DOCUMENTATION

What is Documentation?

- Patient **documentation** is the physical record of the patient information related to the diagnosis and care of the patient.

- It is called as **Patient records** or **Patient charting**

Importance

- Reveals the several function of the record.
- compensates for the limitations of the clinician's memory.
- It is vital in institutions and group practices where several clinicians may eventually treat the patient.
- Reduces time consumption.
- Legal condition.

Features of the ideal patient documentation system

- Quick and easy data entry.
- Quick and easy data retrieval
- Comprehensive and efficient
- Brief and Clear
- Using the data convenient
- Easily expandable
- Versatile
- Economical
- Educational

Different forms of patient documentation

A blank sheet of paper

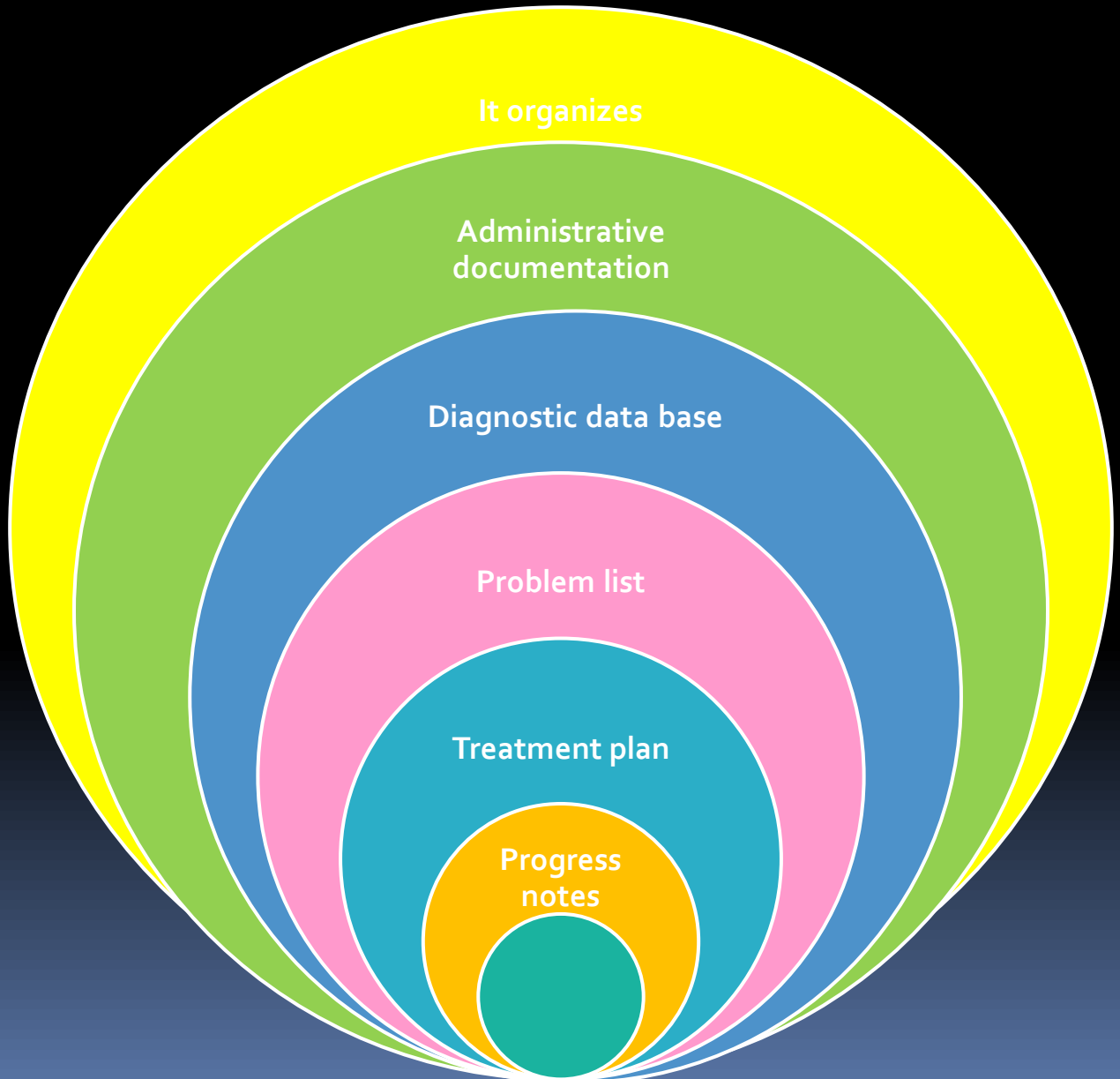
Fill in the blank forms

Computers(EMR…)

Problem oriented patient record

- A general approach to the recording of health information known as problem oriented patient record.
- It focuses not on treatments and results, but perceived upon the health problems of the patient.

Organization of the problem oriented dental record



Administrative documentation

This section records information needed to interact with the patient on non clinical matters.

It includes

- Patient's name, address, telephone no, insurance carrier, place of work, physicians name etc……
- Information needed for billing or insurance claims

Diagnostic data base

It documents the patient status at the initial diagnostic evaluation.

This consist of

- Patients chief complain, past medical history, review of systems, physical examination findings, and result of adjunctive diagnostic procedures
- It is the base for the clinicians diagnostic and treatment planning decisions.

- Patient history :
- Combination of health questionnaire completed by the patient and additional discussion of the responses.
- Some dentist prefers patient history by interview.
- A patient history form should contain
  - A specific space to summarize the patient's medical status.
  - A mechanism to record changes in the patient medical status.

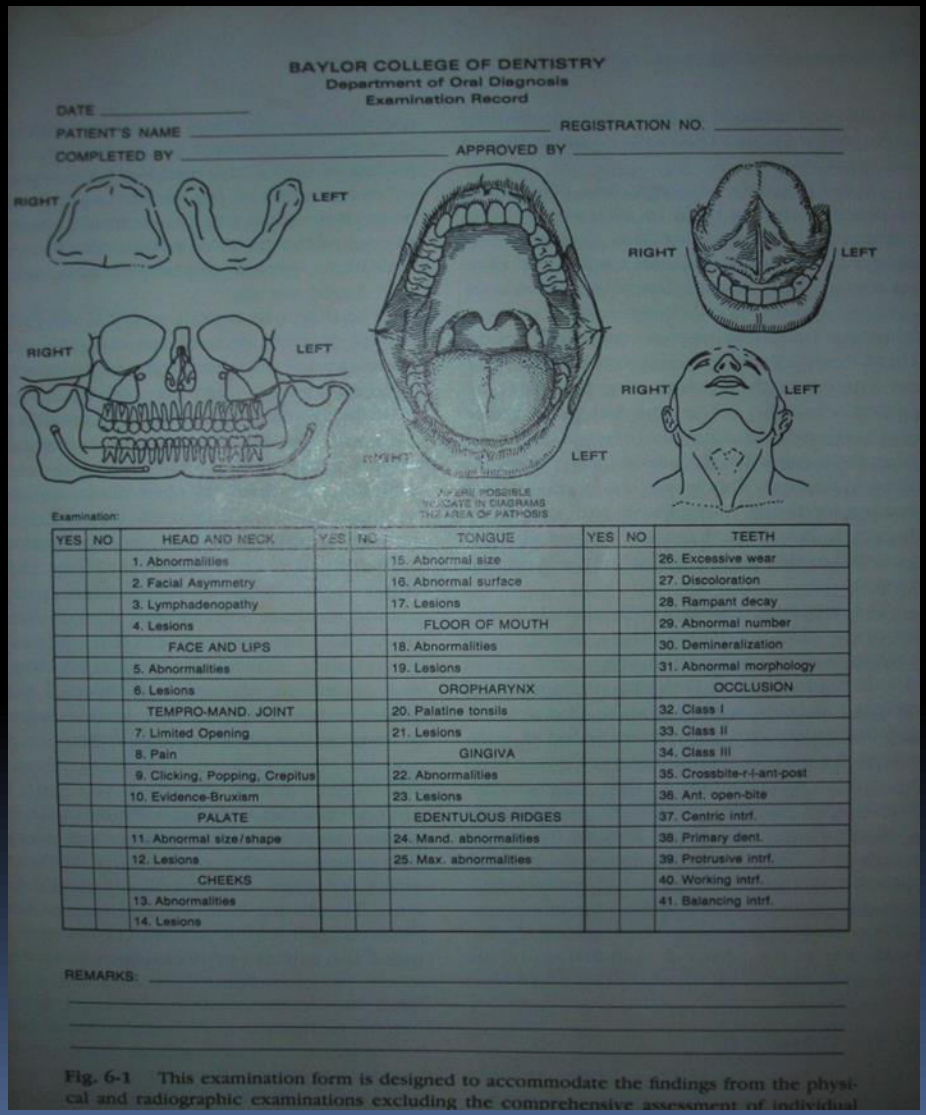
Medical alert

convey the medical warning without risk of misinterpretation.

The medical alert should be located where it will be noticed every time the clinician refers to the record

Sensitive medical information should not be recorded on the cover of the record where it poses a potential breach of confidentiality.

The extra oral evaluation and documentation provides the comparison of original features which changes following the treatment / reevaluation period



BAYLOR COLLEGE OF DENTISTRY
Department of Oral Diagnosis
Examination Record

DATE _____
PATIENT'S NAME _____ REGISTRATION NO. _____
COMPLETED BY _____ APPROVED BY _____

RIGHT LEFT RIGHT LEFT RIGHT LEFT RIGHT LEFT RIGHT LEFT

IF POSSIBLE INDICATE IN DIAGRAMS THE AREA OF PATHOSIS

Examination:

YES	NO	HEAD AND NECK	YES	NO	TONGUE	YES	NO	TEETH
		1. Abnormalities			15. Abnormal size			26. Excessive wear
		2. Facial Asymmetry			16. Abnormal surface			27. Discoloration
		3. Lymphadenopathy			17. Lesions			28. Rampant decay
		4. Lesions			FLOOR OF MOUTH			29. Abnormal number
		FACE AND LIPS			18. Abnormalities			30. Demineralization
		5. Abnormalities			19. Lesions			31. Abnormal morphology
		6. Lesions			OROPHARYNX			OCCLUSION
		TEMPRO-MAND. JOINT			20. Palatine tonsils			32. Class I
		7. Limited Opening			21. Lesions			33. Class II
		8. Pain			GINGIVA			34. Class III
		9. Clicking, Popping, Crepitus			22. Abnormalities			35. Crossbite-r-l-ant-post
		10. Evidence-Bruxism			23. Lesions			36. Ant. open-bite
		PALATE			EDENTULOUS RIDGES			37. Centric intrf.
		11. Abnormal size/shape			24. Mand. abnormalities			38. Primary dent.
		12. Lesions			25. Max. abnormalities			39. Protrusive intrf.
		CHEEKS						40. Working intrf.
		13. Abnormalities						41. Balancing intrf.
		14. Lesions						

REMARKS: _____

Fig. 6-1 This examination form is designed to accommodate the findings from the physical and radiographic examinations excluding the comprehensive assessment of individual

- Listing the anatomic sites and common lesions with the corresponding column of "Normal" or "Abnormal" check-off boxes.
- Diagrammatic depiction of lesions with additional narrative comments are more accurate than a written description alone.
- Photographs provide another effective method of soft tissue lesions for future comparison

- This is ideal for patients with few abnormalities but recording numerous findings for other patients can be tedious.

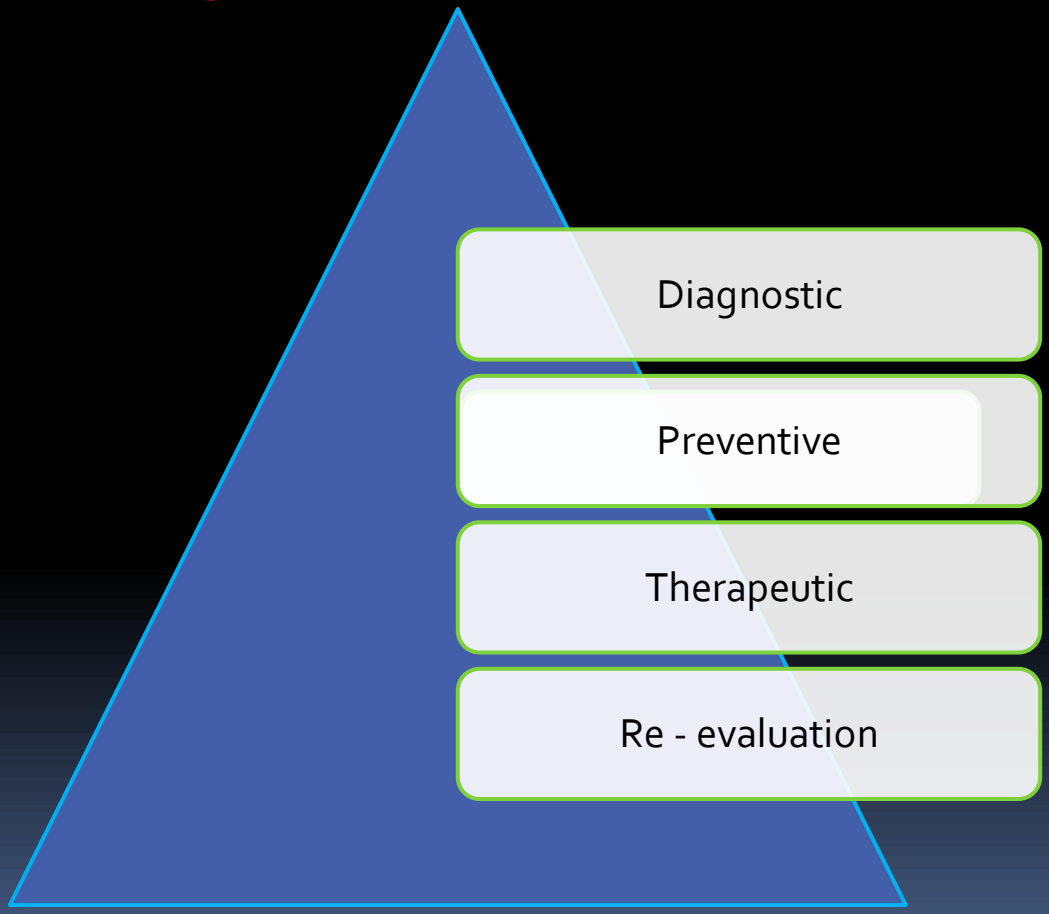
- A common error occurs in documenting non-dental lesions is to record a diagnosis than physical findings which leaves nothing for future comparison and introduces "diagnostic bias".

Problem list

- It is a summary listing of the patients complains, lesions and conditions that warrant additional diagnostic evaluation or treatment.
- It is organized by the priority of the problems in the judgment of the clinicians.
- This is usually in the sequence of chief complains, current medical conditions, general dental problems and specific dental lesions.

Treatment plan

Accurate listing of the patient problems provides a direct format for the generation of the treatment plan.



Purpose of documentation in treatment plan

- Presenting the treatment proposal to the patient.
- Tracking the course of treatment.
- Guiding auxiliary personnel in the completion of insurance claims.

Progress notes

- The progress notes are the chronological description of the event that is related to the patient dental care.

essential functions

- Aids the clinician's memory
- Vital information
- Correction of errors
- Change in medical status of the patient should not be "buried" in progress notes

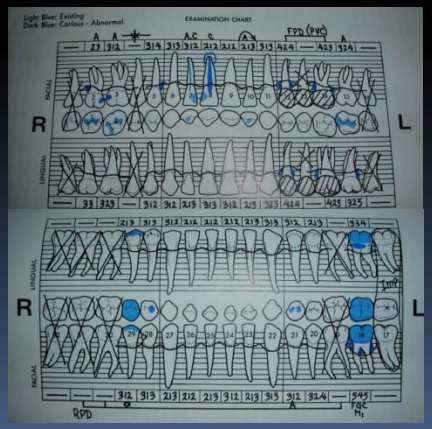
SOAP analysis

Subjective	• History of the problem; what the patient feels or thinks about the problem
Objective	• Doctors findings related with the problem
Assessment	• Evaluation of the problem; the diff. diagnosis
Plan	• Prescription, consultation, advice, control visit…

Charting dental findings

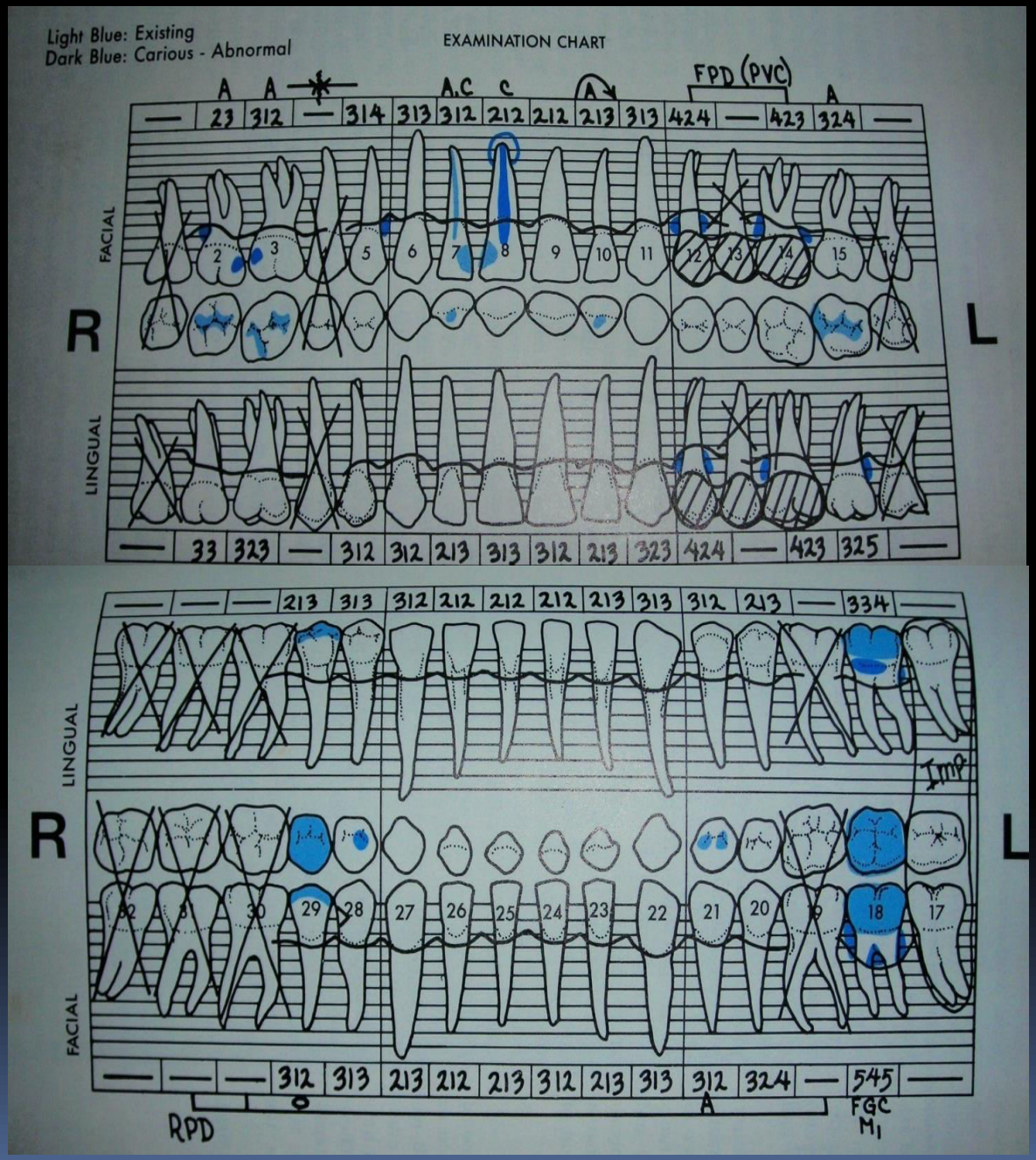
- Diagrammatic representation of dental findings is called dental charting.

- It is quick, efficient and accurate method of recording large volume of detailed information about patient's dental status.



Dental charting relies on diagrams & symbols to represent

- Mobility
- Restoration
- Dental caries
- impacted teeth
- Missing
- Periodontal probing depths



Practical aspects of documentation

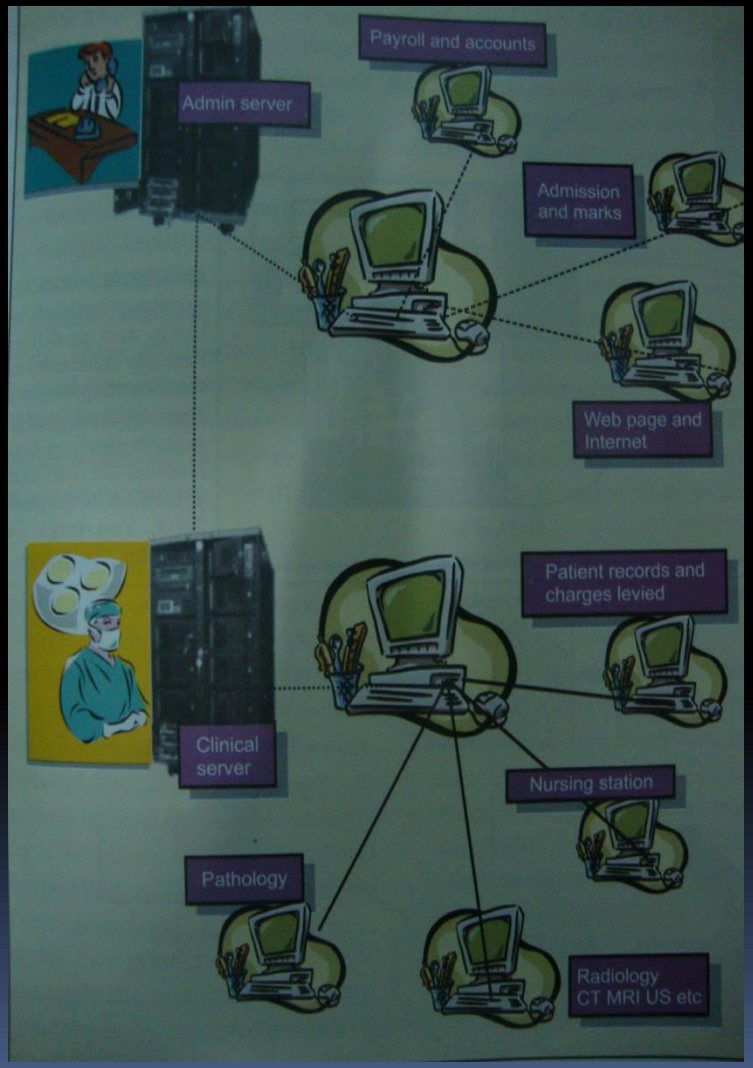
- All entries must be signed and dated.
- Clearly stated and in adequate detail to provide significant information.
- Mistaken entries should be written in single line drawn through them and corrections entered above / after the line.

- All elements of the patient record including
- Original forms
  - Radiographs
  - Supplemental forms
  - Consultation letters

  Should be identified with the patient's name, date, patient's identification number.
- Records should be protected from loss and damage.

Recent advancement

LOCAL AREA NETWORK



EMR

- EMR: electronic medical record
  - An electronic medical record for a patient at a particular site, providing such functionalities as e-prescribing, order/results management, work-flow tasking, communication and messaging

What is Pushing You toward EMRs?

- Quality improvement
- Time consumption
- Rising healthcare costs
- Competitiveness
- Consumer-driven care
  - Internet resources
  - Personal health records

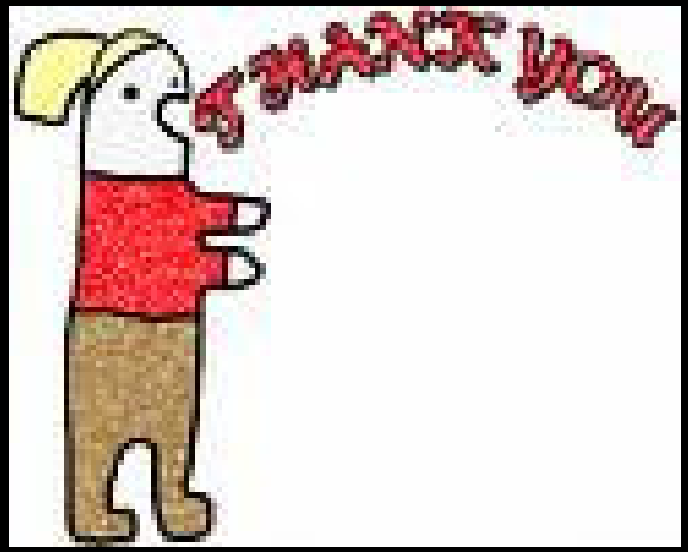

PrognoCIS: A Product by BIZMATICS Inc. - Microsoft Internet Explorer
Valley Medical Center
Welcome Dr. Kemp Stephens
Back | Forward
Home
Appointments
Patient
CPOE
Mail
Report
Settings
Help | About | Logout
Register | Encounter | Review | Letters-Out | Transcribe | Letters-In
*Indicates Mandatory Field
Active
Patient Details
Title
Ms
* First Name
Maureen
Middle Name
* Last Name
Atkinson
* Date Of Birth
02-08-1977
Sex
Female
Marital Status
Married
* SSN
432-68-9854
Primary Doc
Stephens Kemp
Status
Active
Chart Number
SCL00001
Ref. Doctor
Johnston Samuel
Legal...
Insurance...
Address...
Employer Details
Name
Tr-Valley Cedit Union
Address
Same as Patient
Address...
Emergency Contact Details
Name
Frank Atkinson
Same as Patient
Address...
Relation
Spouse
Spouse / Parent / Legal Guardian Details
Name
Same as Patient
Address...
Relation
SSN
Date Of Birth
Employer
Photo
save
delete
reset
Done
Internet

Conclusion

Evolution not only toward electronic medical record but also to computer-guided and -supported healthcare

References

- Principles of Oral Diagnosis – Coleman & Nelson.
- Oral medicine Diagnosis & Treatment – Burket 10th edition.
- www.medicalnewstoday.com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