**Clinical Dental Record Keeping**

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|  | **Action Points** | **Yes** | **No** | **Action Required** |
| **1** | **Record-keeping complies with good practice GDC & Faculty of General Dental Practice Guidance** |
|  | All records are legible, unambiguous, signed, dated and timed. They are accurate, complete and contemporaneous. |[ ] [ ]        |
|  | Where records are not written contemporaneously, this is clearly documented. |[ ] [ ]   |
|  | IT log-ins are secure to ensure confidentiality is maintained and audit trails are accurate. |[ ] [ ]   |
|  | Information is recorded consistently and appropriately to facilitate risk alerts – continual past medical history update. |[ ] [ ]   |
|  | If records are amended, the reason for this is clear and transparent and the audit trail maintains a record of changes or deletions. Where handwritten records are used make the date of the amendment clear and do not use Tippex! |[ ] [ ]   |

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|  | **Action Points** | **Yes** | **No** | **Action Required** |
| **2** | **Records are created for every patient consultation** |
|  | A record is available for every consultation. |[ ] [ ]        |
|  | Advice to patients given by telephone is recorded within the patient record. |[ ] [ ]   |

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|  | **Action Points** | **Yes** | **No** | **Action Required** |
| **3** | **Records are sufficient to provide insight into diagnosis, rationale and follow up** |
|  | The record includes details of information provided by the patient. |[ ] [ ]        |
|  | The record includes details of any observations and clinical findings, whether significant or not – both positive and negative findings. |[ ] [ ]   |
|  | The record includes details of any decisions made and any instructions or advice given to the patient. |[ ] [ ]   |

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|  | **Action Points** | **Yes** | **No** | **Action Required** |
| **4** | **Records are sufficient to provide evidence of patient consent in relation to treatment planning** |
|  | Any discussions in relation to a proposed treatment are fully documented in the patient record. *(see Consent checklist for further details)* |[ ] [ ]        |
|  | Concerns or wishes the patient has in relation to proposed treatment are fully documented. |[ ] [ ]   |

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|  | **Action Points** | **Yes** | **No** | **Action Required** |
| **5** | **Patient results and letters are viewed and processed timeously** |
|  | Clinicians are notified when results or correspondence are available.  |[ ] [ ]        |
|  | There is a system in place to ensure any required actions are implemented and documented as appropriate. |[ ] [ ]   |
|  | There is a system to ensure actions associated with results, hospital letters and referrals are tracked and actions taken. |[ ] [ ]   |

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|  | **Action Points** | **Yes** | **No** | **Action Required** |
| **6** | **Referral to other healthcare professionals is documented** |
|  | The reason for the referral is clear. |[ ] [ ]        |
|  | Appropriate information is included in the referral including urgency level. |[ ] [ ]   |
|  | A copy of the referral is documented within the patient record. |[ ] [ ]   |
|  | Safety netting is included where appropriate. |[ ] [ ]   |

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|  | **Action Points** | **Yes** | **No** | **Action Required** |
| **7** | **There is an incident reporting system in place to record problems encountered in relation to record-keeping** |
|  | Misfiles are identified and rectified as appropriate. |[ ] [ ]        |
|  | Workflow problems in actioning results and letters are discussed and resolved. |[ ] [ ]   |

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|  | **Action Points** | **Yes** | **No** | **Action Required** |
| **8** | **Please ensure that for the following additional entries include:** |
|  | Radiography: *justification, grading, reporting & recording*. |[ ] [ ]        |
|  | Local anaesthetic: *type, dose, site, & expiry date*. |[ ] [ ]   |
|  | Drugs: *justification, type, dose, frequency and duration*. |[ ] [ ]   |

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|  | **Action Points** | **Action Required** |
| **9** | **Ten Essentials for Record Keeping** |
| 1. Patient details
 | 1. Diagnosis
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| 1. Past Medical History
 | 1. Treatment Plan
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| 1. Past Dental History/Social History
 | 1. Consent
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| 1. Clinical Examination
 | 1. Progress notes including local anaesthetic
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| 1. Special Investigations
 | 1. Exit Notes
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