# Peninsula Dental Social Enterprise (PDSE)

## Clinical note taking guidelines

## Version 2.0

Date approved: November 2016

Approved by: The Board

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Policy will be updated as required in response to a change in national policy or evidence-based guideline.

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# Guidelines for Good Clinical Note Taking

- All staff and students should be aware of guidelines regarding clinical notes detailed in The Dental Education Facility Confidentiality Policy and the Dental Education Facility National Data Protection Legislation policy.

- Clinical notes are an essential component of the patient's visit, and form a legal document detailing what occurred at each visit.

- There should be an entry for every contact made with the patient including by telephone and letter.

- Reference should be made to the FGDP (UK) guidelines and these should be used as a matter of best practice.

- The notes should be:
    - Contemporaneous and dated; they must be completed at the appointment when the patient is seen
    - Accurate and comprehensive
    - Signed by the student and the clinical supervisor - the students initials must be next to the item of treatment and this must be countersigned by the clinical supervisor
    - Neat, legible and if hand written, they must be in ink
    - Strictly necessary for the purpose
    - Not derogatory
    - Such that disclosure to the patient would be unproblematic

- The notes should include:
    - Medical history
    - Dental, family and Social history
    - Dental charting

- These should be updated regularly

- Details of what should appear in the patients' notes after each visit include:
    - The date of the visit
    - The name of the Student
    - The name of the Clinical Supervisor
    - Details of any radiographs taken at the visit and a report of their findings
    - Clear and concise details of the procedure completed
    - Pre-operative warnings
    - Post-operative instructions

- Any specific discussions undertaken with the patient about treatment options, referrals etc.
    - LA administered (see below)
    - Medications prescribed
    - Attendance
        - Failure to attend
        - Cancelled appointment
        - Arrived late for the appointment
    - On going care of the patient
        - Follow up appointment
        - Recall date
        - Referral to another practitioner or department

- Remember:
    - No Notes - No Defence
    - Poor Notes - Poor Defence
    - Good Notes - Good Defence

- As a general guide, always write clinical notes with the thought that it may be someday viewed by a third party. This could be the patient, another dentist / other dental professional or the patient's solicitor. In the event of an adverse outcome, inadequate notes could be disastrous.

**Guidelines Regarding Specific Treatment Modalities**

1. Clinical Notes following Routine Exodontia

- The clinician should enter into the notes:
    - Any warnings given to the patient pre-op
    - What LA was used including the dosage
    - What surgery was performed
    - Any difficulties encountered
    - Any unusual findings and the action taken
    - Whether haemostasis was achieved before the patient left the surgery
    - Postoperative Advice Given (POIG) to the patient
    - What follow up arrangements (if any) have been made

| For example: Patient warned of the possibility of the tooth fracturing during extraction due to large restoration in place. LA 3mls of Lignospan Special, 1:80,000 adrenaline, buccal and palatal infiltration, UR6 extracted with forceps. Nil complications. Haemostasis achieved. POIG, written and verbal. |
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2. Clinical Notes Following the Administration of Local Anaesthetic

- The clinician should enter into the notes:
    - The treatment carried out

- The dose and name of the LA used including the vasoconstrictor
- The type of injection given
- The batch number
- The expiry date
- Postoperative Instructions Given (POIG) to the patient

| For example: 2.2mls of Lidocaine Hydrochloride 1:80, 000 adrenaline, buccal infiltration, batch no R342096, expiry date Sep 09. POIG |
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