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A Patient Safety and Risk Management Newsletter from Fortress Insurance

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Consent and Documentation

In this issue, we explore how the informed consent process and clinical documentation enhance patient safety and support dentists in the midst of a claim.

Informed Consent: What Every Dental Practice Should Know

Julie Goldberg, DDS - Dental Education Coordinator



Informed consent in healthcare is a process of communication between a clinician and a patient that results in the patient's authorization or agreement to undergo a specific procedure. It is more than just a discussion. The informed consent form is helpful for documenting this process, including any questions or concerns the doctor and/or patient may introduce. There are several reasons why some may consider this a challenging process. The following will highlight some of the most frequently asked questions related to informed consent that we receive at Fortress:

Do I need to be so candid when describing possible risks of a procedure? What if it creates additional fear and anxiety in the patient?

While discussion of the risks involved in a procedure are necessary, the manner in which you disclose risks is also important. If you gloss over risks, the patient may claim that risks were not fully disclosed or that they did not have the time to understand the risks. While acknowledging that risks are present, take the time to explain to your patients the steps your office takes to help mitigate these risks. The doctor should also discuss of the potential consequences of no treatment, refusing treatment, and how that refusal could compromise the patient's health.

Do I need to get informed consent for EVERY procedure on EVERY patient?

The informed consent process helps the patient understand their diagnosis, all treatment options (including no treatment) and any benefits/risks associated with their treatment options. Without a proper consent for every procedure, the patient may make a claim of negligence due to unknown risk or even battery. Fortress maintains a library of over twenty-five procedure-specific informed consent forms for the dental and dental specialty office. These documents are in Word format and can be edited to include your office logo and information, as well as patient specific details.

I had the informed consent discussion and the patient signed the informed consent form. Is this all I need to do?

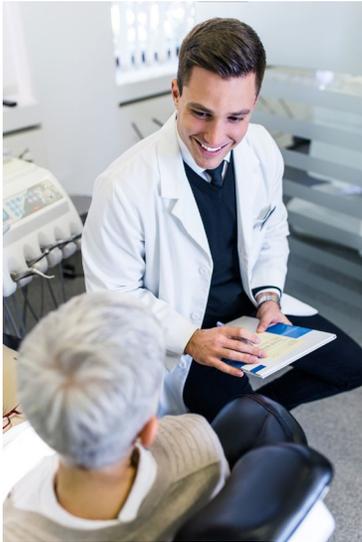
Documentation of the informed consent discussion in the patient's chart and inclusion of the patient-specific informed consent form are equally important. There have been instances in certain states in which an informed consent document or form was deemed inadmissible in court, but the informed consent discussion documented in the patient chart demonstrated the informed consent discussion took place. Similarly, charting the informed consent discussion provides an opportunity for the provider to memorialize any noteworthy aspects of the discussion.

How do I obtain informed consent from a patient with Limited English Proficiency?

Patients with Limited English Proficiency may present certain challenges with the informed consent process. In these situations, by law, your office is required to provide a translator at no cost to the patient. It is not recommended that family members act as translators for several reasons: 1) personal health information may be disclosed; 2) family members may not understand the dental terminology being translated; and 3) you cannot verify what is being translated on your behalf. If a patient with Limited English Proficiency presents on an emergency basis and you do not have immediate access to translator services, you may want to consider alternative options, such as translator phone services. Whether an appointment with a patient with Limited

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English Proficiency is emergent or not, it is best practice to document all translation efforts. The American Dental Association recently endorsed CyraCom, a company that offers phone and video interpretation services, or alternatively you may find a qualified translator through your local dental society or local hospital.

What are some considerations for documenting informed consent with minors?

The best case scenario is when the minor presents with their parent(s) or legal guardian(s); however, this is not always the case. If the situation is not emergent, it is best practice to reschedule the appointment for a time that a parent or legal guardian can be present to give informed consent for the minor patient. If the situation is emergent, efforts to obtain both verbal and written consent from the parent or legal guardian should be documented in the patient's chart (see your state's requirements for specific forms and information required). This might include phone calls, emailed documents and/or written statements. Since it is considered best practice to obtain signatures and provide informed consent discussions in your office, sending informed consent forms home to parents would not be ideal. For minors of divorced parents, try to obtain documentation of custody and financial agreements prior to any treatment whenever possible. For additional information on the informed consent process as it relates to minors, see the "Informational Guide for Treatment of Minors" on our website www.dds4dds.com, Clinical and Office Documents, under Informational Guides.

Can my dental assistant obtain the informed consent from the patient?

No, the doctor performing the procedure should manage the actual informed consent discussion, and document this discussion in the chart. This affords the patient the opportunity to ask questions and have them answered by the doctor. Your assistant can prepare the forms, start educational videos, and ask the patient for signatures.

Does the informed consent expire? If so, when should I consider re-consenting?

While there is no exact timeframe, a recap of the procedure and any possible risks associated with the procedure should be reviewed again for completeness and to ensure that the patient recalls the informed consent discussion. Document these follow up discussions as further evidence that the patient was informed. For some offices, this documentation looks like an additional signature and new date on the original informed consent form; for others a whole new form may be used. Whatever an individual office decides, be sure that policy is in your Office Manual and that all doctors and staff understand and follow the policy.

Obtaining a thorough informed consent can be complex and challenging. It requires the doctor to be flexible in meeting goals for protecting patients' rights, and addressing the administrative needs of the practice. The above suggestions should help facilitate patient involvement in healthcare decisions while also complying with applicable state laws.

Clinical Documentation For Dental Medicine

Michael R. Ragan, DMD, JD, LLM - *Risk Management Consultant*



The importance of clinical documentation in dentistry was not a major focus in many dental curriculums in the past. Clinical documentation is really the story of the care you provided or will provide. After nearly forty years in dental academia and twenty-seven years involved in the defense of dental professional liability claims and licensure actions, one fact remains as true as ever: if it is not documented, [the other side will argue] it didn't happen.

The trier of fact for the defendant dentist will be a "jury of your peers", yet it is unlikely that any member of a professional negligence jury will have a dental background or a demonstrable dental IQ. Therefore, if a dental practitioner's clinical documentation is poor, missing pertinent information, incoherent, or illegible, the documentation could cause jury members to extrapolate that, "if the documentation appears poor then the clinical dentistry might also be substandard". In a court of law, your clinical documentation will likely be copied by the plaintiff's attorney and projected on a screen for the elucidation of the jurors. This theatric has the effect of emphasizing any deficiencies that may be present in your clinical documentation. Careful and complete documentation not only supports quality patient care and improves communication; it can also assist Fortress' defense attorneys in defending you in the event of litigation.

A Complete Record

A dental practitioner's clinical documentation should contain sufficient information to identify the patient, support the diagnosis, justify the treatment options (including no treatment), and document the course and results of treatment. Documentation entered into a patient's chart contemporaneously with the treatment provided will allow for better recollection of what occurred during the treatment. More specifically, clinical documentation should include the following elements:

- accurate medical history;
- diagnosis, including differential diagnosis;
- examinations, tests and results;
- diagnostic images and the results/review of images;
- detailed treatment plan;
- documentation of the informed consent discussion, and any consent forms signed by the patient/guardian;
- medications prescribed, dispensed, or administered;
- any plan for follow up treatment;
- reports of consultations or referrals;
- copies of records obtained from other healthcare practitioners that were taken into consideration when developing the patients' treatment plan.

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Amending Records

It is never appropriate to alter a record. Record alteration can be considered a deliberate misrepresentation of the record. A correction to the record may be necessary at times, but it is important to correct the record appropriately to avoid allegations of record alteration.

Whether using paper or electronic records, the correction should be a separate entry that is clearly noted as a correction, with the date, time and initials of the person making the correction. On paper records, use of a single line to strike through the original entry is best practice to ensure it is still legible. Use of White Out® or other means to permanently redact the original entry should be avoided.

When using EMR, unique logins automatically track the author of any notes and settings are available to “lock” entries to prevent future edits. Do not delete any entry in the chart. “Meta-data” analysis can be done to identify any deleted or altered records. Corrections should be entered as a new entry and make reference to the prior entry.

Back Up Electronic Records

Many dentists are now using electronic dental records. It is important that you follow all state rules and regulations regarding the use of electronic record keeping. It is recommended that you



always have a back-up copy of information stored in the data processing system. This may be stored via disk, tape, or other electronic back-up system. Be aware of any specific state requirements that may mandate specific time frames, such as backing up not to exceed seven days. This will assure that data is not lost due to system failure. It is also recommended, and some states may require it, that any electronic data system be capable of producing a hard copy on demand.

Dentist of Record and the Owner of the Practice

The dentist of record is the dentist who provides the treatment. If there has been more than one dentist providing treatment, it is important that each dentist documents in the patient record. All dental records should also be maintained according to your specific state

law. The owner dentist may be responsible for the records of all patients seen or treated by any employee, associate, or visiting dentist in the practice.

Conclusion

Accurate and comprehensive clinical dental documentation has the potential to serve a variety of important purposes. Said records allow for effective communication between health care providers, enable quality of care assessments, and can provide a database for dental research.

Clinical Documentation For Dental Medicine

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Comprehensive clinical documentation is essential to support the defense of potential malpractice claims, aid in the forensic identification of victims and, most importantly, optimize the safety and effectiveness of patient care.¹⁻⁴ In sum, the interrelationship between clinical practice and comprehensive clinical documentation is undeniable. Therefore, do not squander your excellent clinical treatment with poor documentation.

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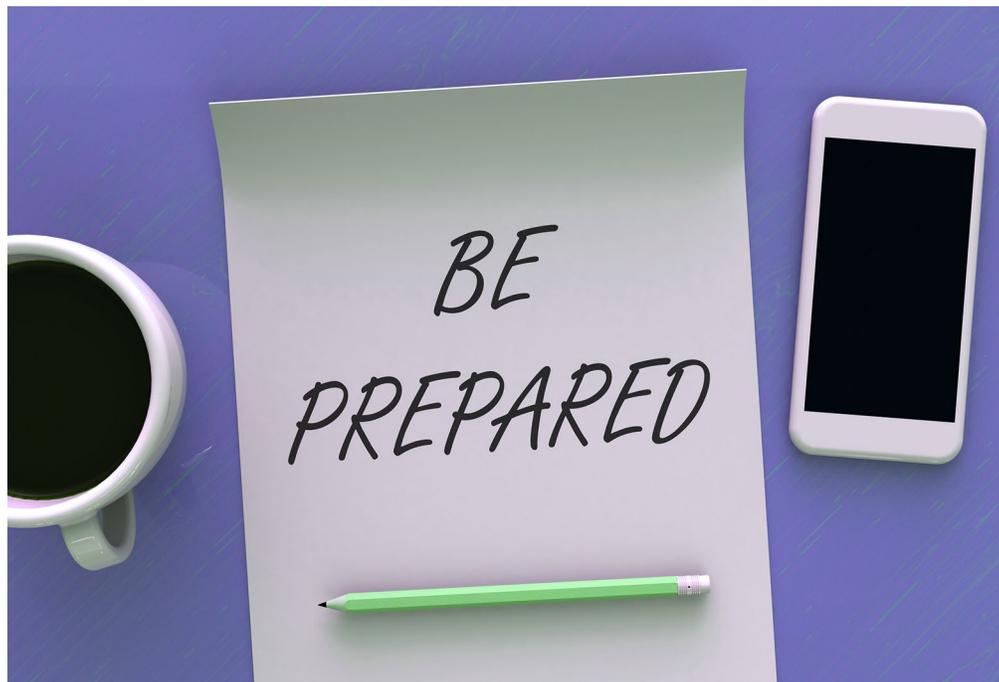
New Year Changes To Your Policy

The New Year offers the perfect opportunity to plan for any anticipated changes to your practice that may impact your malpractice coverage or premium. Your Fortress agent stands ready to help and review any such changes including:

- Change in practice location - adding or joining a new location or reducing the number of existing locations;
- New practice activities;
- Hiring a new associate or notice that an associate is leaving the practice;
- Change in types of procedures performed;
- Contemplating a temporary break from active practice for various reasons including: birth of a child, a medical issue, furthering your education, or a sabbatical for other reasons;
- Planning to retire and want to discuss options.

If you are thinking about any of the above, or some other change to your practice, contact your Fortress agent who will be happy to review your coverage and provide you with the information you will need to make an informed decision regarding your medical malpractice coverage with Fortress.

If you are unsure who to contact, visit the "[Find an Agent](#)" page at www.dds4dds.com to search for the Fortress agent in your state.



The Importance of a Well Documented Dental Record With Noncompliant Patients



This claim was brought by a long time patient of the insured. The patient had poor oral hygiene and periodontal disease. He was seen on a regular basis, but was noncompliant regarding his periodontal health. He often visited the office with new dental pain that the insured treated with fillings, root canal therapy, crown work and extractions.

The at-issue treatment concerns teeth #22 and #23. The patient presented with pain, significant bone loss, and very red and swollen gums around these teeth. The teeth were deemed non-restorable and were extracted with ease. The insured then placed Bioplant grafting material at the sites to help save the adjacent tooth #24. A lower partial denture was planned. The insured continued to see the patient over the next few months. Tooth #24 eventually failed and was extracted. Four months after the extraction of teeth #22 and #23, the patient presented with bone extruding from the edentulous gingival area of teeth #'s 20-22. The patient reported that while brushing that day, a thin piece of brownish material came out.

The insured debrided, rinsed and closed the area. Antibiotics were prescribed and a same day referral to a local OMS was given. Despite the immediate referral, the patient delayed seeing the OMS. A week later, the patient was hospitalized and diagnosed with osteomyelitis. The patient underwent a mandibulectomy and neck dissection surgery including multiple debridements.

The patient subsequently filed a lawsuit claiming that the infection was caused by the insured's extractions. The plaintiff also alleged that the insured was negligent in using grafting material to save tooth #24. The defense argued that the insured's treatment plan was appropriate and the osteomyelitis was not caused by the bone graft material. The insured's well documented dental record demonstrated the plaintiff's contributory negligence. A supportive defense expert was retained and the insured presented very well as a witness in front of the jury.

Following deliberation, the jury returned a unanimous verdict in favor of the insured.



Patient Safety and Risk Management Tips

- Document your treatment plan and indications for treatment;
- Document recommendations in an objective manner made to the patient, especially when he/she is known to be non-compliant;
- Continue to make your recommendations, even to patients known to be non-compliant;
- Timely refer patients who require specialized care and assist the patient in setting up an appointment at the end of the visit.

Earn a 10% Premium Credit



Live Risk Management Seminars

The live Fortress three-hour seminar, Improving Patient Safety: An Analysis of Dental Risks and Liability, discusses several risk management scenarios including extractions, implants, failure to diagnose oral cancer and periodontal disease, and informed consent. For more information about the live seminars, visit our [online calendar](#) for an upcoming seminar in your area or email rm@fortressins.com.

Can't Attend a Live Seminar?

RMC 315 is available in the e-Learning Center on demand. Complete RMC 315 to earn 3 (three) CEs and qualify for the renewable 10% risk management credit off your base rate which is applicable for three policy periods.



Visit the e-Learning Center for Complimentary Online CE Courses

Fortress offers over 10 hours of complimentary, online continuing education credit courses in the e-Learning Center at dds4dds.com. Courses are designed for dentists and staff, and are available on demand to be completed at your convenience. Curriculum covers basic risk management as well as emerging issues in dentistry.

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