* Sheet no. :#7  
    
  Refer to slide no. :#3   
    
  Written by: Maram Abu Ghazaleh   
  Corrected by: Rowa`a  **we are going to talk about 4 main terms:***1-Dental records* *2-Documentation**3-Consent**4-Referral***\*why we need the dental Records ?**   
  we need the dental records in order to have a **documentation** for every single thing we do to the patient , the **history** we take , **examination** , **advices** & each **communications** we did with patient or with another doctor , we also find the **cost of the treatment** there , the **Radiographes** and the **cast** !   
  \*Documentation : may be the patient will forget what they said .so to be in the safe side ,you should make documentation !  
  \*also its essential for Assisting with complaint resolution, medico-legal and professional standards reviews >>> it’s important for the medico legal thing because it’s the first thing that protect us from any accusation from the patients.

\* Professional, ethical and legal responsibilities dictate that a complete chart and record documenting all aspects of each patient’s dental care be maintained >> it’s our responsibility to have a full complete chart.

* Patient records must be well-organized, legible, readily accessible, and understandable (so any another dentist or lawyer should understand whats written in the record ).  
  \*If the practitioner of record were, for any reason to become unable to practise, another dentist should be able to easily review the chart and carry on with the care of the patient.  
    
  **What constitutes records?**
* Accurate patient details
* Completed written medical histories
* Notes made by clinicians and staff.
* Consent documents
* Copies of correspondence about and with the patient.
* Radiograph ,charts, tracings, measurements
* Diagnostic images, reports and casts
* Special tests
* Examination findings
* Photographs
* Records of financial transactions

**\*The contents and details of dental records:  
A) Patient details** : name ,age ,sex , address , details about medical history “allergies” , details about anu drug advearse reaction .  
**B) Substitute decision maker** :when the *the parent, guardian is for a kid or a mental retarde patient.*  
**C) Consents and restrictions on disclosure** :The dental record should include a record of consents provided by the Patient >>> but not all dental procedures need a written consents ,some of them they’re straight forward don’t need to but we must at least write it down theat we have explained the treatment to the patient (اشي ما بصير تحكيه لأي حدا you should keep the patient`s privacy )

* We must write any advices we give to the patients ,options , alternatives , risks , pre- and post-treatment instructions , any questions ,complains the patient talked about and we must know how to deal with it .
* Eventhough we must write any preferred treatment the patient has refused
* Also some patients hate to talk about themselves so you must write that also inorder if any other doctor comes to continue your work would know how to deal with this patient.

Some patients would refuse blood transfusipn when trauma happens  
**D)Practitioner details  
E) Clinical details**   
**certain baseline data should be common to all dental patients. This information includes:**

1-Accurate & concise information   
2-Made in a chronological order (in the way we actually did it).  
3-Legible with standard abbreviations (LA : anaesthesia , AG : amalgam ).  
4-Dentists are allowed only to collect clinically relevant information (not personnel information)  
5-Completed as soon as practicable after the service has been rendered by the dentist (as soon as you finish the procedure because you might forget sth ) and I must write by myself , don’t let anyone else to do it for you because they might forget sth and nurses they aren’t qualified enough to write notes.  
6-Dental records must be understandable by third parties, particularly other health care providers.  
7-Retrievable when required.  
8-All comments must be provided *based upon the facts*, do not include emotional language or make defamatory statements " افترائية “ >> we mustn’t write that the patient was stubborn and he refused the treatment I preferred and actually he didn’t >>> so you must be professional and don’t make any judgements.  
9-A treating dental practitioner must *not delegate responsibility* for the accuracy of medical and dental information to another person.  
10-The treating dentist should ensure that *only authorised and suitably qualified persons* provide clinical information from the dental record to patients and other persons  
11-Dentists should protect the *privacy and confidentiality* of dental records and comply with all relevant Privacy Laws.

* **How to document?**Write if we have a periochart , teeth chart , consents , notes , radiographs , photographs (they’re becoming popular nowadays.**) ,** communications we did with the patient/other doctors (we show the patient before and after the treatment when you are working with millimeters) , notes and videos.
* **Progress notes :**
* An entry must be made in the patient’s record that accurately and objectively summarizes each visit.
* The entry must minimally contain the following information:
* Date of visit
* Reason for visit/chief complaint
* Radiographic exposures and interpretation, if any
* Treatment rendered including, but not limited to, the type and dosage of anaesthetic agents, medications, and/or nitrous oxide/oxygen and type/duration of protective stabilization.
* Post-operative instructions and prescriptions as needed
* **In addition, the entry generally should document:**
* Update of medical history
* Adult accompanying child Verification of compliance with preoperative instructions
* Reference to supplemental documents
* Patient behaviour guidance (like : the patient wasn’t aggressive as the last time )
* And if you need any follow-up visit

A standardized format may provide the practitioner a way to record the essential aspects of care on a consistent basis

* We must know what **ATEN** means :

A: assements T: treatments E: evaluation N: next visit

* **Corrections and deletions:**\*never right with a pencil  
  \*Striking out the incorrect words and rewriting the correct words. (We put a line on them then we rewrite it again).  
  \*If the document is being rewritten the original document should be kept as a reference, we write who wrote it and when he did. \*Liquid paper products or erasable pens should not be used.  
  \*Any amendments to dental records after they have been initially generated should be clearly recorded and dated.   
  \*Corrections to clinical information should not remove the original information  
  **Features which make health information special:**
* **Confidentiality of collection**: because it’s the relationship between you and the patient and we must respect this relation. Health information is collected in a situation of confidence and trust in the context of a dentist/patient relationship and may be of a sensitive nature.
* **Sensitivity of information:**

Details about an individual’s body, lifestyle and practices which are particularly intimate or which may, if improperly disclosed, be misused.

* **Duration of retention:** health records should be retained for a long time (in JU Hospital we keep it for 10 years).
* Those information must have some sort of restrictions we shouldn’t give it to anyone … the first goal is to treat the patient but also there’s secondary goals >>> we can use it when some patient have a problem with the accountant “to see what you have done to the patient and how much he paid for it “
* Also if we are doing a research we must have a consent from the patient.
* **Storage and security of records :**

-Dental practices must take reasonable steps to **protect** the personal information it holds from Misuse and loss and from unauthorised access, modification or disclosure.  
-All file cabinets should be locked and kept in a room which is not accessible to the general public.  
-All computers should be password protected.

\*Dentists should ensure records maintained on durable paper, some forms of medical photographic imaging fade with time and should be copied.  
\*Dental records can be sent by secure fax or email. When sending dental records by post, traceable methods should be used such as registered mail or express post.  
\*If a health record is destroyed after the required retention periods, it must be destroyed in a secure manner, such as document shredding.  
  
-**Retention of Records:**

If health information is for an adult >>> they will be retained for at least seven years from the last occasion (in JU Hospital “10 years”).

If the individual is a child below 18 years we must wait till at least he has attend the age of 25 years.

If you want to delete or dispose a health information, you must keep a record ofor the name of the individual, to whom the health information related, the period covered by it and the date on which was deleted or disposed of.

* A health service provider who transfer health information to another organisation and does not continue to hold a record of that information must keep a record of the name and address of the organisation to whom or to which it was transferred >>> usually we don’t give the original record but if we had to we keep a copy for it.  
  \*Also keeping casts and radiographs is a problem >>> we must keep them for while till we make sure that the treatment is okay. It is a reasonable alternative that diagnostic images and diagnostic casts are given to the patient for retention.  
  **Legal implications:**

Dental chart is a legal document: it’s your first line of defence in a malpractice suit.

* A lot of dentist when they get sued … they try to change in the dental record in order to win the case but once they detected you, you’re guilty and in a big big problem.
* **Documentation and record keeping  
  in JUH**
* Records keeping in JU Hospital were in the “file room” but now it’s in the “screen room” (you can find the files of the student’s patients there).
* 4000 seen in the first term in 2013/2014 year in student clinics only >>> well it’s a huge number and record keeping may not be easy.
* Records retention policy for 10 years.

**Electronic records:**

It makes life easier but once they get destroyed it’s more difficult to be restored.

* Electronic records must provide prompt access to information, be capable of generating appropriate clinical reports, be regularly backed up and supported by an appropriate disaster recovery plan.
* Electronic records should be time logged and, if codes are used, they should be readily convertible to conventional language.
* a dental practitioner’s records must show who made each entry and when it was made;
* it must not be possible for entries to be changed without trace, that is, there must be an audit trail;
* there should be security procedures such as Password only access
* there must be a standard procedure for entering treatment record data that is recorded in an office manual or memorandum to the practitioner’s staff and there must be adequate computer back up and disaster recovery systems in place.
* In the slides there’s an example for an electronic record.

Look at her personal information >> you can a find a picture for her husband

Medical history >> you can see two medical alerts “diabetes type 2 & severe allergy to penicillin”.

In our system you don’t find these things but you can find a red tag that we put on the patient file to describe that the patient is aggressive/trouble maker >> so that allow the doctor to know about this patient without opening his file.

Also we can see a radiographs and photographs in the record.

* **Cessation or Sale of Practice:**

In case when you decide to sell the clinic or you get retired, you can send the patients to other practitioners and send their charts and records to use them.

* **CONSENT**
* Consent may be of three types;

* Implied : it means that when the patient comes to your clinic and sits on the chair he just authorized you to examine him.(general examination )
* Verbal : when we want to do a radiograph , perioexamination ,blood test …. We ask the patient that we are going to do it for him , most of our consents are verbal consents.
* Written : should be obtained for more complex treatment or involves significant risks or adverse effects , involves life or death and serious

-Written consent must be obtained from all patients having an operation.

-In addition all minors and cases of adult guardianship require written consent

-Achieved by asking the patient to sign a copy of the print out of the treatment plan.

-A signature on a consent form does not itself prove the consent is valid: *A signed consent form is not a legal waiver*

-For consent to be valid, patients must receive sufficient information about their condition and proposed treatment **“Informed Consent”**

**-a written consent doesn’t mean it’s a valid consent … so you can’t do whatever you want before you get the informed consent.  
  
Informed Consent**

**When obtaining consent, patients should be informed of:**

* details of diagnosis and prognosis with and without treatment >>sometimes the diagnosis isn’t that clear ,, and treatment failure for an example in endo treatment is in a high percentage.
* uncertainties about the diagnosis >> we need to explore the condition and find either a treatment succeed or failed , and never guarantee.
* Explain options available for treatment
* the purpose of all aspects of a proposed investigation or treatment
* the likely benefits and probability of success
* any possible adverse effects, the risks of the procedure proposed
* the likelihood of one or more of the risks coming to pass
* likely outcomes if a procedure is not carried out
* the need for drains, catheters, tracheostomy, etc.
* a reminder that patients can change their mind at any stage  
  -a reminder that patients have the right to a second opinion.

**\*you should refere to the slides for Examples and more details !!**