

GUIDELINES



**PROVINCIAL DENTAL BOARD OF NOVA SCOTIA
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RECORD KEEPING GUIDELINES ***Adopted June 16, 2006***

In keeping with the Code of Ethics and PIPEDA the following are guidelines for dentists in Nova Scotia regarding **Dental Record Keeping** both written and electronic.

Records

A dentist must establish and maintain adequate records of medical-dental history, clinical findings, diagnosis and treatment of each patient.

There are several reasons why dental records are essential:

1. Records are required to document dental treatments the patient has received and the follow up care provided.
2. Records are required to support claims by dentists for payment of services submitted to private insurance carriers and to government health insurance programs on behalf of patients.
3. Legislation requires the recording of all issued prescribed narcotic or controlled drugs.
4. Complete records are essential if the standards of care provided are questioned.

The extent of detail required for each individual dental record will vary from patient to patient. It will also depend on the conditions with which the patient presents and the complexity of the treatment that is required.

General Record Keeping Principles

1. With a written record make all entries in ink. Any errors should be corrected by drawing a line through the erroneous entry followed by the corrected entry and initialed.
2. Make all entries as soon as possible following the event to be recorded. Entries should be concise, complete and in legible form that can be read and understood by a third party.
3. Dental associates and allied personnel (DH, DA) should record their specific treatment on the patient's chart, date and initial the entry.
4. When referring a patient to a specialist, provide a written referral form (standard referral form) to the specialist and file a copy in the patient's record together with the specialist's report.
5. Individual records should be stored securely, not left unattended or in public areas.

Record Keeping Basics

The following basic information should be recorded in all patient records. This information includes:

1. Accurate general patient information.
2. A medical history that is routinely updated.
3. A dental history.
4. An accurate description of the conditions that are present on initial examination.
5. A record of a thorough clinical extra and intra oral examination / findings
6. Radiographs
 - a) A clinical examination must always precede prescribing radiographs
 - b) In prescribing radiographs, the practitioner must make a judgement that is influenced by a balance between keeping the number of exposures to a minimum while obtaining an adequate number of radiographs for a complete diagnosis. The number, type and frequency of x-rays should be prescribed for each patient according to the clinical signs, symptoms and past dental history.
7. A diagnosis and treatment plan.
8. Document diagnostic options of the treatment plan.
9. Patient choice of treatment plan signed with informed consent.
10. A description of all treatment that is provided, materials and drugs used and where appropriate, the outcome of the treatment.
11. Record any patient refusal of recommended treatment.
12. An accurate financial record.

Release and Transfer of Patient Records

While this Guideline provides advice about the release and transfer of patient records, dentists must ensure that they maintain their responsibility to protect the confidentiality of patient information.

Information Required

Since patients have the right of access to or a copy of their complete patient dental record, dentists are required to follow the direction of a patient and provide copies of what the patient has requested. The information normally required by the patient's new dentist would include:

- A summary of all information pertinent to the patient's continuing treatment. This information may be satisfied by forwarding a photocopy of the patient's chart – assuming that the entries are legible and complete.
- Copies of any radiographs which would be of assistance to the new dentist. In most cases, the most recent full mouth series or panoramic view, and those radiographs taken within the last 24 months, would be all that is required.

The practitioner would retain the original records including radiographs, and would make or cause to be made a high quality duplicate set of records including radiographs. These then would be forwarded to the new dentist or to the patient, if requested to do so.

Expenses Incurred

When requested in writing by a patient or his / her authorized representative, copies of the dental records and / or radiographs must be provided without delay to the patient's new dentist or to the patient.

Where the costs involved are significant, it may be reasonable to recover these out of pocket expenses.

Associates or Partners

A dentist's responsibilities and obligations are no different in circumstances where the dentist who a patient chooses, is a former associate or partner.

Disputes between the dentists should in no way affect the ongoing care of the patient.

The dentist who has possession of the patient records should act in accordance with this Guideline. The dentist must ensure that they co-operate to the extent necessary so that the patient's care is not comprised or delayed.

Retention of Dental Records

According to the *Limitations of Action Act*, the basic time period is two years following treatment completion. However, there are exceptions which may be encountered by dentists, for example:

1. An action can be started up to four years following the two year basic period, provided a judge does not disallow the action.
2. For minors the time period does not begin until a child reaches the age of majority. (19 years in Nova Scotia)
3. The time period for a person of unsound mind does not begin until the person is certified to be of a sound mind.

The medical and legal professions retain records for a period of ten years excluding the above exceptions. This would seem to be a good basic rule for the dental profession. Diagnostic models are considered part of the permanent patient record and must be retained as well.

In deciding on the length of time records are kept over and above the legislated requirements, it would be prudent to retain those records where treatment was extensive and complex, or where the results were less than ideal for an even longer period of time.

Destruction of Records

For secure document destruction use a bonded Paper Shredding Service or in-office shredding.

For secure cast and model destruction, all identifying information on casts and models must be removed prior to disposal.