PEIDC

Prince Edward Island
Dental College

Guidelines:
Dental Recordkeeping

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I Introduction

Professional, ethical and legal responsibilities dictate that a complete chart and record documenting all aspects of each patient's dental care must be maintained. Good records facilitate the provision of effective clinical care and ensure the continuity and comprehensiveness of oral/dental health services.

Patient records must be accurate, well-organized, legible, readily accessible and understandable. If the practitioner of record were for any reason to become unable to practise, another dentist should be able to easily review the chart and carry on with the care of the patient.

These Guidelines are designed to provide assistance to practitioners and comfort to the public that dental patient information is both accurate and confidential.

II Purpose of Dental Records

A dental record should provide an accurate picture of the patient's general health, as well as oral/dental status and any patient concerns and requests. It should include the proposed treatment plan, and any treatment performed, as well as all supporting documentation. The outcome of treatment should be documented and any deviations from expected outcomes should be recorded on the patient chart at the time of service. Patients should be advised of compromised results as soon as the dentist is aware of the situation. All relevant information presented to the patient should be documented.

Basic Assumptions

- Patients have a right to expect that their dental health information will be kept confidential.
- Patients have a right (with a few exceptions) to review and obtain a copy of their dental records, including consultation reports of other practitioners. It is appropriate, where patient consent has been obtained, to share dental and medical records with other health professionals as necessary to ensure continuity and quality of care.
- Every dental team member involved in a patient's care should maintain the confidentiality and security of a patient's dental records, only sharing them with other health care professionals for the purpose of assisting in providing optimal care.
- Dental records should only be disposed of in a manner that ensures that the confidentiality of the information is maintained.

- The exceptions to the right of patients to review and obtain a copy of their dental records, including consultation reports to other practitioners, include records related to ongoing investigations or legal proceedings, records solely relating to quality control or standards of care, records that could cause harm to the treatment or mental or physical health of an individual if released, and records that could lead to the release of personal information about a third party.

For more details and a complete list of exceptions, please refer to the Prince Edward Island Health Information Act.

Essentials of Recordkeeping

The extent of detail required for each record will vary. However, certain baseline data should be common to all dental patients.

This information includes:

- accurate general patient information;
- a medical history, including medications, that is periodically updated;
- a dental history;
- an accurate description of the conditions that are present on initial examination, including an entry such as "within normal limits" where appropriate;
- an accurate description of ongoing dental status at subsequent appointments;
- a record of the significant findings of all supporting diagnostic aids, tests or referrals such as but not limited to: radiographs, study models, biopsy results and photographs;
- all clinical diagnoses and treatment options;
- a record that all reasonable treatment planning options were discussed, including the cost of treatment with the patient;
- the proposed and accepted treatment plan;
- a notation that informed consent was obtained;
- assurance that patient consent was obtained for the release of any and all patient information to a third party;
- clinical notes describing all treatment that was performed, materials and drugs used and, where appropriate, the prognosis and outcome of the treatment;
- details about referrals including copies of correspondence to and from dental specialists or other health care providers;
- dental laboratory scripts and other communication with dental laboratories;

- prescription drug records; and
- an accurate business record.

General Recordkeeping Principles

In keeping and maintaining acceptable patient records, a prudent practitioner would adhere to the following principles:

- All entries should be dated and recorded by hand in permanent ink or typewritten or be in an acceptable electronic format and be complete, clear and legible.
- All entries, including electronic entries, should be signed, initialed or otherwise attributable to the writer and, if different, the treating clinician.
- Radiographs and other diagnostic aids, such as study models, should be properly labelled, dated and the interpretation of the findings documented when considered appropriate by the practitioner.
- An explanation of the overall treatment plan, treatment alternatives, any risks or limitations of treatment and the estimated costs of the treatment should be provided to each patient, parent, legal guardian or government-appointed advocate as appropriate. This fact should be noted in the patient record. In complex or difficult cases, it is advisable to have such informed consent signed.

General Patient Information

It is important that patient records contain the following general information for every patient and that this information be updated at regular intervals. Information should include the patient's name, contact information, date of birth, primary care physician, emergency contact name and number, and insurance information, if applicable.

III Confidentiality and Disclosure of Dental Records

Dentists are also responsible for ensuring that their staff is aware of the requirement of maintaining confidentiality with respect to patient information and dental records. Dentists and their staff must also be aware of the requirement for patient consent before the disclosure or transfer of any patient information or dental records to any third party, including to other family members.

Confidentiality requirements apply to paper, digital, and other forms of patient information and dental records. Records should be stored securely, not left 4 unattended or in public areas of the

office and destroyed appropriately and securely at the end of the required retention period (See Section VII).

IV Privacy Compliance

The purpose of the Health Information Act (HIA) is to govern the collection, use, disclosure, retention, disposal, and destruction of personal health information in a manner that recognizes both the right of individuals to protect their personal health information and the need for custodians, to collect, use, and disclose personal health information to provide, support and manage healthcare. All dentists must comply with the requirements of HIA regarding patient information and dental records, including the disclosure and transfer of patient information and dental records. Under HIA, a dentist is considered a "custodian," and is required to:

- Put in place reasonable information practices that meet the requirements under HIA.
- Information practices should ensure personal health information in the dentist's custody or under their control is protected against theft or loss, and unauthorized access to or use, disclosure, copying or modification of the information.
- Implement, maintain and comply with a complaints policy for an individual to make a complaint under HIA.
- Have the ability to create a record of user activity for all electronic information systems that are used to maintain personal health information.
- Designate a HIA contact person (note: this person can be the dentist).
- Implement additional safeguards for personal health information held in an electronic information system.
- Prepare and make available a written statement about information practices, how to reach the HIA contact person, how to request access and correction of the individual's record, and how to make a complaint.
- Have a policy in place regarding notifying an individual if their personal health information has been breached.
- Receive approval from a research ethics board when using personal health information for research.

Dentists may wish to review the full text of HIA, please refer to the Prince Edward Island Health Information Act.

Consent under HIA

Patient consent, preferably in writing and signed by the patient, should be obtained for the disclosure of any patient information or dental records to, or the obtaining of any patient information or dental records from, another dentist, the patient's physician, or an authorized representative.

The two types of consent under PHIA are knowledgeable implied consent and express consent.

Knowledgeable Implied Consent - Knowledgeable implied consent is the standard under HIA with regard to the collection, use and disclosure of personal health information. Consent will be deemed knowledgeable if it is reasonable in the circumstances for the custodian to believe that the individual knows the purpose of the collection, use or disclosure, and that they may give or withhold consent.

Express Consent - In contrast with implied consent, express consent involves the individual providing oral or written confirmation of their consent regarding the use of their personal health information.

Disclosure of health information without consent must be documented, including a description or copy of the information, identity of recipient, date of disclosure, and authority for disclosure.

Revocation of Consent

A patient can also limit or revoke their consent at any time, whether the consent was express or implied. This applies to all actions under HIA that require consent, and even certain actions that do not normally require consent, such as disclosing information to other professionals in an individual's circle of care. However, no limitation or revocation of consent can be retroactive.

Disclosure of health information without consent must be documented, including a description or copy of the information, the identity of the recipient, the date of disclosure, and authority for the disclosure. One common situation in which information may be disclosed without consent is when information is disclosed to another custodian in the patient's circle of care, where the disclosure is reasonably necessary to provide health care to that patient and the patient has not expressly revoked treatment consent to that disclosure.

V Electronic Records

The use of electronic recordkeeping by dentists, including digital radiography, has grown substantially in Prince Edward Island, and the sophistication of hardware and software continues to evolve. In addition, the public has a heightened sense of awareness and increased expectations around the issues of confidentiality and accuracy. It is important to note that electronic records must comply with all requirements of traditional paper records as outlined in other areas of these Guidelines.

Electronic Recordkeeping System Requirements

Dentists may make and keep electronic records provided certain guidelines are adhered to. Practitioners must also take steps to ensure the reliability of data input and the subsequent accessibility and security of information.

When it comes to accuracy, the most important feature of electronic recordkeeping is an audit trail so the authenticity of the records can be verified by any party who has an interest or requirement to do so. The audit trail should follow any changes that have ever been made to the records to ensure that those changes have not compromised the integrity of the record.

VI Business Records

Dentists must keep business records for the practice, including fees charged and received, scheduling (including day sheets), laboratory services and clinical equipment maintenance. Business records chronicle the day-to-day activities in a practice and although the significance of some of this information may seem to diminish after the fact, it can become very important in the event of a complaint or a lawsuit. Practitioners should be aware of provincial and federal legislation governing business records, such as the Income Tax Act.

VII Stewardship of Dental Records

Ownership of Records

Under common law, and in the absence of an agreement to the contrary, the owner of a dental practice owns all patient charts. A dentist leaving or selling a practice should ideally give patients advance written notice about the change. If the outgoing dentist is unable to do so, it becomes the responsibility of the incoming dentist to notify patients that he or she is in possession of their records.

Retention of Records

Dental records must be retained for at least ten years from the date of last entry or, in the case of minors, ten years from the time the patient would have reached the age of majority, which is eighteen years in Prince Edward Island

In addition to clinical records, other records that must be retained include appointment records, lab prescriptions and invoices. Diagnostic models (also known as study models) are also considered part of the permanent patient record and must be kept for the prescribed period.

Working models do not have to be retained for any specific period of time. A decision to keep working models should be based on the complexity of the case and is left to the judgment of the individual practitioner.

Civil Claims

The timeline for civil claims is governed by the Prince Edward Island Statute of Limitations Act. Those periods may require retention beyond the ten-year period.

Considering this, dentists may choose to retain patients' dental records beyond ten years, either generally or on a case-specific basis. Dentists should consult their legal counsel on this issue.

Release and Transfer of Records

Patients have the right by law to access a copy of their complete dental record and dentists are obligated by law to provide copies of what the patient has requested, including radiographs, study models, photographs and other items. If the patient moves to a different dental practice, records should be transferred within one to two weeks to the new practitioner. If the new dentist requests records electronically, they may be provided in that format.

In most cases, the originating dentist should maintain all original records on file. The dentist may charge reasonable fees for expenses associated with copying records, as long as the patient is advised of these charges in advance. The PEI HIA provides additional information outlining what dentists are allowed to charge for records requests.

Fee disputes or other disagreements between the patient and dentist are not grounds to withhold access to, or transfer of, patient records.

Disposition of Records

At the end of the retention period, records must be disposed of in a manner that protects patient confidentiality and maintains physical security of the information. Methods include:

- confidential return to the individual or dealing with the records in accordance • with the patient's instructions;
- controlled physical destruction, such as shredding or incineration; and
- confidential transfer to another agency that will provide appropriate services to destroy the information. The process used to destroy electronic records must render them unreadable and eliminate the possible reconstruction of the records in whole or in part.

VIII Information Provided to Third Parties – Dental Audits

Dentists must be sure that when they disclose information to Third-Party Insurance companies that they are providing the information in compliance with the HIA. The information disclosed should be limited to the minimum amount of personal health information necessary to carry out a dental audit.

A dentist is permitted to disclose information to an insurance company without consent if the disclosure is reasonably necessary for the administration of payments in connection with the provision of health care to the individual for contractual or legal requirements.

Disclosure of health information without consent must be documented, including a description or copy of the information, identity of recipient, date of disclosure, and authority for disclosure.

While express consent may not always be required by the HIA to disclose information to a third-party insurance company, express consent is nonetheless recommended. This is especially the case if the insurance company is located outside Prince Edward Island, since other legislation will then be engaged, such as PIPEDA, which may have stricter or difference requirements for what constitutes consent.

IX Information Provided to Health Regulatory Authorities

Under the HIA, a dentist may disclose personal health information about an individual without the individual's consent to a regulated health profession body or a prescribed professional body that requires the information for the purpose of carrying out its legislated duties.

The Prince Edward Island Dental College (PEIDC) acknowledges the Royal College of Dental Surgeons of Ontario and the Provincial Dental Board of Nova Scotia for their permission to allow content from their Dental Recordkeeping Guidelines to be incorporated into this document. Some modifications have been made to the original text to reflect requirements in Prince Edward Island.

Revision History			
Approved By	**Date Ratified**	**Review/Revision Note**	**Next Review**
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