

THE VALUE OF GOOD RECORDKEEPING

The importance of good health records cannot be overstated. Because they are essential to good patient care, all health profession regulators articulate and enforce minimum standards for recordkeeping. The quality of a member's records can be the deciding factor in the outcome of an action for alleged dental negligence. The following describes the contents of a good dental record and how good recordkeeping improves the prospects for successfully defending a malpractice claim.

Anatomy of a Good Dental Record

To assist members in creating and maintaining good records, RCDSO published revised "Guidelines on Dental Recordkeeping" in May 2008 available at www.rcdso.org. Among other things, the Guidelines state that patient records must be accurate, comprehensive, legible and accessible. Entries should be dated and signed, initialed or otherwise attributed to the treating clinician. They should be typed, handwritten in ink or recorded in an acceptable electronic form.

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The level of detail required for a record to meet RCDSO standards is patient-specific, but the following baseline information should always be included:

- Current general patient information (e.g. name, address, phone number, etc.)
- Up-to-date medical and dental histories (see "A Guide for Ontario Dentists and Their Patients - Medical History Recordkeeping" at www.rcdso.org)
- A description of the patient's presenting conditions on initial examination
- Diagnosis and treatment options
- A treatment plan for the services to be performed and an estimated timeline
- Documented informed consent (e.g. notes of any discussions about the risks and benefits of the proposed treatment and, where appropriate, signed patient consent form)
- Notes of referrals to or consultations with other health practitioners
- A record of missed appointments and cancellations.



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Progress notes describing the treatment rendered to the patient should be completed for each visit and should contain:

- the date of treatment;
- a concise and complete description of all services provided;
- the treating clinician's identity;
- the materials and methods used; and
- all recommendations, advice and any discussions regarding possible complications or outcomes.

Health Records as Evidence

Since lawsuits are often started years after the treatment in issue was rendered, charts, notes and other records (e.g. radiographs) are often the best and most reliable evidence of what actually occurred. Both the plaintiff and the defence will rely on the records in assessing the merits of the case, proving their versions of events and obtaining expert input. A chart that complies with the RCDSO Guidelines can be useful in persuading a court that the dentist met the standard of care by properly assessing, diagnosing and treating the patient and/or by providing the patient with the information required to make an informed treatment decision. Conversely, a record that does not disclose the dentist's findings and thought processes or include any notation of a discussion of therapeutic options and risks may look sloppy to a judge or jury and creates a credibility contest that is likely to be resolved in the patient's favour.

In order to avoid allegations of tampering, errors or incorrect information should never be erased or eliminated from the chart, but should rather be struck out in such a way that the original notation is still readable.

But even the best records may be of limited assistance in defending a legal action if their integrity has been compromised. For example, a dentist may give original records or radiographs to a patient, who may lose, alter or destroy them, potentially impairing the dentist's ability to mount a full defence to a complaint or claim brought by or on behalf of that patient. Since health records belong to the provider, patients should only be given copies. No patient should ever be left alone with an original chart.

Corrections to a patient record by the dentist may also make a case more challenging to defend. In order to avoid allegations of tampering, errors or incorrect information should never be erased or eliminated from the chart, but should rather be struck out in such a way that the original notation is still readable. Late entries should be clearly marked as such. In no circumstances should a member add to or correct a patient's chart after receiving a demand for compensation or notice of legal proceedings relating to that patient. Any changes made against that backdrop would likely be seen as self-serving, perhaps even fraudulent, and could give rise to an award of punitive damages against the dentist.

Conclusion

Though sometimes time-consuming, keeping good records can be a dentist's best defence to a claim of professional negligence or misconduct. Following these simple rules will enhance patient care and improve the dentist's chances of prevailing in a legal action or College complaint.