PMM news

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To Review

In the December 2001 issue we completed a series analyzing the typical numbers and business statistics in pediatric dentistry. The series appeared in the June, August, October and December 2001 issues. As offered previously, please call the AAPD headquarters office (312-337-2169) for a copy of any issue you may have missed.

Record Keeping in Pediatric Dentistry

Since 1989, I have valued and referred repeatedly to a pair of articles by Gayle V. Nelson entitled, "Guidelines to the prevention of problems and record keeping: Part I" and "Records, charting, and problem areas in documentation: Part II." The articles, which originally appeared in *Pediatric Dentistry*, [1, 2] were intended to help candidates prepare for the site visit section examination of the American Board of Pediatric Dentistry. They have also proved helpful in both private practice and academic settings for recognizing and correcting some common errors in record keeping.

With permission from the author Gayle V. Nelson and the AAPD[3], we have reprinted the article below. In these days of talk about and movement toward "paperless offices," the information Dr. Nelson includes is still pertinent and necessary. Proper record keeping must be done consistently, whether by paper or computer record.

American Board News – Guidelines to the prevention of problems in record keeping: Part I

Flaws and weaknesses in record keeping, including charting and documentation, often contribute to failures in the clinical site visit section examination of the American Board of Pediatric Dentistry. This article, the first of two parts, outlines some common errors that may creep into the clinician's patient records, and offers guidelines for correcting them. The comments apply to candidates in both the academic and private practice settings.

The American Board of Pediatric Dentistry endorses those guidelines previously established by the American Academy of Pediatric Dentistry, which include those applicable to the topics mentioned in this article.

What is in a Good Chart?

Some candidates who fail the clinical site visit because of inadequate patient charts, in addition to other discrepancies, explain to the examiners that the charts are identical to those used in the candidates' training programs. With that line of reasoning, the candidate may be accepting an outdated concept of charting rather than one that is consistent with today's philosophy of pediatric dentistry.

The chart should be well organized, clear, and relatively concise. One method of ensuring logical order is to use a two-hole punch at the top of each page to keep the pages in order, with the oldest toward the back. All items germane to that patient should be attached firmly to the inside of the chart. Insurance papers or other material from third-party carriers should not be mingled with papers that refer to patient care.

*It is best not to use commercially prepared charts. A moment's reflection based on your years of training and clinical experience will remind you that you cannot possibly place **all** the information you need on each and every patient on only one page. Why do we need "pictures of teeth" on our charts? Are we in dentistry reduced to drawing pictures of our cavities and pictures of our fillings onto charts that do not resemble what we are treating? Share with me the image of Tevia from the musical "Fiddler on the Roof." Tevia has a statement about "tradition." Why do we follow what dental management companies have prepared and accept these as our charts? Tradition!*

One way to be sure that your chart is effective and up to date is to borrow charts from respected colleagues, not only in your own area but in neighboring states as well, to get ideas on how to improve your chart. Do not lower your standard of care just for the sake of doing what some commercial printer has prepared for 150,000 other dentists. However, you should work with a print professional in setting up the forms for proper type, spacing, and layout as you put your own ideas about charting into effect.

A complete and thorough chart should have a parent consent form, patient information form, health history, new patient examination form, sequential treatment plan, services rendered/progress form, periodic preventive visit/recall form, mounted sequential radiographs and supplemental papers, i.e., sedation forms, trauma sheets, TMJ questionnaires, correspon-

dence (including those from referring professionals), clinic reports, and hospital dictations.

Patient Information Form

This form which may be considered "vital information", can be taped to the inside left side of the chart for immediate retrieval. It will contain: patient's name; date of birth; chief complaint (at the first appointment); parents' names, their home and work telephone numbers; address (es) of record; referral source; dated photo (optional æbut it will tell you a lot about the child); follow-up areas of interest (e.g., missing teeth, biopsies, injured teeth, etc.; "problem list"); medical alerts (e.g., SBE prophylaxis, asthma, acute lymphocytic leukemia, rhabdomyosarcoma—treatment date); current medications; drug reactions, and allergies. There is an opportunity on this form to highlight such items as "Never use nitrous—Mom's request", or "Don't use restraints unless you check with a parent." Special notes of this kind, placed in a clearly visible location, such as just inside the chart when it is opened, are critical not only to good patient care, but also to good communication within your staff and with the parents.

The information on this form is subject to change, and it should be changed accordingly. Many offices refer to it as the "telephone information sheet." The basic information obtained over the telephone can be combined on this sheet with information usually filled out on the health history form. Good charts have essential items of information that are presented in a clear and forceful, even alarming manner that will quickly get the attention of each staff person. (The health history form can easily become buried in the back of the chart which can contribute to a failure to analyze the patient's health status correctly.)

The important point is that the information is immediately available and draws attention to itself.

Health History

A health history which has been tailored for the pediatric patient is essential, with special emphasis for the patient with special health needs.

Questions should be designed to elicit information about the wellness of all organ systems. With certain critical areas it is often wise to ask the same question again by rephrasing or emphasizing a different point. Parents will interpret the questions differently and possibly answer each similar question differently. If you routinely ask about allergies, you should bear in mind that parents' responses might be different if you asked about allergies and/or drug reactions. Remember, not all drug reactions are allergies.

Stock medical history forms should be avoided. A pediatric patient could have leukemia and the parent could still answer "no" to all of the questions on many stock forms. Do you ask if a child has frequent headaches? With current emphasis on TMJ disorders, you should. Such headaches might also point to chronic sinus problems and subsequent lack of maxillary growth which might have been suspected if the proper questions had been asked. In analyzing the patient's health history, the clinician should continue to keep current on the critical effect that the proposed dental procedures might have in relation to the patient's health.

An important point to consider is whether a patient has ever had a blood transfusion. Many parents would answer "no" to the questions as posed in most standard health history forms even if their child was born with an ABO incompatibility and required complete blood exchange upon birth. The child could have been released in the normal amount of time after birth and thus the parent perceives this event as being "within normal limits." Unless the history of transfusions is elicited, the historical significance of certain events may not seem relevant to the parent. The date of transfusion is also important since heat treatment has greatly reduced the risk of HIV transmittal.

With the increase of managing medical needs on an outpatient basis, it is possible to have a patient with mild hemophilia which is not covered by the question, "Has your child ever been hospitalized?" Questions should be designed to work around parents' wish to use a denial mechanism which they may have concerning the child's illness.

The health history must be updated—habitual updating at periodic preventive visits is best. Simply asking the parent if there have been any changes in the medical status of the child is insufficient. Either provide the parent with the original history form to review and sign, or develop an abbreviated form that will focus attention on the areas you feel are most applicable to the specialty of pediatric dentistry. Again, it is not enough to ask if a child has been ill or hospitalized since the last visit.

New Patient Examinations and Recalls

In reality, a periodic preventive visit/recall is just the same as a new patient examination. We are looking for the same items, albeit on a patient with whom we are a bit more familiar. Take a minute to review the patient's records in relation to the current examination findings.

Some offices simply chart the date, "pro, FT, EXM", and possibly "2BWX." Others have pictures of teeth in succession, and cavities are charted on those areas. What about occlusion? Doesn't that change as a child grows and develops? Are we looking for: midline deviations that can be intercepted; anterioposterior relationships and excessive anterior flaring that might lead to increased susceptibility to injury; severe crowding that is showing signs of gingival recession; open bites and subsequent changes that indicate persistent or resolving habits; or cross-bites that might contribute to disharmony in the developing TMJ?

What about the health of the gingival tissue? Can you show from your present forms that you even glanced at it? We cannot consistently hide behind the adage: "If it's abnormal, we note it; otherwise, you can assume that it is within a normal range." Of course, we are all checking these things, but can we look at our records and prove it? Too often those items are documented only if there is a deviation from a normal range. We get into such a routine of looking only at the teeth that we allow insidious bad habits to creep into our examination procedure. Be certain that your chart dictates what will be examined each time. Train your staff so that they ask for answers to those areas left blank. Do not encourage the development of incomplete findings because you haven't designed a chart to ensure thoroughness in gathering the diagnostic information. What other changes occur as a child grows and develops, besides teeth? Do you mark the child's present age at each preventive visit? Do you go through the mental gymnastics of asking yourself, for example: "What dental concerns does a 6 1/2 year-old girl have? Are her permanent molars erupted (and sealed, if indicated)? Where are her upper anterior teeth? Why are they delayed? Why do I only see three lower incisors? Where are the upper laterals? What radiographs are recommended at this age, etc.?"

Yes, this approach is slightly time consuming, but no more than the arduous and arguably fruitless task of logging the present restorations and sealed teeth, as is done in many offices.

Why not have a routine (e.g., soft tissue, hard tissue, occlusion, growth, and age considerations) built into your charts so your staff can always ask you for specific evaluations at each and every recall. Have a blank on your recall form that requires notation for each evaluation—an empty blank on a form does not mean that is was checked and it was "within a normal range"; rather, an unmarked blank may mean that it was overlooked. In other words, the chart should show that an entity was or was not evaluated and whether there were any problems.

We should have good documentation, not just for the sake of practicing "defensive pediatric dentistry" but rather to ensure our total and unconditional commitment to the comprehensive care of that child. The defensive aspects of our care will always follow.

Updating the health history at preventive visits is the proper standard of care. Also, re-evaluating the soft tissue and recording the findings is an important part of the recall visit.

As with any diagnostic form, a systematic treatment plan should reflect the immediate needs for that particular child: preventive, restorative, surgical, growth supervision, etc. This should be laid out in clearly defined, chronological order and not just by numbered quadrants that address only the most basic information on restorations and extractions.

Sedation Record

Until you have decided what questions are pertinent to the sedation record, you will have an abundance of superfluous information recorded. When was nitrous oxide started; when did it end; when was sedation administered; when and how much anesthetic was given; when did the procedure start; what is the patient's oxygen saturation; when and to what degree did the patient cry; when and to what degree did the patient move? Upon completion, when did the patient leave; was the patient ambulatory, awake, alert, drowsy, sleeping; how would you rate the color; was the patient nauseated? What was your overall rating of the appointment? Do we need pulse rate, respiration rate, CO_2 saturation and blood pressure or are all the bases covered with the regular recording of oxygen saturation, crying, and movement?

No matter what parameters you have chosen for the sedation record, those parameters are to be recorded at regular intervals. Offices will report that they record notes on the sedation record "every 5 min", "every 10 min", or "every 15 min." When pressed with probing questions about recording intervals, it is occasionally found that the intervals are not at regular periods.

Practical hint: Most offices do not have a mechanism to keep these intervals "regular." Buy a kitchen timer ($5-10), tape it to the top of your pulse oximeter, and set it at 15 min. When the alarm goes off, push the rest button three times (most timers will reset to the initial setting) and mark your recording in the chart. Don't try to recapture your numbers after a 2-hr appointment.

Trauma Sheets

A separate trauma sheet will give you a repeatable set of questions that need to be answered following injuries. If an insurance company inquires about a patient accident that occurred nine months ago, can you supply the findings, diagnosis, and treatment related to the accident? Did you consider child abuse and neglect as being contributory? Will your chart alert you to such possibilities? Always be ready to answer the questions of who, how, what, when and where? Calling an injury a Class II fracture is not sufficient. Describe the mobility. Describe the radiographic findings. Can your charts reflect the prognosis and show that these were discussed with the parents, especially the possibility of endodontic treatment?

Do you have a way to highlight the future areas of interest? You cannot allow certain injuries to remain unnoted after the injury. Since external and internal resorption patterns are common responses to injuries, we have an obligation to address follow-up areas of interest. You need a prominent and reliable mechanism in your chart that will remind you to evaluate the injured areas, both clinically and periodically by radiographs.

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Summary

(Editor's note: the first paragraph of Dr. Nelson's summary section addresses criteria for board certification as it existed in 1989. Since the examination process has changed, that paragraph has been omitted.)

Again, let us not suggest that we should have good documentation for the sake of practicing "defensive pediatric dentistry." Rather, the total and unconditional commitment to the comprehensive care of the child must be our goal. The defensive aspects of our care will always follow after that.

The second half of the manuscript will address similar concerns as they relate to the developing occlusion, TMJ concerns, radiographs, progress notes, medical alerts, common sense, insurance papers, and computers.

Preview

In the April 2002, issue of *PMM News*, we will reprint Part II of Dr. Nelson's article. Concerns for some aspects of risk management will also be included.

1. Nelson, GV. American Board News: Guidelines to the prevention of problems in record keeping: Part I. *Pediatr Dent* 11(2): 174-177.
2. Nelson, GV. American Board News: Records, charting, and problem areas in documentation: Part I. *Pediatr Dent* 11(3): 240-242.
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