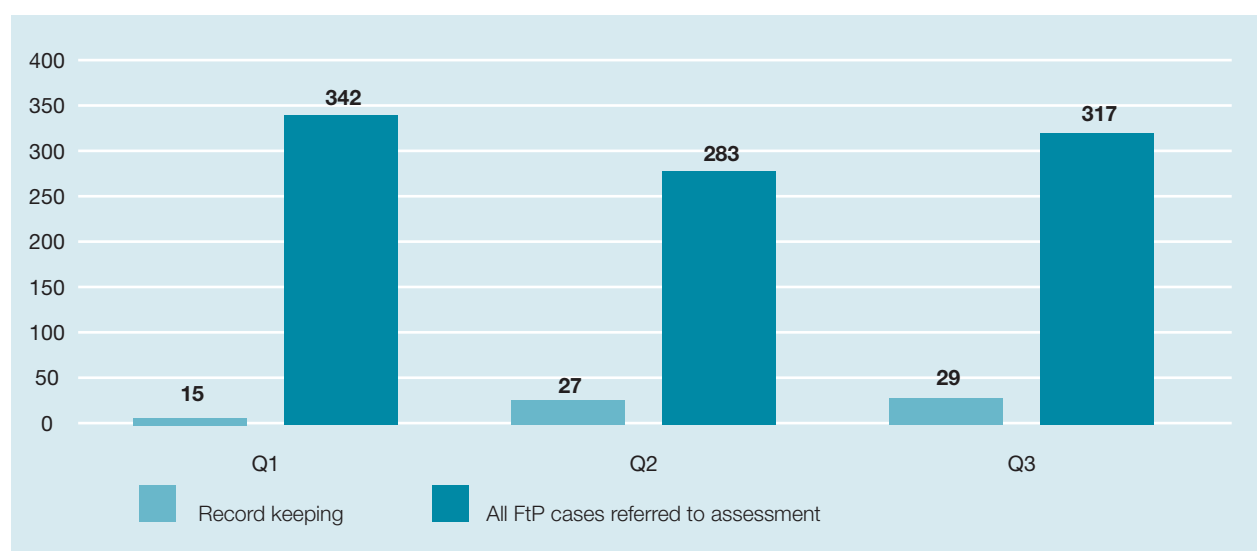


Spotlight on record keeping: Q1 to Q3 2019

1. Record keeping concerns raised in 2019

Figure 1: Number of concerns received referencing record keeping raised in 2019 Q1 to Q3 (part year)



2. About this publication

We are committed to providing a fair and transparent fitness to practise process, where concerns raised with us are dealt with in the right setting and within an acceptable timeframe. The system must protect members of the public and patients and maintain public confidence in the dental professions. Our aim is to do this while reducing costs and the number of concerns raised with us by shifting our focus from enforcement to prevention.

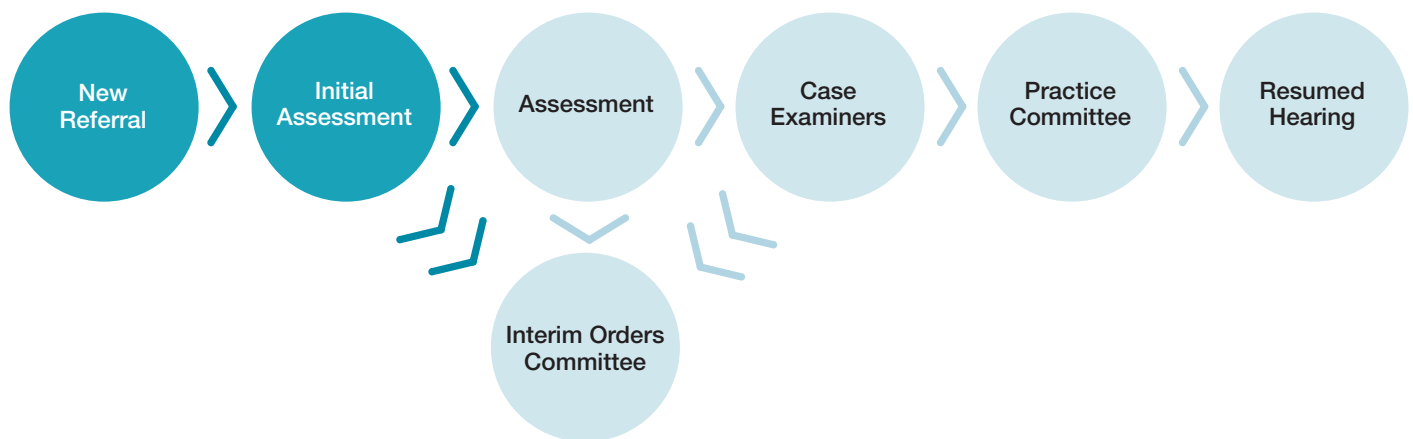
An important part of this approach is to share our insights from the fitness to practise process, to help improve the understanding of the types of concerns raised with us. Equipped with this knowledge, dental professionals can be reassured of their current approach to various aspects of practice or can identify any potential issues or areas in need of improvement.

This publication considers the concerns raised at initial assessment in relation to record keeping in 2019, up to the end of Quarter 3 (Q3) 2019 (30 September).

3. Initial assessment stage of the fitness to practise process

All concerns raised with us are considered by the initial assessment decision group. The group meets daily to review any concerns received and is made up of GDC staff members, including clinical dental advisers. Figure 2 illustrates how the initial assessment stage fits into the fitness to practise process, further details are also available on [our website](#).

Figure 2: Initial assessment stage



4. Record keeping

Over the period there were 71 cases that included concerns relating to record keeping. This means that over the first three quarters of 2019 around 7.5% of all cases referred to assessment stage included a concern about record keeping.

Our expectations of dental professionals are outlined in the [Standards for the Dental Team](#).

To comply with the Standards, you must make and keep contemporaneous, complete and accurate patient records. You must record as much detail as possible about the discussions you have with your patients, including evidence that valid consent has been obtained. You should also include details of any particular patient's treatment needs where appropriate.

How you meet this Standard, and the level of detail you provide is a matter for your professional judgement. The GDC does not define good record-keeping, but directs dental professionals to the relevant laws and guidelines on record keeping, for example:

- [Dental Record Keeping Standards](#): a consensus approach (NHS England and NHS Improvement).
- [Clinical Examination and Record Keeping](#) (FGDP UK).
- [Health and social care advice from the Information Commissioner's Office](#).

5. Why is record keeping important?

Contemporaneous, complete and accurate patient records help ensure a continuous standard of patient care by assisting colleagues or other dental professionals who become responsible for a patient's treatment.

Under the GDC's Standards, good record keeping is an obligation in itself, but it is also to your benefit, in the event of any fitness to practise concern. When a patient and a dental professional have conflicting recollections of the same event, records are often the only evidence that can be produced. Therefore, you should:

- record as much detail as possible about the discussions you have with patients, including evidence that valid consent has been obtained
- follow appropriate national advice on retaining, storing and disposing of patient records, and
- ensure that all records can be understood by others.

6. What types of cases were opened with issues related to record keeping?

The following are examples cases that included record keeping concerns:

- A concern was raised about a dentist following the lease of their practice to another dentist. The leased premises were abandoned, with the fire door left open and the records room left unlocked. On a further visit to the leased premises records were found strewn around the room.
- Concerns were raised by the NHS regarding a dentist. Following a review of the dentist's clinical records, a number of issues were identified which included:
 - poor record keeping
 - inappropriate prescription of antibiotics
 - failure to take radiographs in accordance with FGDP UK Guidelines (Selection Criteria for Dental Radiograph)
 - failing to write clinical notes on some occasions
 - failure to refer patients requiring an OPG or to secondary care
 - failure to recognise, diagnose and treat periodontal disease
 - no BPE undertaken in the examination process
 - failure to recognise, diagnose and treat caries
 - failure to apply NHS Regulations concerning claiming for treatment.

How can a dental professional improve the quality of record-keeping?

We recommend that dental professionals consider:

- Training dental nurses to assist with notes.
- Providing information upfront to patients and providing them with a few days to agree to treatment and give consent.
- Ensuring the training of the dental team is up to date on data protection, record keeping and processes for transferring patient records.
- Recording information straight away and not overwriting records to correct mistakes.
- Undertaking an audit of patient records.