

Records & Consent

-An update in the current Pandemic

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COMMUNICATION



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GDC Development Outcomes

A

B

D

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Record Keeping



Why are they important?

- Keeping proper records of the discussion, care and treatment we provide for our patients is an **essential aspect of an overall duty of care**.

Dental professionals are required to **make and keep accurate dental records** of care provided to patients, whether NHS or private.

Record keeping and paperwork generally is the part of dentistry that most dentists actively dislike; but keeping **full and contemporaneous records** of the care and treatment provided is essential due to the **potential litigation** we face today.

Guidelines and regulations regarding record keeping



Professional responsibilities of all GDC registrants

4.1.1 “You must make and keep contemporaneous, complete, and accurate patient records, including an up-to-date medical history, each time that you treat patients..”

4.1.4 “You must ensure all documentation that records your work, including patient records is clear, legible, accurate, and can be readily understood by others. You must also record the name or initials of the treating clinician”

GDC Standards for the dental team, 2013

Principle Four

Maintain and protect patients' information

Standards

You must:

- 4.1 Make and keep contemporaneous, complete and accurate patient records.
- 4.2 Protect the confidentiality of patients' information and only use it for the purpose for which it was given.
- 4.3 Only release a patient's information without their permission in exceptional circumstances.
- 4.4 Ensure that patients can have access to their records.
- 4.5 Keep patients' information secure at all times, whether your records are held on paper or electronically.



General Dental Council

General Dental Council | Standards for the dental team

Expected purpose of the dental record

“They should be clear, accurate, and sufficient, so that when viewed by another registrant or retrospectively for the purposes of audit, or other reasons, the reader is clear to the actions carried out by the registrant as well as the clinical thinking, judgement applied and the information given to the patient.”

GDC, Fitness to Practise Investigating Committee: Indicative Outcomes Guidance December 2014

Guidelines and regulations regarding record keeping



Meanwhile, Part 13 of the model NHS dental contract requires that, 'The Contractor shall ensure that a full, accurate and contemporaneous record is kept in the patient record in respect of the care and treatment given to each patient under the Contract.'

Guidelines and regulations regarding record keeping



CQC has powers under the Health and Social Care Act 2008 (the 2008 Act) to access dental records for the purposes of exercising our functions (which includes checking that registered providers are meeting the fundamental standards). These powers are always balanced against our responsibilities under the Data Protection Act 2018, the Human Rights Act 1998 and the common law duty of confidentiality.

Guidelines and regulations regarding record keeping



Dental Protection



Guidelines and regulations regarding record keeping



Records have a valuable dento-legal purpose if a dental professional's standard of care is called into question. In DPL's experience, a contemporaneous record of a thorough examination or consent discussion can provide valuable evidence when defending a member against allegations of clinical negligence. Conversely, if you are accused of negligence, inadequate records may make it difficult to successfully defend yourself.

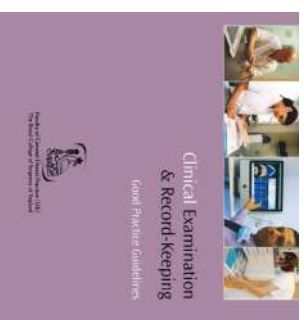
Guidelines and regulations regarding record keeping



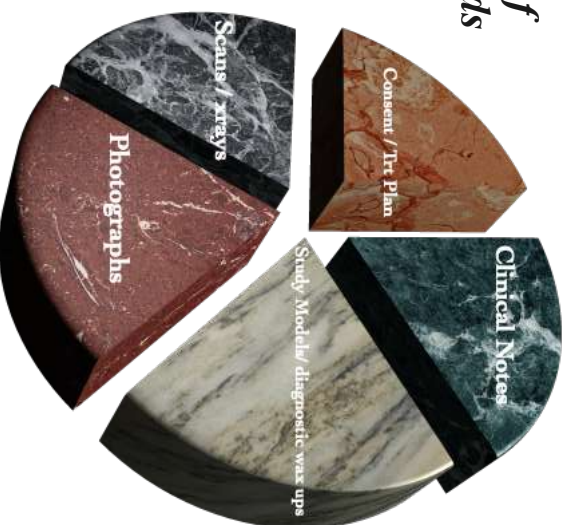
"Faculty of General Dental Practice,
Guidance for Record Keeping in the UK"
3rd Edition 2016

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Components of Clinical records



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CONTEMPORANEOUS

CLEAR

COMPLETE

CONCISE

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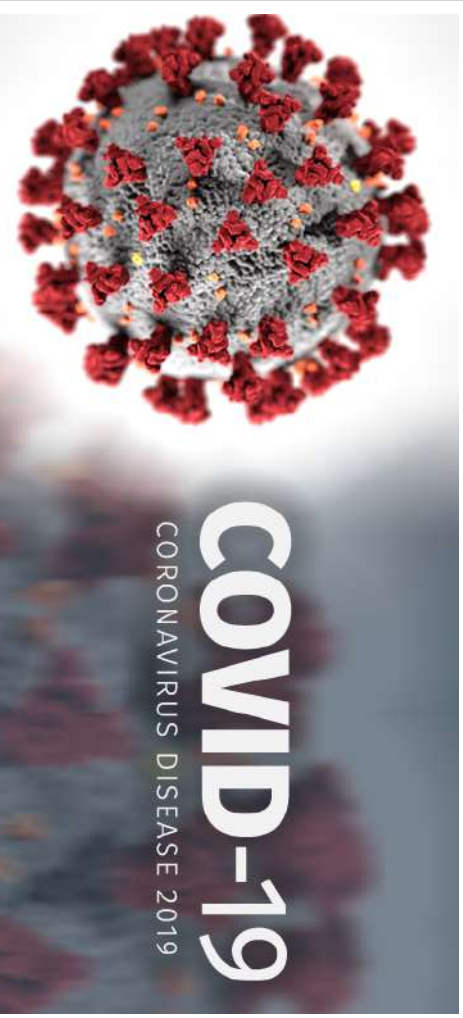
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Contemporaneous: make a record as soon as possible after a patient interaction

Clear: record your findings carefully so that they can be understood by anyone who may need to read and interpret them. For example, avoid abbreviations as far as possible. It should be clear who made an entry and when

Complete: record as much detail as possible of all relevant aspects of a patient's appointment, including: all histories, charting, special investigations and their findings, treatment options, risk and benefits, agreed Rx plans, consent, Rx carried out, complications and any advice post operatively. This extends to any telephone / email communications you may have with the patients

Concise: records should be just long enough to convey the essential information. Avoid superfluous personal comments that could backfire if someone else needs to access the record



The GDC has stated-

"Expert advice on the clinical aspects of COVID-19 will continue to come from the health authorities of the four nations and we will continue to signpost to this guidance as and when it is updated. But that guidance will inevitably not cover every potential scenario, and therefore, dental professionals will need to continue exercising their professional judgement and weigh the risks in any given situation. They will also need to continue to assess whether they are trained, competent and indemnified to carry out the activity in question."



General Dental Council



General Dental Council

"However, in the recent joint statement from the healthcare regulators we said that we understand that in highly challenging circumstances, professionals may need to depart from established procedures to care for patients and that should concerns be raised, relevant environmental and human factors would be taken into account."





— SOLICITORS —

Delays in treatment

Has your dental treatment been significantly delayed?

A positive outcome for dental treatment often relies on the timely conduct of the dentist, and any necessary referrals. Prompt treatment can help to ensure that oral health concerns are identified at the earliest opportunity, and not given the chance to develop. If treatment is delayed then there is a chance that a relatively simple condition can become more difficult to treat.


Potential reasons for delayed treatment:


- o Failure to respond to a patient's concerns and preferences regarding treatment
- o Failure to gain consent
- o Failure to be responsive to the patient's presentation
- o Long waiting lists
- o Delay in referral for scans or other diagnostic methods
- o Administration errors
- o Failure to refer to a hygienist
- o Failure to refer to a specialist e.g. orthodontist or maxillofacial surgeon
- o Delay in referral to Ear, Nose and Throat Department
- o Shortage of NHS funds



Call Now

Dentistry in crisis !





Record keeping standards are unchanged

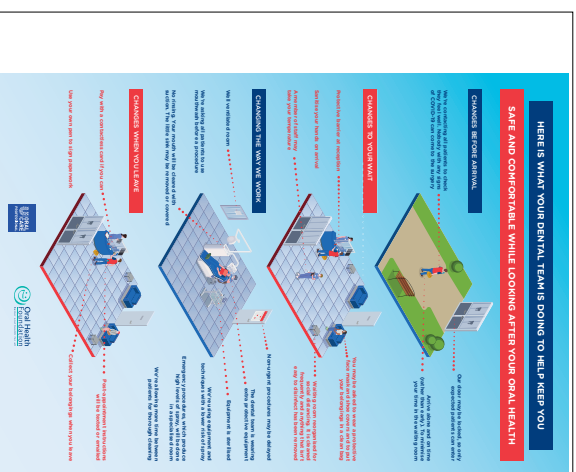
- Despite the challenges we face with Covid 19, this **does not amend or reduce the requirement** to follow the professional standards on record keeping upheld by Dental Councils; in fact there is **emphasis to record even more detail on the interactions** we have with our patients.
- Many patients will have had to wait for their treatment that was commenced prior to the Pandemic and long delays may have now **compromised** such care.
- Where patients are faced with the prospect of limited care, it can be anticipated some individuals will be **disappointed or unhappy** that they are not able to access the full range of services dental clinics would have usually provided.
- In the event of a complaint, your record becomes the **key evidence** you may need to rely on to demonstrate the **detail of your discussions with the patient**, that their request was managed appropriately and in accordance with any current protocols or restrictions in place at that time.

Record keeping standards are unchanged

- For all interactions with a patient, **the reason** the patient has contacted the practice needs to be **recorded**. This may include an enquiry about routine care provision or perhaps a request for urgent emergency care.
- Due to the changing situation of COVID-19 transmission, the dentist should also record the clinic's most **up to date protocol** based upon government guidance. This should include whether the dentist is able to **provide an appointment** to the patient, or if any **other restrictions** are currently in place to prevent this.
- You will need to include the **key issues** that may have restricted the availability of routine care in your records: such as **working remotely** thus may not have access to the patient record and making **diagnosis more challenging**, providing a **limited service** to comply with government guidance; **establishing Covid-19 symptoms** from the patient and their household members; does the clinic have the **capacity to accommodate** the patient based on the symptoms they are experiencing
- Any **digital information** provided by the patient, including your discussions and clinical advice provided must also be documented.

Recording advice to patients- including social distancing

- All practices have had to adopt a '**new method**' of working; sadly many patients are still not appreciative of this.
- This includes **new practice protocols** such as maintaining a degree of social distancing. This may mean the patient is asked to remain outside the clinic until a member of the dental team invites them in, to begin their safe movement through the practice.
- It is very helpful if a patient is **advised of any changes the clinic has implemented**, in addition to their usual treatment experience, prior to the appointment.
- Reassurances can be made regarding changes in clinic protocols that have been put in place to ensure the safety of all staff and patients. This will also help **manage any unrealistic expectations** a patient may have if you are unable to provide certain types of treatments or require additional equipment.
- It is advisable to **record all these interactions with the patient**, to provide a clear picture that they have all the necessary information about clinic protocols and what treatments are currently permitted.



Documenting info for Covid

COVID Protocols

Reception

Surgery

Patient washed hands? ☒ Low

Risk assessment according to local policy

Hydrogen Peroxide Mouthrinse ☒

Patient PPE

Type of Procedure ☒ Non-ACOP ☐ ACOP

Clinical Staff PPE (tick all that apply)

Clinician ☒ IR ☒ FFP2 ☐ FFP3 ☐ PAPR Other

Assistant ☒ IR ☒ FFP2 ☐ FFP3 ☐ PAPR Other

After Treatment

Debriefing in surgery ☒

Debriefing outside surgery ☒

HOCL Fogging Performed ☐

OK Cancel

Barriers to Record Keeping



- Fallow Time
- PPE
- Stress / Fear of managing patients who either have had or may not even be aware they have Covid
- Procedures that have taken longer than expected
- Forgetfulness
- Distractions
- Fear of not meeting targets
- Fear of keeping patients waiting
- Complacency
- System failures
- Staffing issues
- A sense of unwillingness of having to record everything that happened and in as much detail as possible.

RETENTION OF RECORDS



The Data Protection Act states that records should not 'be kept longer than is necessary'. The Department of Health guidance suggests this is no longer than 30 years.

For adults it is recommended that treatment notes, radiographs, study models and correspondence be kept for minimum of **11 years after the completion of treatment**.

For children, records should be retained **until the patient is 25 years old, or for 11 years after the completion of treatment, whichever is longer**.

It is recognised that there are often practical difficulties in storing study models or working models, surgical guides or wax ups, and it reasonable to make a decision to retain these for a shorter period of time. It would be prudent to consider retaining models where complex treatment (e.g. restorative, implant or orthodontic) has been carried out, or if treatment has not gone to plan.

CONFIDENTIALITY



All patients are entitled to **confidentiality**, and it is therefore essential that all members of the dental team understand the importance of this duty. A confidentiality statement should be included in staff employment contracts. There are many instances when confidentiality can be breached unintentionally, such as telephoning to change an appointment and leaving a message with a third party, or discussing personal information in the waiting room in front of other patients. It is vital that all information maintained is kept confidential.

Team members must ensure that they are familiar with current guidelines published by the Department of Health and the GDC. There are some rare circumstances where **confidentiality must be breached**, e.g. where safeguarding issues have arisen or where it is necessary for the detection and investigation of a serious crime. It is wise to discuss any situation where there is a need for a deliberate breach of confidentiality with your **indemnity organisation**.

SECURITY



Any electronic system must be **secure, regularly backed-up, and allow access only to those who require the information to perform their duties**. Each user must have a unique password. For maximum security, **passwords** should contain mixed-case letters and include numbers or symbols and should be changed regularly.

Passwords should not be written down and kept under keyboards or on desks or surfaces where the public may be able to access them. There may be differing level of access, such as clinician, receptionist, manager, owner, etc. Administrative functions can be reserved only for a specific person, thereby helping reduce the risk of accidental alterations of the system settings that may result in data corruption.

For data stored on a central server, similar security measures should be employed. **Firewall and antivirus software** should be employed for computers or servers (including external servers) connected to the internet, and consideration should be given to encrypting data that is transmitted between the practice and the server.

A full audit trail facility must be present to prevent the overwriting, erasure or corruption of data. The system should be **backed up daily**, and a **copy retained at separate premises**, and protected from fire, flood, and theft.

In an area where anyone other than the patient could see the screen, the computer should be sited so the screen is not easily seen by patients. There should be screen closure after a short period of inactivity to ensure that someone inappropriate does not look at the screen if the monitor is unattended after activation.

DATA PROTECTION

The Data Protection Act aimed to:

- Facilitate the secure transfer of information within the European Union.
- Prevent people or organisations from holding and using inaccurate information on individuals. This applies to information regarding both private lives or business.
- Give the public confidence about how the dental practice can use their personal information.
- Provide data subjects with the legal right to check the information dental practices hold about them. They can also request for the data controller to destroy it.
- Give data subjects greater control over how data controllers handle their data.
- Place emphasis on accountability. This requires dental practices to have processes in place that demonstrate how they're securely handling data.
- Require dental practices to keep people's personal data safe and secure. Data controllers must ensure that it is not misused.
- Require the data user or holder to register with the Information Commissioner.

DATA PROTECTION

Since GDPR, the Data Protection Act 2018 aims to:

- LAWFULNESS, FAIRNESS AND TRANSPARENCY
- PURPOSE LIMITATION
- DATA MINIMISATION
- ACCURACY
- STORAGE LIMITATION
- INTEGRITY AND CONFIDENTIALITY

Legal obligations about storage of dental records

A dentist must keep **records safely and securely** (Data Protection Act principle 7). Keeping them securely also requires that they are kept **confidential** (employed staff who have been instructed on your security policy are exempt). Access to the records by others must only be given if necessary, and with necessary and appropriate safeguards. The dentist is expected to make, and be able to demonstrate, an **assessment of risk** in deciding on appropriate security measures.



GDPR AND ACCESSING MEDICAL RECORDS

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The new Data Protection Act enshrined **GDPR** into UK law and also brought up a number of questions for GP & GDP practices, especially when it comes to the matter of when (or if) it's possible to charge for access to patients' records.

Under the DPA 2018, patients have the right to request access to their own medical records under a 'Subject Access Request' **without charge**, including situations where they give consent for a third party such as a solicitor or insurer to access the data.

Key points for general practice staff to bear in mind are:

- GDPR applies to both digital and physical (paper) records
- Information is subject to confidentiality obligations that already exist, e.g. between a doctor and patient
- GDPR only applies to living people, but the Access to Health Records Act (AHRA) extends to deceased individuals

GDPR AND ACCESSING MEDICAL RECORDS



To charge or not to charge...

Where a request is made from an appropriate party for a medical report or record that already exists, then this can be made under a **Subject Access Request**, without charge. You can however charge what the DPA 2018 describes as a **'reasonable fee'** if the request is **'manifestly unfounded or excessive'**. This term is subjective, and depends on the practice's interpretation. If you decide to charge for a SAR for this reason, you should be 100% sure you are justified in doing so.

Another circumstance where you can charge for a SAR is where an individual or body makes repeated request for the same information. You can even refuse to provide information that has already been requested and provided several times.

Contemporaneous record keeping applies
before , during and post Covid !

HISTORY

EXAMINATION

ASSESSMENT- investigations & diagnosis

INFORMATION- discussion & consent

PLAN- management & treatment

FOLLOW-UP



History

- Medical History
- Social History
- Presenting complaint / reason for attendance
- Patients concerns/ expectations
- Timings / constraints of treatment
- Dental history / pain history
- Others present e.g relative / friend/ carer



History

Dental-Pain History

- If applicable, take a detailed pain history
- **Listen** to the patient carefully, the clues are in the history
- Make sure you record your communication and findings in the clinical records

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Assessment-Investigations & diagnosis

- Radiographic examination Incl CBCT scans and findings
- Special tests / investigations, findings
- Diagnosis / differential diagnosis
- Progress or change if a review
- Risk factors

Examination

- Clinical examination e.g. extra and intra oral examination
- Clinical chart and intra oral findings
- Monitoring information e.g BPE / soft tissues
- Positive / negative findings

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Information-discussion & content

- Information given (advice sheets)
- Options- risks / benefit / warnings discussed, including no action
- Important patient considerations / views
- Advice and recommendations- OH, Smoking cessation etc
- Decisions jointly made and consent-Shared Decision Making
- Agreed patient responsibilities & understanding
- Important questions answered
- Treatment declined or deferred

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Plan-management & treatment



- Written treatment plan and costs
- Preoperative instructions
- Treatment carried out
- Drugs used or prescribed
- Adverse reactions noted / details of an adverse outcome
- Details of referrals
- Future treatment discussed



What to record



- Recap your Covid questions with the patient and document the responses; incl when the patient had their Covid vaccinations (if applicable)
- All PPE (for AGP & non-AGP procedures) worn by the dentist, dental care professional and patient
- Thorough clinical history
- Medical history/ incl details if patient had contracted Covid in the past
- Whether the situation can be managed with advice, analgesia or antimicrobials and why (should you be unable to provide an appointment to the patient at that time)
- Clinical assessment and any special tests
- Radiographic reports
- Diagnosis
- Treatment options, including any referral to a specialist colleague
- Agreed treatment plan and estimates

Follow-up



- Post-operative instructions
- Follow-up arrangements if problems
- Future treatment indicated
- Recall interval
- Further actions required by the dental team



What to record



- Additional information provided to the patient in respect of their specific treatment – for example, the **availability of appointment times** and if **any delays** in treatment provision may be experienced
- **Consent** from the patient should it become necessary to share or discuss their information with another practitioner e.g. a second opinion in order to be able to make a decision regarding an urgent care request.

What to record



If there has been an extreme circumstance and you have been unable to comply with the current local guidance when you have been providing care, then **your records must fully demonstrate your reasons to justify your decision**. Any deviation from the local guidelines or government protocols at the time may well attract attention, and you must be able to ensure you can **robustly defend** your decisions by evidence in the treatment records.

TeleDentistry- Digital Communications



- It has been necessary for patients to communicate digitally where dental clinics were required to close or reduce the number of patients to whom they were able to offer an appointment. There has been a huge increase in the practice of **teledentistry, video conference appointments, emails or use of digital photographs** to assist with the dentist's assessment and diagnostic process.

COVID-19 and remote consultations

The following is a summary of the current guidance for remote consultations, based on the latest information available.



The main purpose of a remote consultation is to provide a patient with a clinical assessment and advice, where it is not possible for the patient to attend a dental consultation in person. This can be achieved through a variety of methods, including video conferencing, telephone, or text-based communication. The patient should be advised of the limitations of remote consultations and the need to follow local guidance regarding infection control and social distancing.

Do not use video conferencing for urgent cases - Video conferencing should not be used for urgent cases, such as those requiring immediate treatment or where the patient is at risk of harm. It should only be used for non-urgent cases where the patient can be safely assessed and managed remotely.

Protecting safety and your data security - When using remote consultations, it is important to ensure that the patient's data is protected and that the consultation is secure. This can be achieved by using encrypted communication channels and ensuring that the patient's identity is verified before the consultation begins.

Recording safety and your data security - It is important to ensure that the patient's data is protected and that the consultation is secure. This can be achieved by using encrypted communication channels and ensuring that the patient's identity is verified before the consultation begins.

Guidelines may be frequently updated during the Covid-19 crisis; it is advisable to record in the clinical notes that the most recent and relevant guidance has been followed. This guidance should be referred to by name with the exact publication date in parenthesis. If the patient's records are reviewed for any reason at a later date, then it will be clear that you have adhered to the guidance in place at the time of the remote consultation.

Raj Rattan, JIDA April/May 2020

TeleDentistry- Digital Communications



- Patients have provided images of their mouth, face and even medications. It is important to remember any type of digital information and verbal information provided by the patient is also part of the clinical record and should be recorded as such. You will need to think about how this digital information is stored with a view to the requirements of your Dental Council, ensuring patient confidentiality is maintained and meets national regulation. Remember, any digital communication that is a part of the dental record is expected to be provided to the patient if they request a copy of their records in the future.

TeleDentistry- Conducting a remote Consultation



- Dress professionally- it's still a professional consultation
- Think about lighting
- Think about background
- Clear desk, no other patient records or practice info should be visible that could breach confidentiality
- Avoid interruptions-other phones, background noise
- Ensure video conferencing software is approved
- Check and turn off default recording software
- Use secure internet access & password protected devices
- Do not store patient identifiable data on personal devices
- Disable sharing across devices / cloud

The ongoing importance of clinical records



While we all begin to resume a kind of 'usual' practice, the worldwide situation regarding COVID-19 transmission continues to evolve and change. We are all acutely aware COVID-19 will continue to affect our lives on a personal and professional basis for some time to come, and the pace of dentistry provision will be required to adapt to varying Government alert levels.

Therefore, it is paramount to ensure all **communications** we have with our patients, under whatever circumstances are **appropriately recorded**. Dentists need to continue to **maintain high quality treatment records** to reflect patients' experiences, what treatment was provided, and how this may have been affected by the restrictions in practice based upon local guidance.

Any Clinical photographs taken / shared also become
part of that patient's record

Government temporarily suspends need for patient signatures on dental forms



Patients will no longer have to sign dental forms in a new move to help reduce the transmission rate of COVID-19.¹

The Secretary of State for Health and Social Care approved the temporary measure this week. It will last for a five-month period, ending on 31 March 2021.

Where patients attend NHS dental services, contractors should complete any parts of the practice record form (PFI) or treatment plan (FP17DC and FP17DCO) that would usually be completed by the patient.

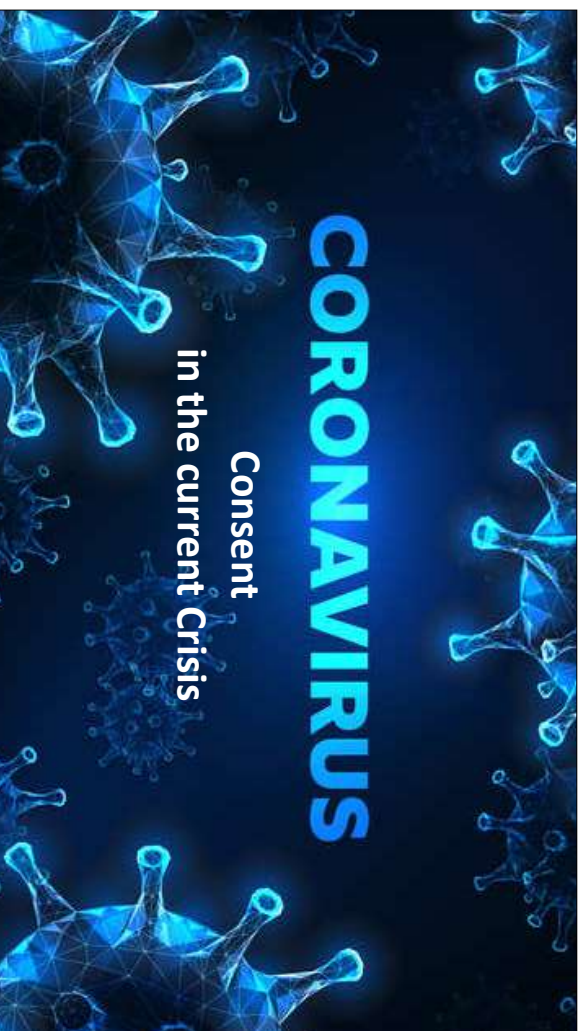


¹ A temporary suspension of these signatures is now in force and will last until 30 June 2021. This will, however, be kept under review and may be extended, if there continues to be a cross infection risk, or removed, as soon as it is deemed safe for patients to resume signing forms.

When to write more detailed entries

Patients who:

- Disagree with your decisions or decline recommended treatment
- Have unrealistic expectations
- Request cosmetic work
- High 'risk' situations- Implant work, extensive treatment plans
- Bad / poor experience at by previous GDP
- Receive telephone advice
- Experience an adverse outcome or are unhappy with their care
- Fail to attend / cancel their appointments



Consent

The Importance to achieve consent remains unchanged but certainly can prove more challenging in the current working environment

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Are we meeting
Regulatory body
expectations?

Definition of Consent

Lord Diplock in 'Sidaway v *Bethlem Royal Hospital governors*' [1985]

'A state of mind personal to the patient whereby he agrees to the violation of his bodily integrity'

Definition of Consent

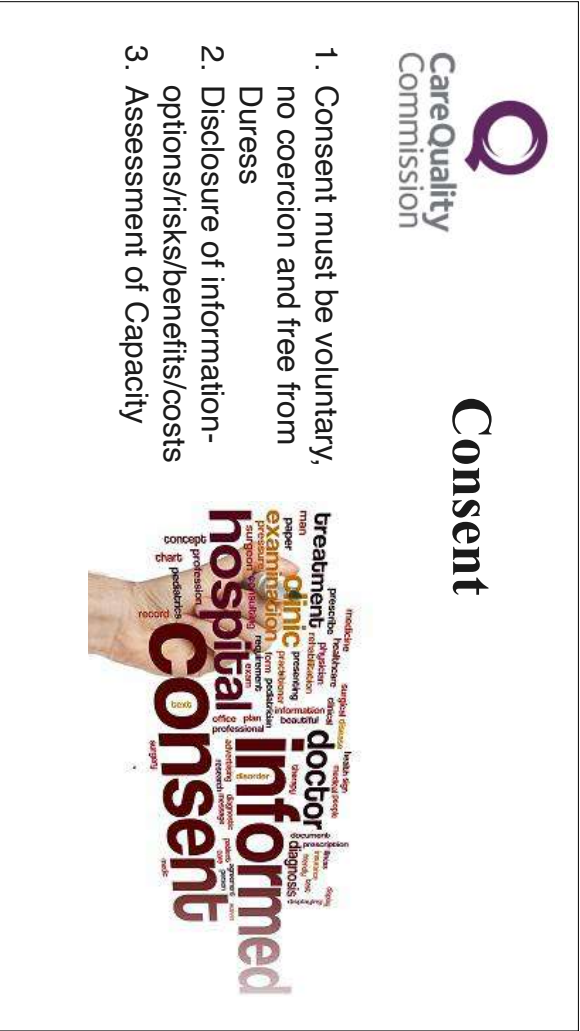
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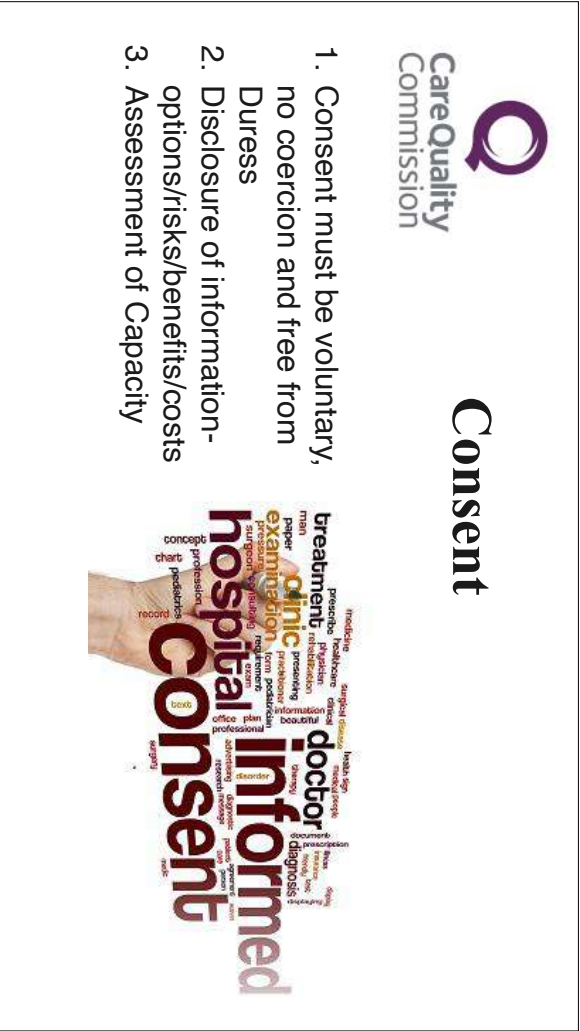
Definition of Consent

Lord Diplock in 'Sidaway v *Bethlem Royal Hospital governors*' [1985]

'A state of mind personal to the patient whereby he agrees to the violation of his bodily integrity'

[illegible]

- [illegible]



Department of Health

“The voluntary and continuing permission of the patient to receive a particular treatment. It must be based upon adequate knowledge of the purpose, nature and likely effects and risks of that treatment, including the likelihood of its success and any alternative to it”

Department of Health

“The voluntary and continuing permission of the patient to receive a particular treatment. It must be based upon adequate knowledge of the purpose, nature and likely effects and risks of that treatment, including the likelihood of its success and any alternative to it”

Bolam Test



"A doctor is **not** guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art"

Montgomery ruling



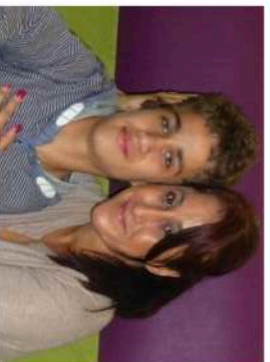
"The doctor is under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatment.

The test of materiality is whether, in the circumstances of the particular case, a **reasonable person** in the patients position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the **particular patient** would be likely to attach significance to it"

Montgomery v Lanarkshire Health Board[2015]

The Facts

Nadine Montgomery was a pregnant woman with diabetes and small build. She was carrying a large baby but was not informed by her obstetrician of the risk of shoulder dystocia. During delivery in 1999 there was a 12 minute delay in freeing the baby's shoulder during which her son was starved of oxygen, sustained brain injury (cerebral palsy) and paralysis of arm caused by force used in pulling him out.



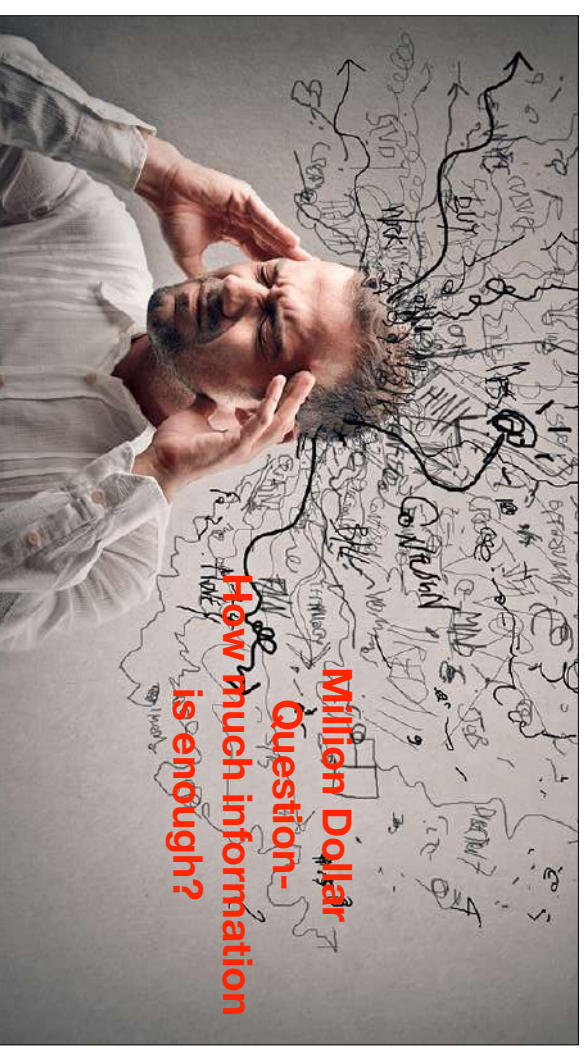
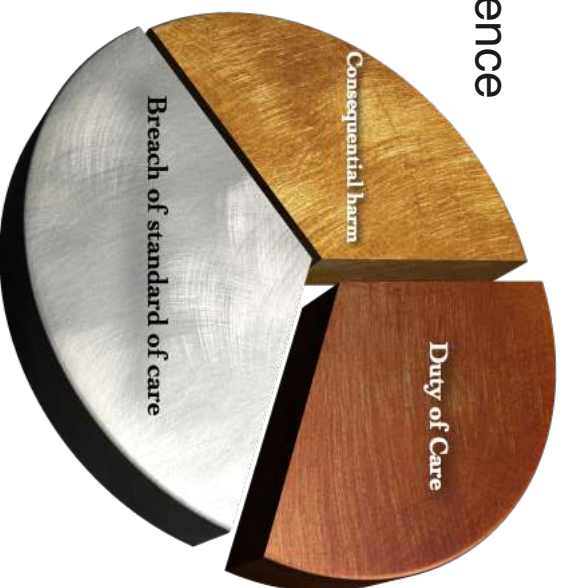
Breach of Duty

Your member failed to obtain **valid informed consent** to the extraction of the lower left third molar.

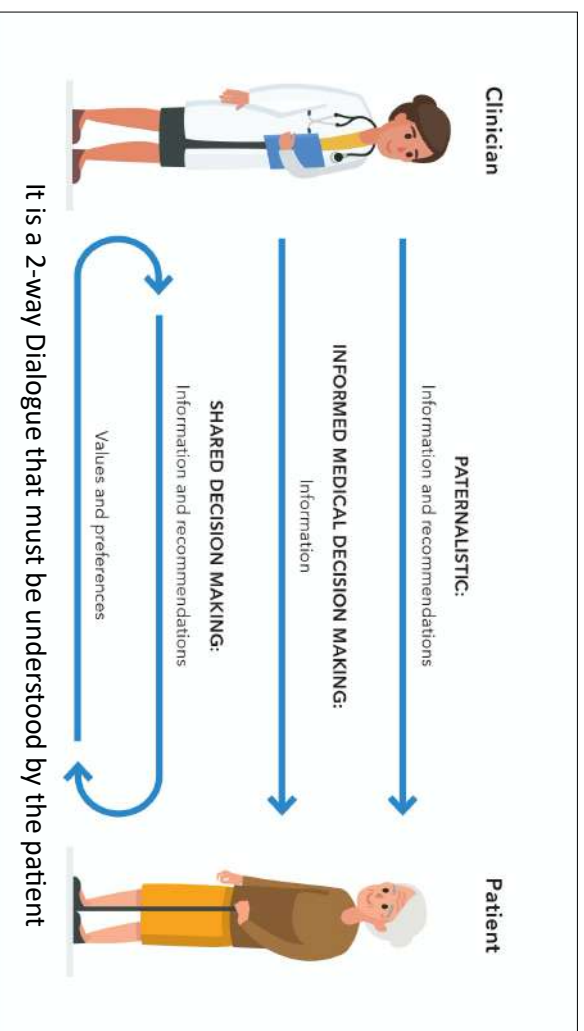
Your member failed to advise of the **risk** of damage to the nerve causing temporary or permanent paraesthesia.

Our client confirms that no risks or benefits were explained to her prior to the procedure

Negligence



Consent-must be an accurate reflection of the discussion, treatment options and treatment plan agreed with the patient. It relies on the principles of Shared Decision Making



Communication

When I wear a respirator mask it is difficult to communicate with patients: it's difficult to hear each other. How can I ensure that I have got their consent for treatment?

It is important that you make reasonable changes to the way you communicate with patients during this Pandemic. You could consider explaining to patients the **limitations of any communication before** you place your respirator mask on. Try to ensure that you have **adequate time for any discussions** before you start generating an aerosol.

When treatment planning, consider following up any discussions with the patient **in writing** and give the patient the chance to **ask any questions either verbally or in writing, before the treatment starts**. Keep records of the way you obtained consent for the patient.

Consent

Is it OK for me to accept verbal consent to treat a patient during the pandemic?

When a patient gives verbal consent to treatment, you should make a note in their clinical record of the advice given, **including any risks, benefits and likely outcomes, and the fact that the patient has understood and consented**. This is particularly important where treatment is significant and not routine.

However, it is mandatory to have a written consent form, which should be signed by the patient or their representative, when treatment is being provided under sedation or general anaesthetic.

Consent: three components

The diagram shows three components of consent, each with an icon:

- Information:** Represented by an icon of a hand holding a document.
- Capacity:** Represented by an icon of a head with gears.
- Voluntariness:** Represented by an icon of a pen signing a document.

A large double-headed arrow connects the three components, indicating they are all essential and interrelated.

**What do we mean
by an Adverse
outcome ?**

‘An adverse event or outcome is an unexpected and undesired incident which results in **unintended harm to the patient**, and is related to the care provided to the patient rather than to the underlying medical or dental condition.’

At least 98%
of patients want
to be told the
truth about error

**Why are
these actions
important?**

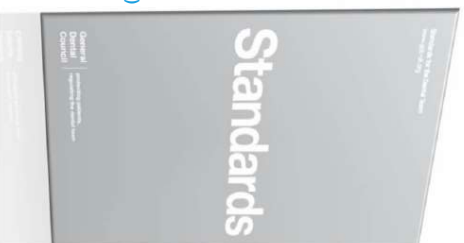
- Help patients (and professionals) recover psychologically
- Essential and expected part of our role as a caring and ethical dental professional
- May influence the patient's decision to take further action

Tierman and Rattan 2004

Situational Ethics

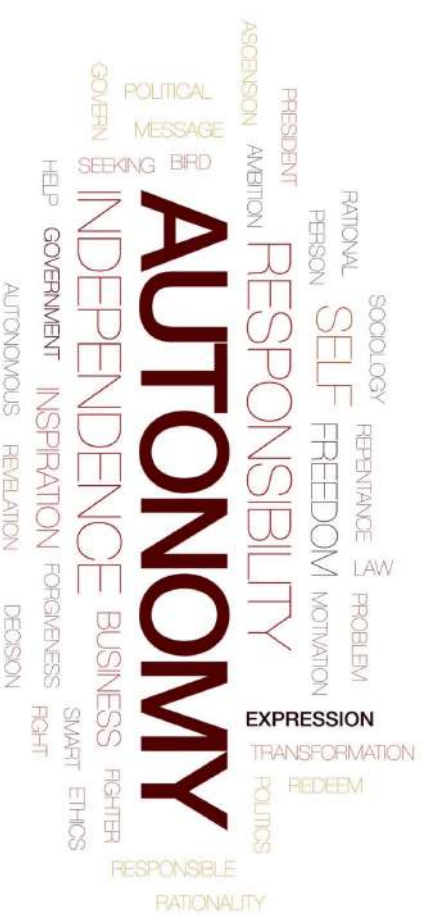
"You should offer an apology and a practical solution where _____ appropriate."

General Dental Council, Principle 5, Standards for the Dental Team (2013)



Is an expression of regret admitting liability?

Although it is sometimes possible to infer that a person is at fault from the nature of their apology or expression of regret, an expression of regret/sorrow is not the same as an admission of liability



GDC &
Lawyers
are constantly
on the watch!



GDC are finally seeing the light



Claim

return

So, what is
your
occupation?

I am a lawyer... well
a personal injury
lawyer to be precise





Dangers of automatic templates in electronic records

- Automatic templates are drawn up by some practices to make it quicker and easier for dentists to record the routine advice they provide to patients after certain treatments.
- However, using templates to record information in patient notes can also lead to an inaccurate account of what happened at an appointment. Examples include:
 - 'Crown checked' after an onlay was fitted.
 - 'Patient warned about contraceptive pill' to a male patient being provided with an antibiotic.
 - 'Patient warned not to bite tongue' after an anaesthetic in the upper mouth.
 - Similarly, identical entries in every record (eg 'examination, medical history checked, bp recorded' at the start of every entry or 'patient understood/agreed/happy' at the end of every entry) can make it difficult to justify what information was actually provided to a patient if a complaint or claim later arises.
- Automatic templates should also not be entered into a record in advance of a future appointment, for example as anticipation of what the dentist is planning to provide as part of the patient's treatment plan.
- While the use of automatic templates from drop-down menus is not in itself wrong, for safer patient care you should bear in mind the following:
 - If using automatic entries for record keeping, make sure they are tailored to reflect the advice given to each patient.
 - Only complete the record of the treatment provided and the discussion had with the patient at the time of the actual consultation.
 - If the purpose of the template is to provide a memory aid for patients to be provided with all relevant information, it might be more appropriate to have a checklist for the information to be provided before, during and after certain treatment, rather than an automatic entry for the records.
 - The accuracy and integrity of patient records should be maintained at all times.



Keep safe
with your records &
consent

COMPLIANCE
risk management
CONSENSUALLY
guidelines
Laws adherence
Practices mitigation
regulations

