WASHINGTON HEALTHCARE INSURANCE COMPANY

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Mitigate Risk – Building Trust Through Informed Consent and Other Everyday Practices

May 14, 2021

HONESTY • INTEGRITY • RESPECT • TRUST

Outline

- What is the “standard of care”?
- Communication is key
- Obtaining informed consent do’s and don’ts
- WA recordkeeping rules and best risk management practices

Standard of Care (SOC)

- **How is it defined?**
  - **Practice guidelines, position statements, etc. (e.g. ADA)**
    - **Although not meant to be standards, may be used in court to define SOC**
  - **Evidence Based Dentistry**
    - **Evidence may be used to define SOC**
- **How is SOC addressed in Washington?**
  - **Not defined in dental practice act**
  - **One reference by DQAC is an interpretive statement "Dentist Standard of Care – Radiographs"**
    - **https://www.doh.wa.gov/Portals/1/Documents/2300/2017/DQAC-XrayFiled20170830.pdf**
  - **Failure to follow the laws related to dentistry is a violation of the Standard of Care**

Standard of Care

- **What a reasonably prudent dentist would have done under similar circumstances**
- **A general dentist is held to the specialist's standard of care when:**
  - **A procedure is attempted and the available or known evidence suggests that it should only have been performed by a specialist**
  - **Insists on completing a procedure where:**
    - **Complications arise which are best handled by a specialist**
    - **Continuing the procedure (when circumstance allows the treatment to be stopped without serious complications to the patient) and not referring patient to the specialist to complete.**

Communication

- **Goal is to build trust and allay fear/anxiety**
- **Provide information prior to appointment**
  - **Via webpage, brochure or phone**
  - **Educational, procedural, policies of office**
  - **Sets expectations for patient during visit**
- **Patient satisfaction is based upon communicative behavior of dentist and staff**

Communication

- **First impression developed at first appointment**
- **Based on mutual trust and respect**
- **Built through verbal and nonverbal communication**
- **Communication is credible and empathetic**

Communication

- **Your patients believe and expect:**
  - **You will provide them with only necessary treatment**
  - **Ancillary businesses you use provide excellent products and services**
  - **You refer to only highly qualified specialists when needed**
  - **The standard you expect for your own care, is the same as what you provide your patients**

Importance of Good Communication

- **Patient's satisfaction is based on quality and effectiveness of communication**
- **Patient's assessment of clinical treatment largely based on communication**
- **Good communication promotes healthy doctor-patient relationship**
- **You obtain the necessary information to satisfy informed consent and treat**
- **Patients tend to be more compliant**

Low Patient Satisfaction

- **Correlated to:**
  - **Rushing through appointments**
  - **Lack of explanation about procedures/treatment**
  - **Barring parents from exam room**
  - **Demonstrating impatience**

- **Significantly increases probability of malpractice actions!!!!!!!!!!!!**

Informed Consent

- **Historically 30-35% of claims involve informed consent allegations**
- **P-A-R-B-Q (Procedure, Alternatives, Risks, Benefits, Questions)**
- **Use procedure-specific forms**
- **Document consent process and any educational materials provided to patient**
- **Have staff present, if possible**

Parental Consent

- **If a parent represents that they are authorized to consent, then the healthcare professional can accept consent without incurring liability.**
  - **True regardless whether the parents are married, divorced, separated, or the consenting parent is not the custodial parent**

RCW 70.02.130

Informed Consent for Minors

- **Persons authorized to provide consent:**
  - **Parents**
  - **Guardian/legal custodian appointed by court**
  - **Person given written permission by parents**
  - **Competent adult that is a relative (by declaration)**

Capacity vs Competence

- **Competency is a legal determination with court documentation**
- **Capacity is the ability to understand**
  - **If one lacks the capacity to understand you will not be able to satisfy informed consent**
  - **Dentist's obligation to make that determination**
  - **Consider surrogates?**
    - **Spouse**
    - **Siblings**

Surrogate Decision Maker - Hierarchy in Washington

Identifying the surrogate - ***If not specifically identified, WA statute makes this easier than some states for sequential hierarchy of surrogates:***

- **Court Appointed Guardian**
- **Durable Power of Attorney (DPOA)**
- **Surrogate Order in WA State:**
  - **Partner or spouse**
  - **Adult child(ren)**
    - **Requires consensus amongst children**
  - **Parents (does not define 'parent')**
    - **Requires consensus**
  - **Adult sibling(s)**
    - **Requires consensus amongst siblings**

- **https://app.leg.wa.gov/rcw/default.aspx?cite=7.70.065**

Informed Refusal

- **Inform patient of the risks and consequences of refusing dental care**
- **Document warnings in chart**
- **Request that the patient sign an informed refusal form**

Record Keeping - The Law

- **WAC 246-817-305, Patient record content.**
- **(1) A licensed dentist who treats patients shall maintain legible, complete, and accurate patient records.**
- **(2) The patient record must contain the clinical records and the financial records**

Record Keeping - The Law

- **(3) The clinical record must include at least the following information:**
  - **(a) For each clinical record entry note, the signature, initials, or electronic verification of the individual making the entry note;**
  - **(b) For each clinical record entry note, identify who provided treatment if treatment was provided;**
  - **(c) The date of each patient record entry, document, radiograph or model;**
  - **(d) The physical examination findings documented by subjective complaints, objective findings, an assessment or diagnosis of the patient's condition, and plan;**
  - **(e) A treatment plan based on the assessment or diagnosis of the patient's condition;**
  - **(f) Up-to-date dental and medical history that may affect dental treatment;**

Record Keeping - The Law

- **(3) The clinical record must include at least the following information:**
  - **(g) Any diagnostic aid used including, but not limited to, images, radiographs, and test results. Retention of molds or study models is at the discretion of the practitioner, except for molds or study models for orthodontia or full mouth reconstruction which shall be retained as listed in WAC 246-817-310**
  - **(h) A complete description of all treatment/procedures administered at each visit;**
  - **(i) An accurate record of any medication(s) administered, prescribed or dispensed including:**
    - **(i) The date prescribed or the date dispensed;**
    - **(ii) The name of the patient prescribed or dispensed to;**
    - **(iii) The name of the medication; and**
    - **(iv) The dosage and amount of the medication prescribed or dispensed, including refills.**
  - **(j) Referrals and any communication to and from any health care provider;**

Record Keeping - The Law

- **(3) The clinical record must include at least the following information:**
  - **(k) Notation of communication to or from the patient or patient's parent or guardian, including:**
    - **(i) Notation of the informed consent discussion. This is a discussion of potential risk(s) and benefit(s) of proposed treatment, recommended tests, and alternatives to treatment, including no treatment or tests;**
    - **(ii) Notation of posttreatment instructions or reference to an instruction pamphlet given to the patient;**
    - **(iii) Notation regarding patient complaints or concerns associated with treatment, this includes complaints or concerns obtained in person, by phone call, email, mail, or text; and**
    - **(iv) Termination of doctor-patient relationship; and**
  - **(l) A copy of each laboratory referral retained for three years as required in RCW 18.32.655.**

Record Keeping - The Law

- **(4) Clinical record entries must not be erased or deleted from the record.**
  - **(a) Mistaken handwritten entries must be corrected with a single line drawn through the incorrect information. New or corrected information must be initialed and dated.**
  - **(b) If the record is an electronic record then a record audit trail must be maintained with the record that includes a time and date history of deletions, edits and/or corrections to electronically signed records.**

Record Keeping - The Law

- **WAC 246-817-310 Patient record retention and accessibility requirements.**
  - **(1) A licensed dentist shall keep readily accessible patient records for at least six years from the date of the last treatment.**
  - **(2) A licensed dentist shall respond to a written request from a patient to examine or copy a patient's record within fifteen working days after receipt. A licensed dentist shall comply with chapter 70.02 RCW for all patient record requests.**
  - **(3) A licensed dentist shall comply with chapter 70.02 RCW and the Health Insurance Portability and Accountability Act, 45 C.F.R. destruction and privacy regulations.**

Record Keeping Errors

- **Most common charting mistakes**
  - **Not noting PARBQ (Informed Consent)**
  - **Leaving out the DX**
  - **Failure to document Rx**
  - **Not documenting shortfalls in treatment**
    - **Not documenting follow-up efforts when there were treatment shortfalls**
    - **The dentist should do the follow-up**
  - **Insufficient information**
  - **Medication issues**
  - **Incomplete or missing entries**
  - **Phones calls not charted**
  - **Patient instructions not documented**
  - **Delayed charting**

Record Keeping Errors

- **Self-inflicted wounds – Common Mistakes**
  - **No record of care to staff/family (Treat them like all other patients)**
  - **Not keeping accurate track of CE accomplishment including BLS/CPR and medical emergencies for dentist and staff (including up to date licenses and registrations)**
  - **No health history**
  - **No diagnosis**
  - **No record of Rx**
  - **Changing the record after you gave out a copy**
  - **Patient noncompliance not charted**
  - **Patient response to treatment not charted**
  - **Lack of a treatment plan**

Lawyers charting rules

- **If is was not recorded, it was not done**
- **If it was not recorded, it was not important**
- **If it was not recorded, it was not considered**
- **If it was not recorded, it was not within the standard of care**

Documentation

- **All chart entries should be dictated and transcribed or legibly handwritten, dated and signed with the writer's full name or the first two initials and last name**
- **Use standard charting format**
- **Entries should be comprehensive enough to demonstrate clinical rationale for treatment**
- **Use diagrams where appropriate to note size and locations of physical findings or lesions. Photos help.**
- **Chart type/amount of anesthetic used and the patient's response**
- **Record entries as close to the time of service as possible and file in chronological order**

Documentation

- **Drug allergies are conspicuous**
- **Problem lists and medication flowsheets are up-to-date**
- **Prescriptions and samples are noted**
- **Phones calls during and after-hours are documented**
- **Informed consent is obtained and charted**
- **Patient education, instructions and recommendations for follow-up care are documented**
- **Return dates are included**
- **Patient noncompliance is charted**
- **Information is factual**

Documentation

- **Blanks and check boxes are filled in if used**
- **If using paper records**
  - **Entries are permanent (no pencils)**
  - **Write Legibly**
  - **Don’t Write in the chart margins**
  - **Late entries in the chart are identified as such**
  - **Avoid leaving spaces**
  - **Don’t use Post-It Notes**

Documentation

- **List Patient Name on Every Page in Chart**
- **Add any additional info after last entry**
- **Don’t squeeze it in the prior notes**
- **Avoid any disparaging remarks**
- **CONSISTENCY!!!!**

Documentation

- **Include:**
  - **Charts, Referral, Test Results, Correspondence with Specialists, Lab Slips, and Prescriptions**
  - **Good idea to document patient's chief complaint (if any) for each visit**
- **How Much?**
  - **Enough to allow anyone with similar training/experience to understand treatment provided/planned and why**

Correcting chart errors

- **If information was omitted, an addendum may be added after the most recent chart entry. You should never obliterate, cut out, erase, overwrite, or squeeze words into an existing chart entry. By doing so, you run the risk of alleged fraudulent chart tampering.**
- **If the chart needs to be corrected, the proper way to do so is by drawing a single line through the error, adding the correction, and dating and signing the change.**
  - **For electronic records make addendum entry**
- **Entry in wrong chart: strikethrough and write ”Wrong Chart” date/sign**
  - **For electronic records make addendum entry noting wrong chart**

What **Not** to Document

- **Personal opinions about the patient**
  - ***"Patient is a malicious liar and a drug addict"***
  - ***"She is one of my most challenging patients"***
  - ***"Patient came in drunk again today"***
- **Negative comments regarding the care of other providers**
  - ***"I can't imagine why he was started on that medication"***
  - ***"Care previously rendered to this patient not up to the standards of this office"***
  - ***"I can not consider them qualified to assume responsibility for my patients"***

What **Not** to Document

- **Administrative complaints and operational matters**
  - ***"Patient was sent to collections without my knowledge"***
  - ***"Dictation once again lost by our incompetent transcription service"***
  - ***"Patients scheduled too closely - not able to fully address patient's concerns today"***
- **Keep in Mind**
  - ***If it's in the chart, it's discoverable***

Charting in the electronic record

- **Encrypt!!!**
- **Have a redundant backup**
- **Conduct an audit to confirm data backup**
- **Have two sources of backup protection**
  - **Example:**
    - **Off site disk**
    - **Cloud service**
    - **Server provided backup**

Reminders

- **When special conditions occur, special rules apply:**
  - **Take extra time to chart**
    - **Draft format first**
    - **Consult with key personnel staff that assisted**
  - **Are all mishaps mentioned in the record?**
    - **Must be there to protect the creditability of the record (e.g., patient cried or patient yelled)**

Reminders

- **Know your level of expertise**
- **Don’t attempt treatment just to make the patient happy**
- **Fully inform patient regarding proposed treatment, alternatives, risks and benefits**

If you suspect a claim

- **Are matters involving risk prevention activities and matters having legal implications omitted?**
- **Keep a separate file of legal documents, correspondence with WHI, attorneys, etc.**
- **Give the original records to your attorney**
- **Don’t talk to the patient or plaintiff’s attorney on the telephone**
- **Don’t treat the patient who is suing you (exception emergency care)**
- **Don’t conduct the trial in the chart**

Liability Theories

- **Negligence/Standard of Care**
- **Informed Consent Was Not Obtained**
- **Breach of Promise/Didn’t Meet Expectations**

Record Retention (the laws)

- **Sterilization: Weekly Documentation (5 Years)**
- **Infection Control Training: Annual Documentation (5 years)**
- **Waterline Testing: Per manufacturer or quarterly (5 years) 12/1/2021**
- **Lab Rx (3 years)**
- **Washington State Law: Maintain Complete Patient Records (6 Years)**
  - **Including:**
    - **X Rays**
    - **Treatment Plans**
    - **Patient Charts**
    - **Patient Histories**
    - **Correspondence**
    - **Financial Data**
    - **Billing**

Record Retention (best practices)

- **WHI Guidelines:**
  - **10 years from date of last treatment (inactive)**
  - **6 years from date of death**
  - **21 years from birth of child if treatment was provided to an expectant mother**
  - **Appointment books 10 years**
  - **Keep potentially litigious patient records indefinitely**

WHI Dentist Program 2021 Calendar

JANUARY	FEBRUARY	MARCH
January is Office Safety/WISHA month! • Schedule your monthly staff office safety/WISHA meetings for the year Hold your first 2021 office safety/WISHA staff training	**February is HIPAA month!** • Review/train/educate your employees every February on HIPAA and privacy requirements Conduct monthly office safety/WISHA staff training	**March is Bloodborne Pathogens month!** • Review/train/educate your employees every March on bloodborne pathogens Conduct monthly office safety/WISHA staff training
APRIL	**MAY**	**JUNE**
April is Infection Control month! • Review/train/educate your employees every April on infection control – Infection Control Rules Conduct monthly office safety/WISHA staff training	Mark your calendar for 5/14/21 for a WHI Dentist Program webinar on informed consent, standard of care and documentation Conduct monthly office safety/WISHA staff training	Conduct monthly office safety/WISHA staff training
JULY	**AUGUST**	**SEPTEMBER**
July is Healthcare Provider Basic Life Support (BLS) month! • Certification is required every two years – is this the year you need to re-certify? Conduct monthly office safety/WISHA staff training	Conduct monthly office safety/WISHA staff training	Conduct monthly office safety/WISHA staff training
OCTOBER	**NOVEMBER**	**DECEMBER**
Do you have a Business Owners Policy (BOP) with Optima? Watch for your renewal documents and provide updates on your property and equipment as applicable. • Pending or potential acquisition, merger, sale, retirement or closure of your practice • Change of practice location • Formation of a legal entity for your practice • Additional/new equipment • Any NEW COIs or AI endorsements • Increase or decrease in employees Conduct monthly office safety/WISHA staff training	Watch for your renewal documents/invoice for your WHI Dentist Program (professional liability) policy • Check your renewal documents – is your name correct? Do you need coverage for an entity? Conduct monthly office safety/WISHA staff training	Pay your WHI Dentist Program renewal premium Pay your BOP renewal premium (Travelers) Conduct monthly office safety/WISHA staff training

IMPORTANT REMINDERS:
All licenses/registrations renew on you and your staff's birthdays.

WHI DENTAL PRACTICE RESOURCE LIST (SAMPLE)

Washington State Dental Association: Website

- Continuing Education: PNDC New Date 11/11 – 11/13/2021 in Seattle.
- See Infection Control Rules Update for education, checklists, and plans.
- **Key Dates on new Infection Control Rules:**
  - **Jan. 23, 2021 – New Rules Take Effect**
  - **Dec. 1, 2021 – Water Line Testing Requirement Begins**
  - **By Jan. 23, 2022 & Annually Thereafter – 1-Hour Infection Prevention Standards Education**
  - **Aug. 31, 2022 – Sterilization of Low-Speed Hand Piece Motors Requirement Begins**

Washington State Department of Labor & Industry: Website

- Dental Safety: Requirements & Videos, Training & Prevention includes occupational health education for dental hygienists and topic information on emergencies, formaldehyde, hazardous drugs and chemicals, and blood borne pathogens for monthly office safety and annual trainings.

What is WISHA?

- The Washington Industrial Safety and Health Act (**WISHA**), Chapter 49.17 RCW, requires all state employers to maintain work practices and work environments which do not endanger the health or safety of employees.
- WISHA & OSHA: The difference between federal and WA State safety regulations.
- WISHA requires monthly office staff safety education.

Continuing Education

- Washington State Department of Health Dentist Continuing Education Requirements
- University of Washington School of Dentistry: Continuing Dental Education
- Teledentistry: Seattle King County Dental Society: 1/2021 CE Available here

ACORA The Foundation of Delta Dental of Washington: Website

- Learn & Share Resources: Blogs, Data Reports, Professional Training and Videos

Annual Training: HIPAA, Bloodborne Pathogens, Infection Control

- List dates/topics (i.e., CDC Infection Prevention Checklist for Dental Settings, New Rules)

Staff Birthday Reminders: License & Registration Renewals, BLS every Two Years

- List staff/renewal dates

Other Topics

- Dentist License Requirements and Sedation levels and CE requirements

/RV – 02.2021