

Preventive Action

Quarterly Risk Management Newsletter for Policyholders of FPIC

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DEFINING A WELL-DOCUMENTED DENTAL RECORD

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In light of the increasing severity of malpractice claims, the need for a well-documented dental chart has never been more important. Good record keeping not only prevents claims, but mitigates damages. Unfortunately, some dental practices remain lax in their documentation procedures.

One of the first steps taken by a plaintiff attorney when evaluating a potential malpractice case is a thorough review of the dental record. A well-documented chart often prevents further action beyond this stage. A record that supports that the course of treatment rendered was justified, or that the result complained of was a risk inherent to the procedure performed, are cases that are generally not pursued by plaintiff attorneys. Complete

and accurate dental records, written at the time you have contact with a patient, are your best defense against a malpractice action.

“Good record keeping not only prevents claims, but mitigates damages.”

In most cases, the dental record is the most important piece of evidence in a malpractice defense. Incomplete or inaccurate records not only precipitate lawsuits that could have been avoided (through proper documentation), but often undermine an otherwise defensible case. Good records help unmask the non-meritorious claim before it reaches the courtroom. A poorly documented or incomplete chart not only creates a question of fact, but can make a non-meritorious claim impossible to defeat.

The importance of good dental records is obvious notwithstanding liability concerns. Factors such as patient volume and the length of time between visits make good records vital for the continuity of care and treatment. In terms of content, dental records must serve three objectives: communicating essential information among the healthcare team, providing a permanent written record of treatment, and the reasoning behind that treatment.

Elements of a well-documented dental chart:

- The patient’s name must appear on every record page.
- The day, month, year and time of day of the appointment must be on all entries.
- All entries must be permanent.
- Entries are specific - avoid generalizations and characterizations.
- Notations are objective - use facts only. Record what actually occurred and what is clinically relevant. Avoid personal comments regarding a patient’s characteristics.

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First Professionals Insurance Company publishes Preventive Action on a quarterly basis as a service to policyholders. Information in this publication does not establish a standard of care, nor is it a substitute for legal advice. The information and suggestions contained in this newsletter are generalized and may not apply to all practice situations. First Professionals Insurance Company recommends you obtain legal advice from a qualified attorney for a specific application to your practice. The information should be used as a reference guide only.

For comments, questions or to obtain additional copies contact the First Professionals Insurance Company Risk Management department at 800-741-3742, ext. 3016.

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- Accuracy has been double-checked. A misplaced decimal point or inadvertent use of the wrong term can, and has, precipitated dental disaster. Take the time to double check your accuracy.
 - Exactly what is meant is written and in precise terms. Encourage a healthy skepticism within the healthcare team so that illogical instructions will not be followed blindly.
 - Entries are complete. If in doubt, write it down.
 - Entries are timely. Record events as they occur, write or dictate notes immediately after seeing each patient.
 - All entries are legible. Use standard abbreviations. Good records are useless if no one can read them. If you cannot write legibly, dictate your office notes before signing them.
 - Lines are not skipped or spaces left between entries.
 - Alterations are made intelligently.
- If you make an error while writing notes, do not erase or use White Out. Draw a line through the error, write the correction above it, and date and initial the correction.
- Electronic dental records should have the capability to capture and store revisions and deletions made to the original entry.
 - No part of a dental record has been destroyed. This raises the presumption that records were destroyed to conceal damaging evidence and will result in almost certain disciplinary action.
 - Consistency. Once a pattern has been established, avoid deviating. This is especially important in long-term care.
 - Global procedures pertaining to dental records are HIPAA compliant.
 - Documentation of all patient contact – both phone and office conversations. Note the date and time of the conversation and any important details. ■



FPIC INTRODUCES NEW DENTAL RISK MANAGEMENT PRODUCT

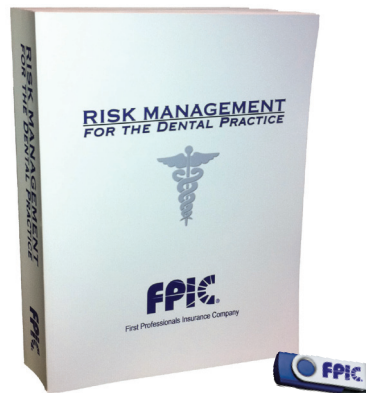
FPIC is proud to announce the development and release of *Risk Management for the Dental Practice*, a comprehensive manual for risk management covering such topics as communication, dental records, informed consent, HIPAA, incident reporting, and many others.

Risk Management for the Dental Practice was developed as a comprehensive risk management reference tool for policyholders of FPIC that utilizes a highly-focused approach to loss prevention.

This reference guide contains many of the liability challenges commonly

confronted by dental practitioners, including:

- Management and control of risk
- Evolving legal theories
- Fee-based e-consultations
- Emergency preparedness
- Informed consent
- Insurance issues



- Liability inherent to EMR systems
- Patient identity theft

Risk Management for the Dental Practice evidences FPIC's commitment to effective risk management products and services. This publication is available in hard copy and, for your convenience, electronic formats.

To request your copy of this new risk management product, please call FPIC's Risk Management Department at (800) 741-3742, ext. 3016 or send an e-mail to rm@fpic.com. ■

News Briefs

Crossing Boundaries: When Doctors and Patients Become Online Friends

The social networking tool Facebook blurs the line between professional and a social relationship. While Facebook can be used positively for communicating information, according to an article on Health Care News Feed, there are a number of problems healthcare providers and their staff need to avoid when using it. Some of these problems include unprofessional photos that may be viewed by patients; comments by

friends and family that a patient should not read; and stories shared by the healthcare provider that was not meant for patients to read. Healthcare providers can avoid these problems by discussing patient and doctor boundary issues with staff and emphasizing the importance of upholding HIPAA, even in social media. (*Health Care News Feed*, 6/8/11) ■

New Jersey Awards \$11 Million in Dental Professional Liability Case
A New Jersey jury awarded more

than \$11 million to the family of a man who died after having his wisdom teeth pulled. The patient had a genetic condition that caused swelling as a reaction to the trauma. Twenty-one year-old Francis Keller suffocated in August 2005 after the surgery. The man's dentist was cleared of negligence while the oral surgeon was found at fault. The family's attorney said the award is believed to be the largest award in the state's history for dental malpractice. (*News Day*, 3/9/11) ■



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Legal FAQs

For information specific to your state of practice, contact FPIC's Risk Management Department

What elements should comprise a letter terminating the dentist-patient relationship?

1) a diagnosis; 2) an offer to render “emergency care only” for the next 30 days; 3) a specific ‘final treatment’ date, beyond which no care will be rendered; 4) a recommendation to immediately find another dentist, if appropriate; 5) a description of possible outcomes if no further treatment is obtained; and 6) an offer to furnish the records to the patient or

patient’s new dentist. Send the letter by both certified and regular mail.

What are ‘punitive’ damages?

Damages on an increased scale awarded to the plaintiff where the wrong done was aggravated by circumstances of violence, oppression, fraud, or wanton and wicked conduct by the defendant. The purpose is to punish the defendant. Punitive damages are generally not covered by professional liability insurance.

How does the ADA (American with Disabilities Act) affect a solo dental practice?

The ADA labor provisions do not affect employment practices for businesses that have less than 15 employees. However, the practice is considered a public accommodation and is generally required to be accessible to disabled patients. Barriers to access must be removed if alterations are “readily achievable”, which is determined by considering factors such as the nature and cost of the action, the owner’s and tenant’s financial resources and the impact

of the action on the operation of the business. Such accommodations might include installing a ramp, making curb cuts, widening doorways, and modifying restrooms. Generally, these accommodations are made at the expense of the building owner. In most cases, local commercial building codes require such accommodations and may preempt ADA requirements.

Is there a reference site for information, guidelines, and instructions pertaining to HIPAA Security Rule compliance?

Yes. Visit <http://www.cms.gov/hipaageninfo>.

May records be furnished to an HMO/MCO without an authorization from the patient?

No. However, most HMO/MCO providers require such authorization as a condition of coverage. Therefore, the HMO/MCO should be asked to furnish a copy, evidencing the patient’s authorization. ■