

CLINICAL RECORD EVALVATION FORM

Would your office pass the following Clinical Record Evaluation?

1. Charting is legible to staff without doctor input; second practitioner could easily discern and follow treatment plan.
2. Evidence of good review of medical history form, medications identified and cleared with physician when appropriate.
3. Medical history updated appropriately.
4. Dental history, oral findings, diagnoses and treatment plan clearly outlined.
5. S.O.A.P. format used.
S = Subjective "What the patient says....."
O = Objective / what you see"
A = Assessment Assess and Eval
P = Plan / Treatment Plan
6. Diagnosis is appropriate for physical findings.
7. Each treatment appropriately based on diagnosis.
8. Consent forms properly filled out in layman's terms, signed by patient and doctor. Alternative treatments discussed with patient and noted on consent form.
9. Brief chart note refers to consent discussion, patient questions answered.
10. Allergies noted and chart flagged in manner to avoid privacy violations.
11. Adequate treatment notes, findings during treatment, prescriptions, etc.
12. Appropriate instructions to patient and follow-up appointment given.
13. Telephone advice and conversations recorded in chart.
14. Brochures discussed and supplied to be documented
15. Staff notes limited, without any medical advice, initialed, and reviewed by doctor.
16. Fees, billing and insurance data on separate document. Chart documentation matches billing codes.

17. Radiographs labeled, dated, protected.
18. Hospital cases include admit/discharge dates, diagnosis.
19. Separate anesthesia record, including pre-assessment, baseline vitals, and monitoring equipment.
20. Discharge status of patient and care instructions.
21. Lab and pathology reports reviewed, initialed and reported to patient by doctor.
22. Provision for loose papers and envelopes.

CHARTING DON'Ts

DON'T Use "liquid paper" white-out, scribble over, cut off, or in any way obliterate a chart entry, which has been made.

DON'T Chart subjective comments about the patient, e.g. "Patient is crazy." Instead, quote the patient's words ("I'm Napoleon Bonaparte"), which describe the behavior.

DON'T Chart names without describing their function in relation to the patient's care. Chart "Referred to Bob Jones, DDS for periodontal consultation (treatment)." Not "Referred to Bob Jones."

DON'T Chart information that is not pertinent to the care of the patient.

DON'T File a chart until it has been checked for completeness.

DON'T ALTER RECORDS AFTER A SUIT HAS BEEN FILED. DO NOT CLARIFY, ADD-TO, CHANGE, OR MODIFY AN ENTRY IN ANY WAY.

Here's what the State of Ohio Dental Practice Act has to say about Alteration or Amendment of Records.

"An intentional alteration, falsification or destruction of medical records by a doctor to avoid liability for his/her medical negligence is sufficient to show actual malice, and punitive damages may be awarded whether or not the act of altering, falsifying or destroying records directly caused compensable harm."
[69 Ohio St. 3d 638]

CHARTING DO's

- DO** Record patient identification information on each page in the chart.
- DO** Document all contacts with the patient. Include all telephone calls and all services rendered.
- DO** Document all prescription refills.
- DO** Chart the complete date (day, month, year) on each chart entry.
- DO** Sign each entry with your name and title/position.
- DO** Use black ink. It is best for photocopying purposes.
- DO** Write legibly. Print each chart entry if your handwriting is difficult *to* read.
- DO** Chart all information immediately (delay leads to inaccuracies):
 - Modes of contact, i.e. telephone call, visit, etc.
 - Reason for contact.
 - Procedures performed, or information/advice given. . Outcome of contact.
 - Plan for future care/follow-up.
- DO** Fill in every blank. Record negatives as well as positives.
- DO** Use ONLY "Standard abbreviations."
- DO** Chart precise amounts. Be particularly careful to accurately place decimals.
- DO** Correct any error or mistake in charting by drawing a single line through the incorrect portion, label "error" above and initial and date correction.
- DO** Date and sign any addendum, additions, or corrections on the chart.
- DO** Record an emergency contact mechanism for patient and next of kind.