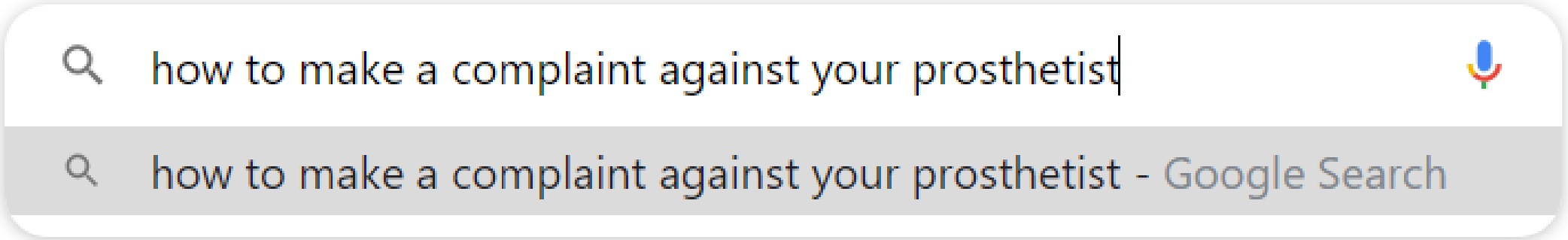
What does the DBA Reflective Tool Contribute?

- Provides guidance on what specific elements should be included as part of the dental record
- Gives a self-directed checklist for making sure your record-keeping systems are compliant
- Substantial overlap with previous Guidelines document, which I'll point out in just a moment after Dom advises what some of the common problems with Dental Records are…

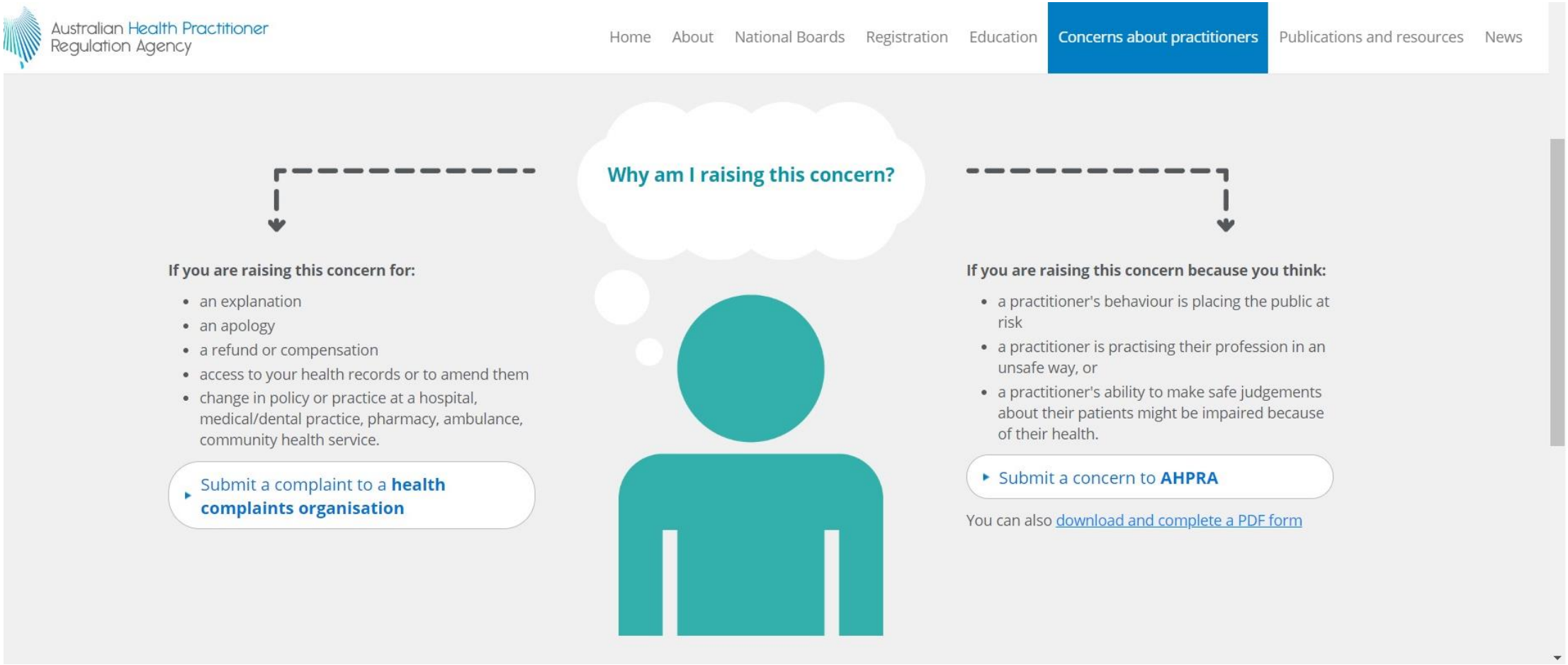
- Details identifying the practitioner providing care, including professional division or specialty
- Date care was provided
- Radiographs, scans, images models, charts (including a record of your interpretation radiographic/scan/images/models/charts)
- Other diagnostic data (e.g. dental charting of examination findings, soft tissue and temporomandibular joint examination findings, pulp sensibility tests, percussion tests, mobility tests, palpation tests, periodontal probing, etc.)
- Diagnosis/diagnoses
- Treatment options and agreed treatment plan(s)
- Details of discussions of the diagnosis/diagnoses and treatment plan(s)
- Advantages and disadvantages of plan(s)
- Details of referral(s) and handover to other practitioners
- Details of referral of work to laboratories
- Procedures carried out
- Relevant infection control details, e.g. instrument batch processing where appropriate
- The prescription or administration of therapeutic agents including the name, quantity, dose and instructions (note: for

Reference: https://www.dentalboard.gov.au/Codes-Guidelines/Dental-records.aspx

What tends to go wrong with dental records?



The AHPRA website



Please describe what occurred*

Tell us:

- what happened
- who was involved
- when and where it happened
- when you became aware of the problem
- the main issues you are concerned with.

You may want to provide supporting documentation about your complaint or concern. Use the related documents section below to upload documents with this form, or contact AHPRA on 1300 419 495.

I needed a new denture and all of my teeth were perfect. After I got my new denture my teeth started falling out. The prosthetist doesn't know what they're doing and I want to protect everyone else from this horrible work. I'm now too sad to smile.

Do you have related documents?*

○ Yes ● No

Have you discussed your complaint or concern with the health practitioner?*

○ Yes ● No

Have you made a complaint or raised a concern about the health practitioner to any other organisation?*

○ Yes ● No

Previous Step | Next Step

Contemporaneous records

There are two ways this can go…

Option 1	Option 2
• There are no or minimal dental records • They do not document the teeth present, their condition or any referrals/recommendations • There is no documentation of previous dental history, medical history or clinical findings • There is no mention of a discussion of treatment options	• There is a complete dental record available – Kate will outline this shortly

Brown, L. F. (2015). *Inadequate record keeping by dental practitioners. Australian Dental Journal 60* (4) 497-502

So what happened?

Discontinued or escalated for further investigation?

How can good clinical records improve patient outcomes?

CLINICAL HEURISTICS – practical decision making by clinicians

AS CLINICIANS WE MANAGE UNDER UNCERTAINTY

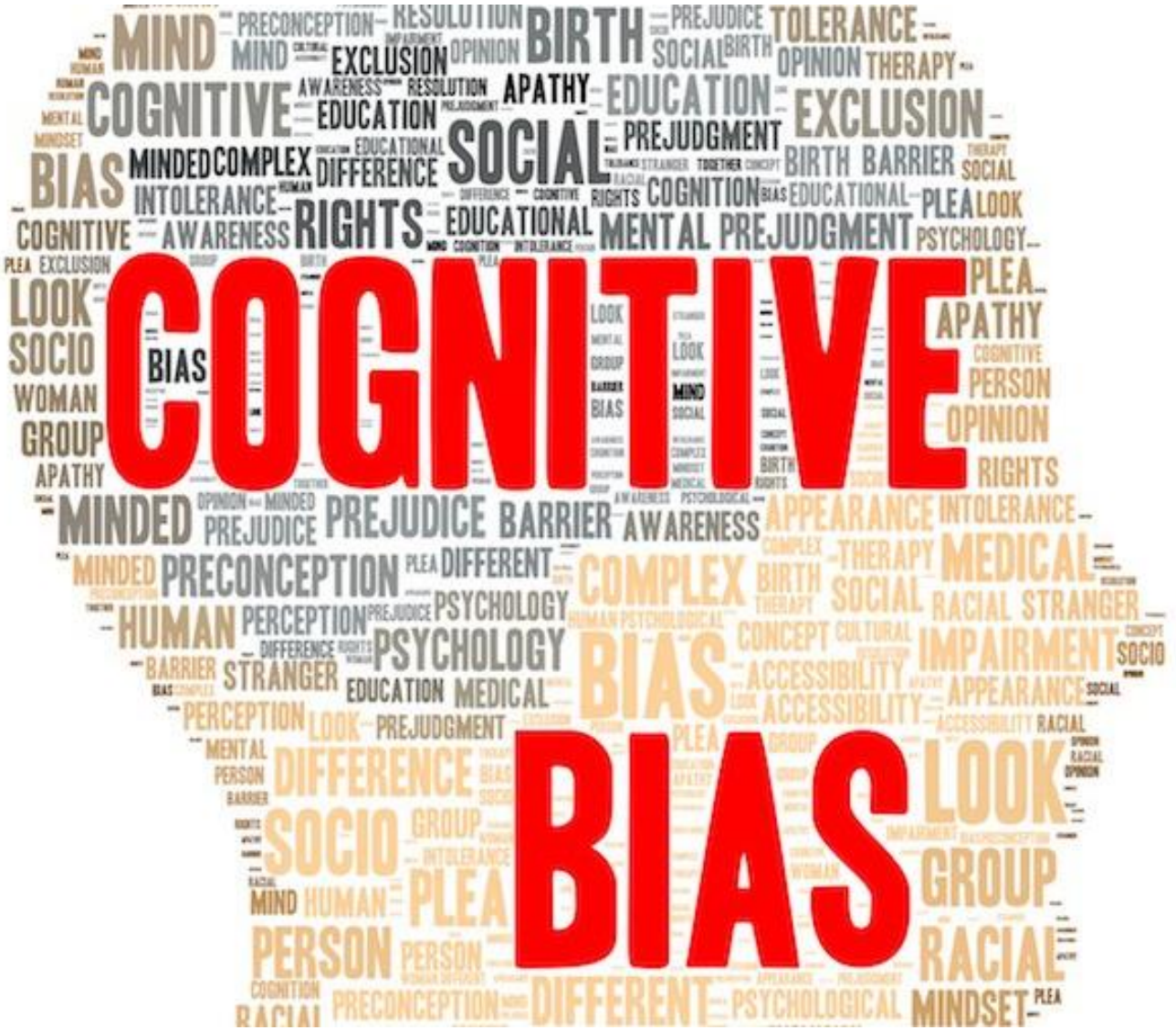
OUR DECISION MAKING IS LIMITED BY SEVERAL FACTORS

SYSTEMS CAN IMPROVE DECISION MAKING

The 6 steps of decision making

Collecting information	History of condition, medical dental, social history, examination, radiographs, diagnostic tests
Reacting to and consider the information	Probing depths or mobile teeth may lead to consideration of an x-ray. Discoloured tooth may warrant further investigation etc.
Incorporating emotional responses to possible choices	Managing the anxiety of the patient and dealing with historical experiences of your own
Evaluating alternatives	Differential diagnosis and possible treatment options
Reacting and responding to risk and uncertainty	Reviewing the risk-benefit for that patient, biological/ financial/ psychological
Making a judgement or choosing a course of action	Definitive diagnosis and management plan.

Clinician and patient cognitive biases

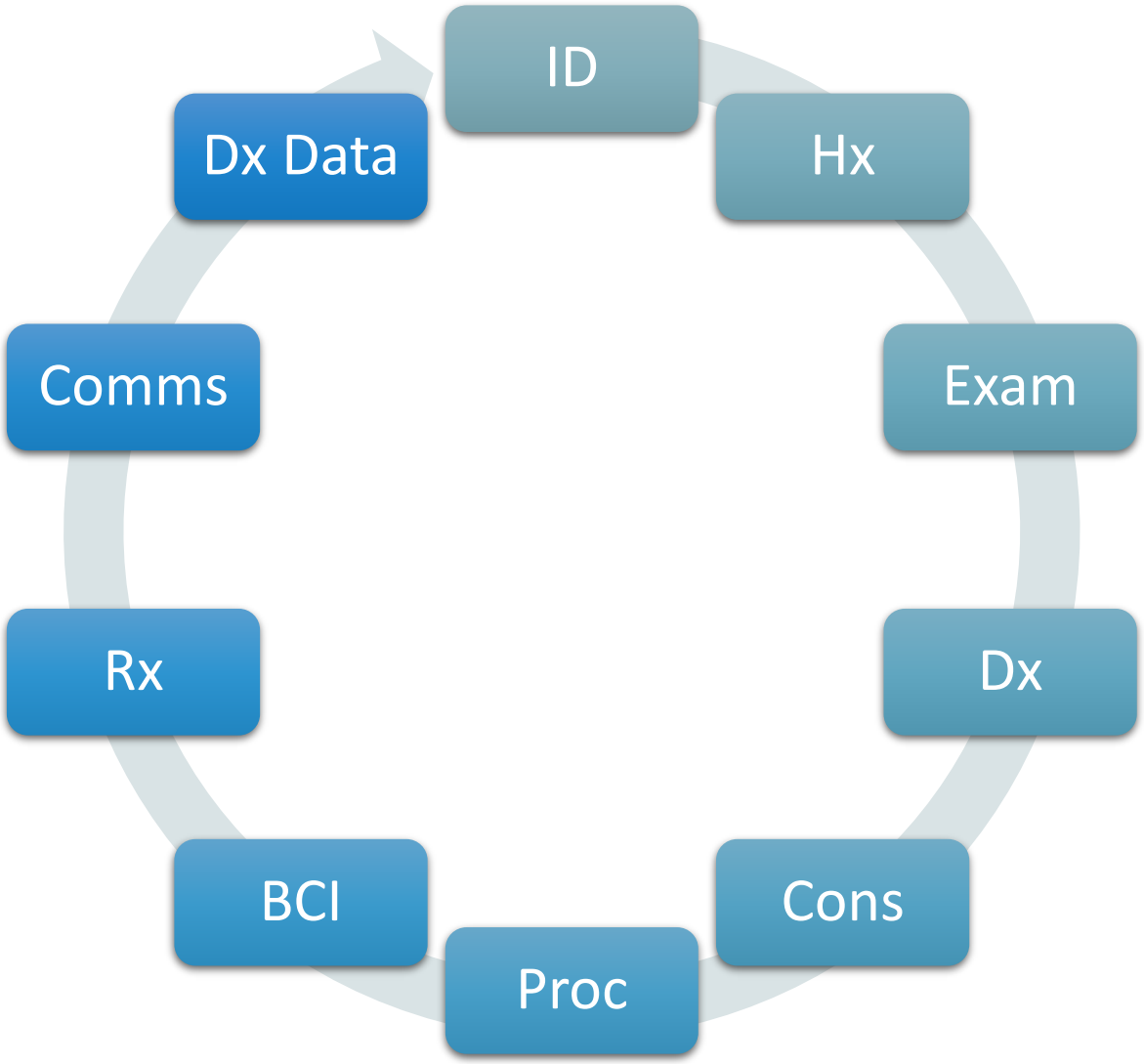


Decision making under uncertainty is what we do every day

Decisions are limited by a number of factors including time, knowledge, skills, money and biases

Decision-making is improved by being aware of our biases and creating systems that are clear and consistent

Combat bias and aid decision making with structure and systems



DBA CODE	PRIOR GUIDELINES ON DENTAL RECORDS
Clinical history	Identifying details of the patient, patient history applicable to decision making including health, social and cultural factors, complete and current medical history, patient capacity and special needs, patient or guardian consenting, date of visit, details of practitioner providing treatment including professional division or specialty presenting complaint, relevant history
Clinical findings	Type of exam conducted, clinical findings and observations
Investigations	Radiographs and other relevant diagnostic data/scans (including a record of your radiographic/scan interpretation), other diagnostic data (e.g. dental charting of examination findings, pulp sensibility tests, percussion tests, mobility tests, palpation tests, periodontal probing etc.) other digital information including CAD-CAM files
Information given to patients or clients	Diagnosis, treatment plan and alternatives, advantages and disadvantages of plan(s), consent process, estimates or quotations of fees, any relevant communication with the patient
Medication and other management	All procedures conducted, instrument batch (tracking) control and relevant infection control details where appropriate, any medicine/drug prescribed, administered or supplied or therapeutic agent, details of advice provided (as part of management), instructions to and communication with laboratories, all referrals (and handover) to and from other practitioners, adverse or unusual outcomes

Auditing

Dental Record Audit Tool

DATE OF AUDIT:	
AUDIT COMPLETED BY:	

GENERAL PRINCIPALS	HELP?	Record 1	2	3	4	5	6	7	8	9	10	Number of X's
Accurate												
Factual and objective												
Legible												
Protected from unauthorised access												
Respectful												
Date care was provided												
Record made at the time or as soon as possible afterwards												
Author and contributors clear including professional division or specialty												
Allow continuity of care												
The practitioner has taken responsibility for the adequacy of the health record												

PATIENT INFORMATION	HELP?	Record 1	2	3	4	5	6	7	8	9	10	Number of X's
Patient Details												
Relevant health, lifestyle, social and cultural factors												
Current medical history including medications and allergies												
Patient capacity and special needs												
Patient or guardian consent												
Billing information												

CLINICAL INFORMATION	HELP?	Record 1	2	3	4	5	6	7	8	9	10	Number of X's
Radiographs, scans, images, models, charts and a record of interpretation												
Examination findings (e.g. charting, TMJ, soft tissue, periodontal probing, tests)												
Diagnoses												
Treatment options												
Agreed treatment plan												
Advantages and disadvantages of plan(s)												
Details of referral and handover to other practitioners												
Details of referral of work to laboratories												
Procedures carried out												
Relevant infection control details such as batch control identification												

What are the features of a complete dental record ?

A quick self AUDIT: is it clear that there was inherent CONSENT?

Pneumonic	Considerations
C = Clinical history	Complete and current relevant dental and medical history
O= Observations	Clinical findings and observations, radiographs and other relevant diagnostic data/scans (including a record of your radiographic/scan interpretation), other diagnostic data (e.g. dental charting of examination findings, pulp sensibility tests, percussion tests, mobility tests, palpation tests, periodontal probing etc.)
N = New findings	Diagnoses
S = Strategies discussed	Treatment alternatives and plans discussed
E = Expectations	Advantages and disadvantages of plan(s) discussed, estimates or quotations of fees
N = Names of involved parties	Identifying details of the practitioner and patient or guardian consenting, patient history applicable to decision making including health, social and cultural factors, patient capacity and special needs
T = Treatment delivered	All procedures conducted, instrument batch (tracking) control and relevant infection control details where appropriate, any medicine/drug prescribed, administered or supplied or therapeutic agent, details of advice provided (as part of management), all referrals (and handover) to and from other practitioners, adverse or unusual outcomes

How can we make sure we meet the mark?

- Aide memoire / prompt
- Template / autonotes
- Structured approach to records and consent to avoid missing important steps

Reference: Journal of dental education 2015

Evidence Regarding Teaching and Assessment of Record-Keeping Skills in Training of Dental Students.

Kate J Amos, M. Bearman, C. Palermo

Final tips on how to improve dental records

The bus test… if I was hit by a bus (or Covid) tomorrow, could you continue the care for this patient? Would it be clear:

→What I did

→Why I did it (including diagnostics and pt. preferences)

→What's next

It remains to be seen what the interpretation of the new documents will be, but keep a structured consistent approach to note taking to give yourself the best chance of compliance during this transition period.

Member training access

- $275 incl GST for ADPA members
- Available from https://www.adpa.com.au/events/event/record-keeping-online-course
- Approx. 2-hours on-demand online step by step training on how to meet record keeping requirements

What other references can help?

- **ADA Policy on Dental Records** available from:

https://www.ada.org.au/Dental-Professionals/Policies/Third-Parties/5-17-Dental-Records/ADAPolicies_5-17_DentalRecords_V1

Charangowda BK. **Dental records: an overview.** *J Forensic Dent Sci* 2010; **2**: 5– 10.

Royal College of Surgeons Faculty of Dental Practice Clinical Examination and Record Keeping Good Practice Guidelines: https://www.fgdp.org.uk/clinical-examination-record-keeping-standards/title-page

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