

Record Keeping Self-assessment Checklist

Record keeping organization

- ☐ Do you maintain a record keeping system that allows you to locate a patient's record quickly?
- ☐ Do you maintain a record keeping system that facilitates finding misplaced patient records?
- ☐ If you keep computerized records, do you make a system backup daily and store it off-site?
- ☐ Do you have an established office protocol for record handling and record access?
- ☐ Do you have a record keeping system that deters your staff from making unauthorized entries in patient records?
- ☐ Do you have a method for training new employees in the record keeping methods of the office?

Record confidentiality

- ☐ Do you and your employees handle patient records with attention to confidentiality?
- ☐ Do you require a written authorization from a patient to release confidential information?
- ☐ Do you have the original of all patient authorizations in the record (release of records, signature on file, etc.)?
- ☐ Do your records document HIPAA compliance?
- ☐ Do you refrain from placing confidential patient information (including health alert stickers) on the covers of patient files so that protected health information will not be inadvertently disclosed to other patients?

Access to information

- ☐ Do you allow patients access to the information in their dental record?
- ☐ Do you have a written policy for documenting copies of records sent out of the office?
- ☐ Do you have a written record release policy?
- ☐ Have you established a protocol for addressing the cost of copying records for patients and others?

Record retention and record purging

- ☐ Do you retain your records for at least the minimum amount of time of either your state statute of limitations or record retention requirement, whichever is longer?
- ☐ Do you maintain and store all after-hours and telephone logs and diaries?
- ☐ Do you have a system of storing inactive patient records?
- ☐ Have you established parameters for retention of diagnostics and if/when to discard them?
- ☐ If you should no longer need a diagnostic, do you document in the patient's record the information on that diagnostic?
- ☐ Do you document whenever an original diagnostic is given to the patient or to a subsequent treater, or otherwise removed from the patient record?

Record review and quality assurance

- ☐ Do you have a system in your office for record review/quality assurance?
- ☐ Do you and your staff perform record audits on a regular basis?
- ☐ Do you discuss the results of your record audits with your staff?
- ☒ Do your dental records contain information that mirrors the notations in the following documents:
 - ☐ Patient ledger?
 - ☐ Referral forms?
 - ☐ Consultation letters?
 - ☐ Recall cards?
 - ☐ Patient correspondence?
 - ☐ Telephone communications?
- ☐ Do you include checking the documents against your records during your record audits?

Individualized records

- ☐ Do you have a separate record for each patient?
- ☐ Have you maintained the patient's radiographs in the patient's individual record?
- ☐ Do you have the original of all patient records in your files?

Record keeping practices

- ☐ Do you write the patient's name on every page of the record?
- ☐ Do you make a note of every patient visit?
- ☐ Do you record the date in full (day/month/year)?
- ☐ Do you record information during patient visits or very promptly afterward?
- ☐ Are your written entries legible?
- ☐ Do you use dark ink for written records?
- ☐ Are your entries factual, objective, and clear?
- ☐ Are your entries comprehensive, addressing who, what, when, where, and why?
- ☐ Do your entries use appropriate language and a professional tone?
- ☐ Do you refrain from recording disparaging or subjective comments or abbreviations about the patient?
- ☐ Do you refrain from recording disparaging or subjective comments about the prior dentist?
- ☐ Do you refrain from leaving open lines in the record?
- ☐ Do you contemporaneously sign and date any late entry?
- ☐ Is each entry signed (or at least initialed) by the person making it?
- ☐ Do you label each diagnostic (radiograph, model, photo, etc.) with the patient's name and the date it was taken?
- ☐ Do you use quotation marks "..." to accurately record patient complaints and comments?
- ☐ Do you record information in a patient record for all emergency treatment, even new patients seen for the first time for an emergency only?
- ☐ Do you retain copies of all dental laboratory prescription forms?
- ☐ Do you handle records in accordance with current infection control protocols?
- ☐ Do you refrain from routinely recording the patient's daily fees in the progress note?
- ☐ Based solely on your records, can you determine what treatment the patient has had and why it was necessary?

Patient personal information

- ☐ Do you have a comprehensive patient personal information section in the written patient record?
- ☐ Do you update this information regularly, such as at each recall?
- ☐ Do you maintain current emergency contact information, including cellular telephone numbers?
- ☐ Do you have written documentation of guardianship for minors, especially in cases of minors with divorced parents?

Health history

- ☐ Do you take a comprehensive medical history on every new patient?
- ☐ Do you document the patient's current medications and over-the-counter remedies and check for potential interactions (including calling the patient's physician or pharmacist if needed) before prescribing any additional medication?
- ☐ Do your records alert you to important medical conditions or other healthcare complications for each patient?
- ☐ Is this information prominently displayed inside the record?
- ☐ Does every provider review the patient's medical history prior to every treatment or consultation visit?
- ☐ Do you complete an abbreviated update of the patient's medical history at every visit?
- ☐ Do you complete a comprehensive update of the patient's medical history at every recall?
- ☐ Is the health history discussed with the patient at each visit to confirm the written information?

Dental history

- ☐ Do you document a patient's dental history?
- ☐ Do you have a written policy for obtaining the patient's authorization and contacting a prior treating provider concerning a dental history?
- ☐ Do you document the information received?

Diagnostic records

- ☐ Do you have a policy for determining the diagnostics necessary for each patient?
- ☒ Do you document your examination of all patients for:
 - ☐ Periodontal disease?
 - ☐ TMJ problems?
 - ☐ Oral cancer?
 - ☐ Caries?
 - ☐ Defective restorations?
 - ☐ Occlusal problems?
 - ☐ Other oral health problems?
- ☐ Does your periodontal examination document areas of inflammation, periodontal pocketing, furcation involvements, mobility, mucogingival defects, root proximity problems, violations of the biologic width, and your radiographic findings?
- ☐ Do you have a baseline periodontal charting, including pocket depths for each tooth, for all patients who have been diagnosed with periodontal disease?
- ☐ Do you complete all appropriate blanks and boxes on the dental examination form?
- ☐ Do you send only copies of radiographs, never originals?

Informed consent and informed refusal documentation

- ☐ Do you and your staff know the components of informed consent?
- ☐ Do you know when to have an informed consent discussion with your patient?
- ☐ Do you document in the patient record the receipt of informed consent when received from a patient?
- ☒ If you use written informed consent forms, do they:
 - ☐ Have a patient-friendly title?
 - ☐ Discuss the nature of the proposed treatment?
 - ☐ List alternative treatments?
 - ☐ Discuss possible complications of the recommended treatment?
 - ☐ Use the simplest language possible?
 - ☐ Allow you to customize the form for each patient?

☒ If you use written informed consent forms, do you:

- ☐ Also have a face-to-face discussion with the patient?
- ☐ Give the patient as much time as needed to ask questions?
- ☐ Answer all patient questions?
- ☐ Give the form to the patient on a date prior to the treatment date so the patient has time to think about the decision?
- ☐ Give a copy of the form to the patient to retain?
- ☐ Document the use of the form in the patient record, or maintain a copy in the patient record?
- ☐ Do you document a patient's refusal to follow your recommendations?
- ☐ If so, do you include that you informed the patient of the refusal risks and the probable consequences of failing to follow your recommendations?
- ☐ Do you give the patient written documentation of the information he or she was told about the refusal to follow treatment recommendations?

Treatment plans

- ☐ Do you have a written treatment plan for all patients, when appropriate?
- ☐ Do you give the patient a copy of the written treatment plan?
- ☐ Do you notify the patient when there has been a change in the treatment plan during treatment and obtain his or her informed consent for the revised plan?

Progress notes

- ☐ Do you make a note of every patient visit?
- ☒ Does your note include the following:
 - ☐ Date in full (day/month/year) of examination or treatment?
 - ☐ Review of medical history?
 - ☐ Chief patient complaint?
 - ☐ Clinical findings and observations, both normal and abnormal?
 - ☐ Your diagnosis?
 - ☐ Receipt of informed consent?
 - ☐ Referral, if necessary?
 - ☐ Treatment performed, including anesthesia used, materials used, patient protection?
 - ☐ Prescriptions and medications (includes confirmation of premedication)?
 - ☐ Postoperative and follow-up instructions?
 - ☐ Plans for next visit?
- ☐ Do you use the SOAP format to document emergency visits and treatment not in the original treatment plan?
- ☐ If you do not follow a previously documented plan of action, do your records indicate why your treatment plan changed?
- ☐ Do you document cancelled and failed appointments in the patient record?
- ☐ Do you document patient satisfaction and dissatisfaction, including any complaints and concerns?
- ☐ Do you document patients' lack of compliance and discussions with patients regarding the risks of lack of compliance?
- ☐ Do you document treatment complications, unusual occurrences and the corrective action taken?
- ☐ Do you document all pertinent discussions (in person and by telephone)?
- ☐ Do you document all referrals to specialists and consultants?
- ☐ Do you give patients written postoperative instructions?
- ☐ Are your written instructions specifically tailored to each different procedure?

Abbreviations and symbols

- ☐ Do you use abbreviations and symbols in the dental record?
- ☐ Do you use the American Dental Association and standard pharmacology abbreviations and symbols?
- ☒ If you use other abbreviations and symbols in your record keeping, do you:
 - ☐ Have a formal policy and list so that others can interpret your notations and ensure that all staff utilize the approved list?
 - ☐ Use the same abbreviation or symbol consistently for the same item?
 - ☐ Refrain from using the same abbreviation or symbol for more than one item?
 - ☐ Use abbreviations that make common sense?

Staff entries

- ☐ Do your staff members write in the dental record concerning treatment they witnessed or in which they participated, as well as pertinent conversations they had with patients?
- ☐ Do your staff members sign, date and time each entry they make in the dental record?
- ☐ Do you read and initial every clinical entry in the record made by one of your staff?

Correcting the dental record

- ☐ Do you correct records without obliterating the incorrect information?
- ☐ When you make an addition to a treatment entry, do you do so in the next available space in the record and date it contemporaneously rather than in the margin or the body of a previous entry?

Consultations

- ☐ If you obtain a consultation over the telephone, do you document in the patient record both the individual to whom you spoke and the information received?
- ☐ Do you keep a copy of all written consultations received from other healthcare providers?
- ☐ Do you explain the pertinent dental information clearly to non-dental professionals from whom you seek consultation?

Referrals

- ☐ Do you use a written referral form for every referral and retain a copy in the patient record?
- ☐ Does that referral form contain, at a minimum:
 - ☐ The name of the patient?
 - ☐ How long the patient has been with the referring practice?
 - ☐ What diagnostics are available to the specialist, and the date they were collected?
 - ☐ What diagnosis you have made for the patient?
 - ☐ What treatment has been completed to date?
 - ☐ What treatment you expect the specialist to complete?
 - ☐ What treatment is planned when the patient completes specialty care?
 - ☐ What information you need back from the specialist?
 - ☐ How you want to handle maintenance, if applicable?
- ☐ Do you require a written referral form from all providers who refer to you?
- ☐ Do you call the provider to whom you referred a patient to follow up on whether the referral was pursued?
- ☐ Do you check with the patient to determine if the patient followed your referral recommendation?
- ☐ Do you inform the patient of the consequences of refusing a referral when the patient does not follow your referral recommendation?
- ☐ Do you document this information in the dental record?

Telephone calls

- ☐ Do you have a system in place for alerting you to patient calls for emergency care or information after office hours?
- ☐ Do you and your staff record all attempts to reach a patient by telephone, including the number called and any message left?
- ☐ Do you and your staff record all telephone information received in the office concerning a patient in the patient's record?
- ☐ Do you and your staff record all telephone information received in the office from a patient in the patient's record?
- ☐ Do you document in the patient record all telephone conversations concerning patient care you have received outside of the dental office?

Computerization

- ☐ If you record patient treatment notes, medical histories or other patient information on a computer, do you have:
 - ☐ An adequate backup system?
 - ☐ A print-out or electronic storage medium with all patient information on it, labeled, dated, sealed and updated at regular intervals, such as quarterly?
 - ☐ A method to detect alteration or deletion of patient information?
 - ☐ A method for accessing the patient information before, during and after treatment?
 - ☐ Is the software/operating system current and in compliance with healthcare information security requirements?
 - ☐ Has a security risk assessment/gap analysis been conducted?
 - ☐ Are appropriate controls in place to limit access, such as sufficiently complex passwords and encryption technology?

Documentation of recall

- ☐ Do you have a patient recall system?
- ☐ Are recall notifications recorded in the patient record or in a recall system log?
- ☐ Do you record all missed recalls and patient appointment cancellations in the patient record?
- ☐ Do you monitor the number of missed recalls for each patient?
- ☐ Do you have a written policy in place to address patients who do not keep scheduled recall appointments?

Insurance documentation

- ☐ Do you maintain a written authorization from the patient to release information on an insurance form?
- ☐ Do you have an established office procedure for completion of insurance forms?
- ☐ Do you always review insurance forms for accuracy before they are sent to the insurance company?
- ☐ Does your original signature appear on all insurance forms filed on behalf of a patient?

Financial documentation

- ☐ Do you provide each patient with a written financial plan when appropriate?
- ☐ Do you provide a "Truth-in-Lending" disclosure to all patients against whose accounts you may charge interest?
- ☐ Do you check your patient record for completeness before sending a patient to collection or initiating a court action to collect a debt?
- ☐ Do you review the relationship you had with the patient before sending a patient to collection or initiating a court action to collect a debt?

Notice of termination

- ☐ Do you evaluate the stability of the patient's health prior to terminating the relationship with a patient of record?
- ☐ Do you notify the patient in writing when you terminate a dentist-patient relationship?
- ☐ Do you offer (and document) to assist the patient in obtaining alternative dental services, assist in his or her transition and document the patient's response to the offer of assistance?
- ☐ Do you retain a copy of the notification in the patient record when you terminate a relationship with the patient?
- ☐ Do you document all actions taken to assist the patient in obtaining alternative dental services or his or her refusal of such assistance?
- ☐ Do you document in writing in the patient record when you terminate a relationship with the patient?

This checklist is designed for general use and is not intended to include every possible record keeping concern nor every possible professional liability risk you may encounter in your practice. Use of this checklist is one of several risk management tools that you may implement as part of your program to identify risks and help reduce the risk of a professional liability claim. Check the Professional Protector Plan® for Dentists website for more information, including downloadable forms and tools at www.protectorplan.com/dental-risk-management