



ORTHO2

Proper Documentation is Essential

by **Andrea Cook**

The recording of accurate patient information is essential to orthodontists. The patient chart is the official office document that records all diagnostic information, clinical notes, treatment given, and patient-related communications that occur in the office, including instructions for home care and consent to treatment. Protecting health information — as well as accurate and complete record keeping — is extremely important for many reasons.

With the increasing awareness among the general public of legal issues surrounding health care, and with the worrying rise in malpractice cases, a thorough knowledge of orthodontic record issues is essential for any orthodontist as well as their team members. The ability to produce and maintain accurate orthodontic records is essential for good-quality patient care as well as it being a legal obligation. The orthodontic chart provides for the continuity of care for the patient and is critical in the event of a malpractice insurance claim.

The patient's chart will consist of several different elements, which include health history, signed consent forms, diagnostic records, treatment plan, clinical entries, as well as many other documents. Obviously this is a large amount of information and it is essential that it is maintained in an easily accessible manner. Any team member that maintains patient records must understand the importance of accurate, complete, and consistent documentation.

One of the most common areas of inadequate record taking is the clinical records. Missing or blurry photos and X-rays that are unclear are of little diagnostic value. If these records are the foundation of your treatment planning there may not be adequate information to defend yourself if the patient takes any legal action. Excellent pre-treatment, mid-treatment (if taken), and post-treatment records are your best line of defense.

Much of the information in the orthodontic record will be clinical in nature. The team should be very meticulous and thorough in the documentation. All information in a patient's chart should be clearly written, and the person responsible for entering new information should initial and date the entry. The information should not be ambiguous or contain many abbreviations. In practices with more than one orthodontist, the identity of the doctor providing the treatment should be clearly noted in the record. Clinical team members must make sure that ALL instances of patient non-compliance (elastic wear, oral hygiene, etc.) are well documented in each patient's chart.

Be sure to document the status of the case upon debonding. Specific attention should be paid to decalcifications, caries, occlusion, and periodontal status. Take all necessary records to show that this was the status of the case upon finishing treatment so that any post-treatment changes might be able to be attributed to the patient's lack of compliance with the retention protocol or might be the result of any post-treatment restorative care that the patient receives.

Information best left out of patient charts would be personal opinions or criticisms. Do document a patient's refusal to accept the recommended treatment plan and cancelled or missed appointments.

Keeping the patient aware of any compromise or change in treatment can often save you from having to deal with a dissatisfied patient after you have been working with them for a few years. Any sign of dissatisfaction by the patient should immediately be detected, discussed, and well documented. Some patients pursue legal actions against orthodontists long after completion of treatment, many of whom believe they are under the care of these

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doctors forever and that these specialists are responsible for any problems that may arise in future.

The final word here is documentation, documentation, documentation. You can never have records that are too complete or comprehensive. Your team must understand the importance of their complete and accurate documentation. If you need photographs or radiographs to document clinical findings, make sure the quality is good and that they remain with the patient's record. This is your best defense against a malpractice claim. Protect yourself!

I will be presenting a lecture on the importance of proper documentation at the 2014 Ortho2 Users Group Meeting in San Antonio. I look forward to seeing you all there. ☺

About the Author



Andrea Cook is a clinical consultant and trainer for premier orthodontic offices across the country with more than 20 years experience chairside. She is presenting a class at the 2014 Users Group Meeting in San Antonio.