

Following is an excerpt from the February 2, 2007 Board of Dentistry Meeting Minutes. The "Better than S.O.A.P." article is courtesy of the Florida Dental Association.

SOAP Format for Records

Dr. Levsy presented information regarding a five year review of cases showing most common allegation is practice below minimum standards and records violations. He presented the Subjective, Objective, Assessment and Plan (SOAP format) and examples for the board's review. The board members were also provided with an article published in a recent FDA Today magazine suggesting six areas for charting patient records.

It was noted that the majority of dentists disciplined by the Board have problems with patient charting. There was discussion to mandate proper charting by rule, however, after discussion, it was determined that the Board should strongly recommend to dentists to chart and give examples on the web site such as were in the FDA article. Even usage of a rubber dam which may be standard practice in every endodontic procedure should be noted in the patient's chart.

Mr. Graham Nicol, General Counsel for the Florida Dental Association, gave permission for board staff to post a copy of the FDA article on the Board's website to encourage Florida dentists to properly chart after each patient.

■ DENTAL ABSTRACT

Better than S.O.A.P.

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The appropriate risk management criteria of the dental treatment record is that it be written so that a subsequent reader of like training can clearly understand what the treatment was and when and why it was rendered.

This speaks to legibility, and the need for the hand writing to be reasonably legible to other readers. In this context, we must also consider the use of abbreviations. Dentistry, medicine and even law are replete with common abbreviations. It would be absurd to have to write mesial-occlusal-distal instead of m-o-d. However, if in your practice you use any abbreviations that are unique to your practice you must have them listed for reference by a reader of the treatment record. If there is the potential for misunderstanding, the note should be written out.

The procedure notes for patient treatment in the treatment record

should adhere to proper risk management principals and provide all information necessary to fully document the treatment rendered and the reason for the treatment.

It has been suggested that we use the acronym S.O.A.P., which stands for Subjective, Objective, Assessment, and Plan for guidance as to the content of a note. I suggest that a more specific guide would better satisfy legal and risk management requirements in dentistry and that the content of the treatment note be sequenced as follows (see page 19 for treatment note).

Medical And Dental History Update: Whereby the patient is interviewed about any change in their medical or dental condition since the previous visit. You should document if there is no change, or changes in prescriptions or over-the-counter medications. An illness or a new dental complaint may affect the treatment of the patient. The update is placed at the beginning of the treatment note so it will be less likely to be challenged as an afterthought.

Reason Or Diagnosis Necessitating Treatment: A notation indicating the why for the treatment, such as caries, defective restoration, abscess, etc.

Anesthetic Used: Indicate if topical was applied and the type, concentration and number of carpules of injectable anesthetic.

Treatment Rendered: The details of the treatment must be documented to satisfy the what of the criteria. The use of a rubber dam, depth of the preparation, bases placed and the filling material used would be the type of information that should be provided.

Postoperative Instructions: Indication of communication and patient education.

Planned Treatment For Next Visit (N.V.): To demonstrate continuity of care and the treatment was part of a treatment plan.