Denturist Society of Saskatchewan

Patient Recordkeeping Guidelines

Council Approved

Table of Contents

A	Introduction	3
B	Disclaimer	3
C	Use	3
D	Risk Management	4
E	Definitions	5
F	Patient Charts & Patient Records	6
G	Basic Recordkeeping Assumption	6
H	Patient Recordkeeping Principles	7
I	Confidentiality of Information	9
J	Use of Symbols, Abbreviations & Terminology	9
K	Consent	10-12
L	Patient Signatures	12
M	General Patient Information	13
N	Medical History Information	13
O	Dental History Information	14
P	Patient Clinical Examination	15
Q	Treatment Planning & Prognosis	16-18
R	Personal Comments	18
S	Information Presented to Patients	18
T	Entering Information	19
U	Choice of Chart & Entering Information	20-21
V	Progress Notes	22
W	Progress Notes Methodology	22-23
X	Documentation of Referrals & Conversations	23
Y	Recall – Continued Care	23
Z	Electronic Recordkeeping	24
AA	Financial Records	25
BB	Forensic Matters	26
CC	Retention of Patient Records	26-27
DD	Security, Storage & Disposal of Patient Records	28-29
EE	Access to Recorded Information	30-31
GG	Specific Situation Considerations	32
HH	Additional Records	33

A. Introduction

Good records not only help to facilitate good patient care and continuity of care, but they also provide legal and financial records.

These Patient Recordkeeping Guidelines stipulate the minimum requirements for patient recordkeeping that Regulated Members must use in meeting the professional, ethical and legal requirements related to patient recordkeeping. The Guidelines have been developed by the Quality Assurance Committee and have been approved by the Council of the Denturist Society of Saskatchewan.

It is essential that the Regulated Members read and understand the Guidelines, then take any necessary steps to ensure that their practices meet or exceed the contained minimum requirements.

It is the Denturist Society of Saskatchewan (D.S.S)'s position that the requirements contained herein are flexible enough for the Regulated Members to exercise reasonable professional judgment with respect to specific patient situations that may occur within their individual practices.

Patient recordkeeping must comply with all applicable legislation, including the Denturist Society of Saskatchewan Bylaws and the Health Information Protection Act.

B. Disclaimer

These Guidelines detail the minimum requirements that must be met by all Regulated Members; however, they are not exhaustive.

Further, these Guidelines document the minimum standard for record keeping protocols, but do not imply or cannot be interpreted as implying legal opinion or advice. As such, all Regulated Members should seek independent legal advice regarding issues related to record keeping protocols in order to ensure compliance with all applicable legislations.

The D.S.S. accepts no responsibility for the use or lack of use of the information contained herein.

C. Use

These Guidelines are for use by the Regulated Members and the Denturist Society of Saskatchewan only.

No duplication, in whole or in part, or use by any third party is allowed without first obtaining written consent from the Denturist Society of Saskatchewan.

D. Risk Management

These Guidelines will afford the Regulated Members a level of risk management with respect to Patient Recordkeeping.

Requirements of Patient Recordkeeping have always been in effect in healthcare settings; however, requirements have recently been enhanced to address continuity or patient care, privacy of information, and security of patient records.

Adherence to the requirements for patient recordkeeping is an integral and paramount procedure in any denture clinic for both the Regulated Member and his/her employees. It is essential that all Regulated Members are familiar with the requirements of the Guidelines for patient recordkeeping, and that Members recognize that they are responsible and accountable for the record keeping practices of their employees. The Regulated Member is ultimately responsible for any and all information recorded (or not recorded) in the patient record.

Adages such as “never charted-never done” and “no record- no defense” sum up the necessity of adequate records. Canadian case law has found accurate, clear, concise and detailed patient records to be a “testament” to the high level of care provided by the practitioner.

In the event of an audit, complaint or malpractice suit, the Regulated Member’s records become one of the most important pieces of evidence of their defense or conversely, for their lack of defense.

E. Definitions

The following provides definitions of wording used in this document:

Denturist:	Refers to a Regulated Member of the D.S.S.
Regulated Member:	Individuals registered with the D.S.S. as Resident Practicing Member, Non-resident Practicing Member, Intern Member, and Retired Non-Practicing Member.
Patient:	The individual receiving the healthcare services.
Practitioner:	Refers to a denturist or other health care provider.
Responsible Individual:	Refers to a guardian, parent, or other legally responsible person.
Staff:	Any individual employed by the Regulated Member or other practitioner.
Recordkeeping:	Refers to all matters pertaining to the patient chart and record.

The following define the qualifying words used throughout this document:

Must/Shall/Only/ Will/Required:	Indicates a direct need and or requirement.
Should:	Indicates a recommended item to achieve the minimum standard; it is desirable.
May/Could:	Indicates an item which is left to professional discretion.
Appropriate/Pertinent:	Indicates an item where professional judgment is to be used.
Prudent:	Indicates an item which should be handled practically and Judiciously.

The following are abbreviations which appear throughout the document:

DDA:	Dental Disciplines Act.
DSS:	Denturist Society of Saskatchewan
PIPEDA:	Personal Information Protection and Electronic Distribution Act.
DSS:	Quality Assurance Committee of the D.S.S.
FIPPA:	Freedom of Information and Protection of Privacy Act
HIPA:	Health Information Protection Act.

F. Patient Charts & Patient Records

The DSS considers a **PATIENT CHART** as a collection of patient specific information and items pertaining to an individual, including but not limited to:

- All written or electronic information, notes, records, consents, documents, referrals, laboratory prescriptions, photographs, and/or test results relating to a patients treatment; and
- All written or electronic information, notes, records, or documents regarding the financial, insurance, and/or business matters relating to a patient and his/her treatment; and
- All radiographs.

The DSS is of the view that patient charts have four general purposes:

1. **Managing Patient Care**. This would involve documentation pertaining to the commencement of the denturist-patient relationship (first appointment and the initiating of a patient record), and any ongoing treatment.
2. **Documenting Business Aspects**. This includes the financial records related to services provided, and information pertaining to applicable public and/or private insurance transactions related to providing treatment for that patient.
3. **Communicating Patient Information**. This includes authorized communication (via PIPA consent) between denture clinic professionals and their employees, and third parties (including other denturists/healthcare providers).
4. **Providing Evidence**. This includes presenting evidence in malpractice or other litigation and in professional conduct processes and proceedings.

The DSS considers a **PATIENT RECORD** to include:

- The patient chart; and
- Other pertinent information such as diagnostic model(s), impression(s), and the appointment book/schedule, (collectively –not separate per individual).

G. Basic Recordkeeping Assumptions

The following are the basic assumptions related to patient recordkeeping:

- Patients have a right to expect that the information contained in their patient record will be maintained as confidential at all times by the denturist and any staff as per **FIPPA** and **HIPA**.
- Patients have the right to obtain a **copy** of their records or to review their record in its entirety.

- Distribution/sharing of any information in the patient record will **only** be done if consented to by the patient and further, **only** in a discretionary manner to ensure the continuity and required level of care for the patient, or as required by law.
- Transfer of patient records from one practitioner to another will **only** be done when legally required or in the “selling” of a practice.
- Eventual disposal of a record will **only** be done after the expiration of the required retention period, and then in such a manner as to ensure the confidentiality of the information is maintained.

H. Patient Recordkeeping Principles

It is understandable that required or requested treatments will vary depending on the individual patient and as such, the amount of information contained in a patient record and the depth of detail will also vary. However, there are minimum requirements for what must be recorded for each patient. The minimum requirements are specific to and dependent on the venue in which patient treatment takes place.

i.) Patient Physically Present in Your Office or the Denturist Attends to a Patient in and out-of –office Location

When a patient is physically present in the denturist’s office, or when a Regulated Member attends to a patient in an out-of-office location, the Regulated Member shall:

a. Ensure that the patient signs *a Personal Information Protection Act (PIPA) consent form* (if applicable); and
b. Record the patient’s *General Patient Information*; and
c. Record the patient’s *Medical History*; and
d. Record the patient’s *Dental History*; and
e. Perform the appropriate *Clinical Examination*; and
f. Formulate a *Treatment Plan(s);* and
g. Record appropriate *Progress Notes*; and
h. Record information *Presented to the Patient* (whether verbal and/or written); and
i. Maintain a separate *Financial Record*; and
j. *Document any Referrals* (where applicable); and
k. Ensure that any *Correction of Entries* is done appropriately.

ii.) Patient Not Physically Present

When a patient is not physically present (such as when another individual provides a patient's denture for repair), the Regulated Member shall obtain/provide and record:

a. The patient's *General Patient Information*; and
b. The patient's *Medical History* (if available); and
c. The patient's *Dental History* (if available); and
d. Appropriate *Progress Notes*; and
e. *Information or Instructions Presented* to the Patient (via attending individual), whether verbal and/or written); and
f. Financial information in a separate *Financial Record*; and
g. *Referrals*; and

Regulated Members are to determine the specifics for each of these items based on **Evidence Informed Decision Making**. The DSS's Patient Recordkeeping Guidelines can be utilized as one of the reference documents considered in making such decisions.

By legislation, a health care provider can only collect, use, or disclose the amount of health information essential to carrying out the purpose for which the information was provided in the first place. In other words, you must collect, use and disclose the least amount of information necessary, and preserve the highest degree of patient anonymity possible, to carry out the intended purpose.

I. Confidentiality of Information

In Saskatchewan, the **HIPA** and **PIPEDA** require that Regulated Members maintain patient information as confidential and that they must have consent from the patient for use of the patient's information.

i. Contact with other Practitioners

If in the treatment of a patient it becomes necessary to discuss the patient with any other practitioner, you **should** comply with requirements of the *Health Information Protection Act.*

ii. Staff Awareness

All staff members **should** be advised of the **requirements** of confidentiality and the legal obligation to obtain patient consent prior to transferring or releasing any patient information to a third party. It is the Regulated Member's responsibility to ensure that employees comply with the requirements of HIPA.

iii. Record Storage

All patients' records **are to be**:

- Located and maintained in secured storage; and

- In an environment that maintains the integrity of the record; and
- Not readily viewable by the public or other patients; and
- Not left unattended or in public areas of the clinic; and
- Destroyed appropriately only after the expiration of the **required retention period of seven years** from last date of any denturist services having been provided.

J. Use of Symbols, Abbreviations & Terminology

In order to prevent any possible misinterpretation of the recorded information, it is preferable that symbols and/or abbreviations **are not used or limited in use.**
If you choose to use symbols and/or abbreviations in your patient records, all symbols and/or abbreviations **should** be consistent throughout all patient records. In addition, any abbreviation or symbol **should** be industry accepted (for example; **WNL** <within normal limits>, **CUD/CLD** <complete upper denture, complete lower denture>, **URPD** <upper removable partial denture>, **LRPD** <lower removable partial denture>, **↑TC** <upper tissue conditioning>, **↓TC** <lower tissue conditioning>).
If you use abbreviations or symbols, you are **required** to maintain and secure an easily accessible "**legend**" which fully identifies and defines your abbreviations and symbols. As with all entries into records, symbols and abbreviations **should** be legible to anyone viewing the record.
The terminology used in patient recordkeeping **should** be standard medical/dental terminology which is utilized by the profession. The HIPA requires that a practitioner who has received a request for access to health information explain any term, code, or abbreviation used in the record.
It is recommended that the FDI System *(Federation Dentaire Internationale)* be employed in charting to identify natural dentition. This system is widely recognized and utilized by dental health care providers and insurance companies. It is **suggested** that an anatomical Odontogram be used (drawings of each tooth, crown and root structure) to record the presence or absence of natural dentition.

K. Consent

In obtaining consent for a treatment, it is essential to remember that each and every patient has the right to consider and control the decisions made regarding his/her health and health care – if mentally competent and legally able to execute such authority.

Consent does not merely consist of providing the patient with a document to read and sign. Consent **requires** that you discuss the proposed treatment plan with the patient so that he/she can make an informed decision.

The level of consent required for treatment, and that is required to disclose information, must be delineated. Whereas consent to treatment may be implied, consent to disclose information must be written – implied consent is not sufficient.

i.) Implied Consent

Implied Consent is granted through the patient's actions or words.
For example, when a patient voluntarily attends for treatment, understands and is fully aware of what is being done or will be done, allows him or herself to be treated, and does not object to or refuse treatment.

ii.) Expressed Consent

Expressed Consent is clear and unequivocal consent for treatment, whether verbal or written, provided to you by the patient.
For example, a patient stating "You can fit me with new top and bottom dentures", or providing a written and signed consent to a specific treatment plan.

iii.) Informed Consent

Informed Consent occurs when a patient has been specifically informed of all aspects of a treatment that a reasonable person in the same circumstance would want or need to know including the estimate costs- and he/she has agreed to proceed with the treatment (either by implied or expressed consent).
In order for it to be valid, the patient must provide informed consent voluntarily, and consent must be for specific procedures indicated in an accepted treatment plan.
It is prudent to have **Written Expressed Consent** in cases such as, but not limited to, the following:

- Complex/lengthy treatment plans;
- Major services such as those involving surgery;
- Treatments with known risks;
- Cases that involve referral of the patient to other practitioners;
- Cases in which the patient is referred to you by another practitioner;
- Cases where the patient refuses recommended treatment(s);
- Cases in which the patient has unrealistic expectations of treatment outcomes.

In order for a patient to be able to provide **Informed Consent**, the details of the treatment plan **should** be explained to the patient in terms that the patient can understand.
Content that should be explained includes, but is not limited to:

- All viable treatment options – including no treatment;
- Initial prognosis and indication of the expected outcome/success of all treatment options;
- Recommended treatment and the justification for the recommended treatment;
- Materials to be used;
- Risks or possible complications associated with each treatment option;
- Materials to be used;
- Risks or possible complications associated with each treatment option;
- Fees related to the recommended treatment, and where applicable, the anticipated estimated portion covered by third party insurance;
- Financial terms and agreements; and
- Recommended referrals to other practitioners.

Immediate Consent Forms (Example in PDF)
Reline Consent Forms (Example in PDF)
Bleaching Consent Forms (Example in PDF)

iv.) Consent of Dependent Adult Patients

An *adult patient* is an individual who is **Eighteen (18) years** of age or older.

An adult patient who cannot continuously look after him or herself, has a mental disability, or is otherwise unable to make reasonable decisions regarding his/her health care, will **usually** be under the control of a ***Legal Guardian***.

A **prudent** Regulated Member is confident that an accompanying adult is in fact the legal guardian of the patient, **prior to providing any services.**

v.) Consent for Minor Aged Patients

A *minor aged* patient is any individual who is **less than eighteen (18) years** of age. Usually minor aged patients attend a denturist clinic with one or both parents. It is reasonable for a Regulated Member to make the assumption that the parent or parents are the legal guardian(s) of the child.
A **prudent** Regulated Member will be confident that the accompanying adult is in fact a legal guardian of the minor aged patient, **prior to providing any services.**

L. Patient Signatures

It is **prudent** to obtain the patient's signature and to record the date on the patient record for matters of significance. Such matters would include, but not be limited to:

- Medical histories at initial date, and at all medical history updates.

- Dental histories at initial date, and at all dental history updates.
- Consent to treatment.
- Consent to the fees for the treatment.
- Instructions provided for major procedures/treatments.
- Any financial arrangement.
- Consent to obtain and/or release patient information (As per law such as HIPA), including for the transfer of a copy of the patient record to another practitioner.
- Any patient refusal of recommended treatments.
- Any patient refusal of recommended referrals to other practitioners.

M. General Patient Information

For each and every patient, the personal information section of the patient record, (which is completed by the patient and/or guardian or clinic staff member), must contain the following information. This information **should** be updated at regular intervals upon the patient's return to your office, or upon notification by the patient of a change to their information:

- Full legal name;
- Date of birth;
- Gender;
- Home and mailing address;
- Home and work telephone numbers;
- Name and telephone number of patient's primary healthcare provider;
- Name and telephone number of patient's family dentist (if applicable);
- Name and telephone number of previous denturist (if applicable);
- Name and telephone number of referring health care provider (if applicable);
- Legal Guardian/responsible individual (if applicable);
- Emergency contact name and phone number(s);
- Name of the individual or agency responsible for patient account; and
- Dental insurance information (if applicable).

N. Medical History Information

The patient's **Medical History** is obtained at the initial appointment, and **should** be reviewed with the patient and initialed by the attending Regulated Member. Further, the medical history (*completed by the patient and/or guardian, or clinic staff member*), **should** be signed by the patient, or if applicable, by the responsible individual.

The goals in obtaining an accurate medical history are to:

- *Identify any significant medical condition(s), and/or drug interaction or drug side effect, in order to determine the level of risk in treating the patient at that time;*
- *Provide an indication of the patient's level of stress, and determine whether it might affect how the treatment is best provided to that patient; and*
- *Determine if the treatment can be provided safely.*

Any conditions which are or may be pertinent to the treatment being provided **should** be conspicuously noted in the chart.

Responsorial areas of the chart must be in a positive/negative response format, utilizing "closed" (yes/no) questions.

The medical history must be updated at regular intervals:

- Once per calendar year (if patient attends annually); or
- Upon the patient's return to your office after a period of more than one year; or
- Upon notification by the patient of any change to their recorded information.

Upon a patient's completion of the medical history form, the Regulated Member **should** review the responses with the patient, and discuss any necessary notes charted, signed, or initialed by the Regulated Member. Updated entries must **include both the date of updating and the signature of the patient/guardian**. Further, the denturist and patient are to review all updates together, and both the denturist and patient **should** sign or initial the updates. It is essential that there be sufficient room for the recording and updating of entries, and for adding the required signatures associated with the collected information.

O. Dental History Information

The patient's **Dental History** supplements the findings of the clinical examination, providing the Regulated Member with information needed to formulate the treatment plan, and to determine a prognosis for the recommended treatment plan.

The goals of obtaining a complete dental history include to:

- *Provide additional information for consideration with the findings of the examination;*
- *Provide additional information for consideration in treatment planning;*
- *Provide information on the patient's previous dental experiences and dental knowledge;*
- *Provide an indication of the patient's level of concern with and knowledge of their oral health.*

The dental history **should** be updated at regular intervals:

- Once per calendar year (if the patient attends annually); or
- Upon the patient's return to your office after a period of more than one year; or

- Upon notification by the patient of any change to the information contained in their dental history record.

Most commercially available dental history forms are not designed for patient requiring or having dental prosthetics, but rather for patients with natural dentition. Therefore, denturists need to ensure that their dental history forms have all the required information specifically pertaining to patients who have or require dental prosthetics.

P. Patient Clinical Examination

The patient record **should** contain a **Clinical Examination** chart in which the conditions present on the initial clinical examination of the patient are recorded by the Regulated Member *or staff member recording on instruction from the Regulated Member*. The initial record of these findings should remain **unaltered**.

At a minimum, the following should be evaluated and the findings from the evaluation recorded (where applicable). The information in a clinical examination falls into the following categories:

i.) Extraoral Examination

- General physical appearance
- Head
- Lips
- Neck
- Lymph nodes

(Example in PDF)

ii.) Temporomandibular Joint Complex

- Joint and/or masticatory muscle tenderness or soreness
- Range of vertical opening
- Range of lateral movement
- Presence of clicking, popping and/or crepitus

(Example in PDF)

iii.) Intraoral Examination

- Appearance of mucosa
- Ridge classification
- Residual ridge condition
- Tori (if present)
- Tongue size, mobility and condition
- Resiliency and depth of floor of mouth
- Pharynx and tonsils

- Saliva – quantity and viscosity
- Soft and hard palate condition
- Lateral throat form

(Example in PDF)

iv.) Evaluation of Existing Prosthesis

- Centric relation and centric occlusion
- Interocclusal distance
- Tooth contact in lateral excursions
- Tooth contact in protrusive excursions
- Classification of current occlusal relationship
- Condition of prosthesis, including the base, teeth and/or framework.

(Example in PDF)

v.) Dentition & Periodontal Evaluation

- Status of remaining dentition
- Missing dentition
- Oral hygiene assessment
- Tooth mobility measurement
- Tissue color, position, shape, texture & consistency
- Bleeding and/or exudates

(Example in PDF)

vi.) Radiographic Evaluation

- If applicable, copies of any radiographic findings

Q. Treatment Planning & Prognosis

1. Treatment Plan (Example in PDF)

The **Treatment Plan** is based on information gathered from the examination.
It **should** be recorded in the progress notes section of the patient record by the Regulated Member, or by a staff member recording on instruction from the Regulated Member. Alternately, the treatment plan can be a separate form contained within the patient record. The treatment plan **should** list the services to be performed for that patient.
The proposed treatment should incorporate the following criteria wherever possible:

1. Removal of the identified disease of diseases present, considering the urgency and order of that treatment.
2. Maintenance of aesthetics, function, and phonetics.

3. Achievement and maintenance of maximal dental/oral health for the patient in their given set of circumstances.
4. Prevention of recurrent disease, malocclusion, and/or future degenerative changes to the stomatognatic system.

It is **prudent** that treatment plans take into consideration the severity and urgency of the patient's condition, and that plans be supported by clinical findings and accurate records.
As well, treatment options **should** be discussed and reviewed with the patient, and that such a discussion is subsequently duly recorded.
In cases where consent is being given for an extensive treatment involving numerous appointments, referrals, surgeries and/or extended post-delivery follow-up, it is **prudent** that the treatment plan be a separate document, and that this document include **signed expressed consent.**
The treatment plan can be on a separate form or document which becomes a part of the patient record. Alternately, the *recommended treatment plan* and the **consented to treatment plan** can be incorporated into the progress notes section of a patient chart.

2. Prognosis

Denture Prognosis is defined as:

" An opinion or judgment given in advance of treatment for the prospects for success in the fabrication of dentures and for their usefulness."

The prognosis **should** be determined with consideration to objective anatomical and physical considerations, and also to subjective considerations such as the patient's psychological acceptance and expectations of the treatment.
The prognosis **should** be recorded in the progress notes section of the patient record, and/or in separate treatment plan document/form, by the Regulated Member or staff member recording on instruction from the Regulated Member.
Should the prognosis change during the course of treatment, the change **should** be noted and recorded in the patient record, and **should** be discussed and reviewed with patient.

It is **prudent** to describe the prognosis one of the following four terms:

- **Excellent:** It is highly likely that the patient will be successful with the provided treatment (very minor or no concerns).
- **Good:** It is probable that the patient will be reasonably successful with the procided treatment (some minor concerns).
- **Guarded:** It is likely that the patient will have some difficulty with the provided treatment but may overcome the difficulties with time.

- **Poor:** It is very likely that the patient will have difficulty with the treatment and will likely experience long-term, ongoing problems (major concerns).

If a Regulated Member chooses to utilize terms with other than those indicated above to describe and document a prognosis, a secure and easily accessible "legend" which fully describe and defines the terms of use, **should** be maintained.

R. Personal Comments

Regulated Members may include appropriate personal comments regarding the patient and/or their families in the patient record.
However, all personal comments **should** be discreet accurate and relevant to the care that is or will be provided to the patient.
Be reminded that patients have the right to review or to obtain a copy of their record, **including** all personal comments recorded therein.

S. Information Presented to Patients

Information presented to a patient **should** be documented in the progress notes section of the patient record, and where appropriate, a written copy of the information provided to the patient **should** also become part of the patient record.
If presented information is a standardized letter or brochure, then the entry into the progress notes section **should** specify which letter or brochure was provided. Further, an example of all standard letters and brochures **should** be maintained and secured in an easily accessible location.
When information is complex or critical, it is **prudent** to have a comprehensive discussion about the information with the patient, and to present the information in writing.

- New Dentures (Example in PDF)
- Immediate Dentures (Example in PDF)
- Cleaning Instructions (Example in PDF)
- Bleaching Instructions (Example in PDF)

T. Entering Information

The patient record is a legal document, regardless of the process used for recording the information. To prevent the possibility of misinterpretation of entered information, it is essential that all entries **should** maintain the following qualities:
Legibility: be printed cleanly in pen (or printed from a computer program) and utilize accurate spelling, grammar, and punctuation.

Consistency: be systematically organized.
Accuracy: be truthful, factual, and without prejudice or exaggeration.
Brevity: be recorded in short, succinct sentences.
Clarity: the meaning of any entry should be immediately clear to any reader (dental terminology and abbreviations notwithstanding).
Chronology: be dated and recorded in the order in which they occurred.
Signature: whether hard copy or electronic records via digital signature, be signed by the providing Regulated Member, and by the intern if applicable. Further, computer software programs **should** allow the used place digital signatures onto each entry.
As previously stated, the use of recognized symbols/abbreviations can assist in maintaining brevity and clarity of the entries; however, in order to lessen the possibility of misinterpretation of the recorded information, the use of symbols and/or abbreviations should be limited.
With a computer software program recordkeeping system, it is **prudent** to have a program that has the ability to spell check and that allows the dictionary to be supplemented.

U. Choice of Chart & Entering Information

The choice of patient chart/form and recording methodology rests solely with the Regulated Member.
Regardless of the type chosen, it is essential that there be adequate space to record all relevant information from the initial examination, as well as room to document ongoing procedures, changes and updates as necessary.
In addition, the ability to easily add pages to a hard copy patient record is highly recommended. Multiple will require a substantial amount of space to record progress notes. The ability to add supplemental sheets to a patient record will facilitate a consistent recordkeeping methodology.

i.) Extraoral Examination

The patient chart **should** contain an extraoral examination record.
It is **prudent** to have a form which is systematically organized so that the Regulated Member can utilize routine methodology when performing extraoral examinations.
(Example in PDF)

ii.) Intraoral Examination

The patient chart **should** contain an intraoral examination record.
It is **prudent** to have a form which is systematically organized and provides space for entering notes on the findings.
(Example in PDF)

iii.) **Odontogram**

Patient charts for patients with natural dentition **should** contain an odontogram large enough to allow for the charting of all pertinent clinical findings.
The choice of the type of odontogram is solely the Regulated Member's, however, for consistency a single type should be adopted for use with all patients. The DSS **recommends** an anatomical Odontogram.
As with all other information documented in the patient record, the initial visit odontogram **should remain unaltered**.
Subsequent changes to the status of the dentition should be charted on a separate odontogram or recorded using a different color of ink than was used for the initial information. All entries or additions to an odontogram **should** be dated and signed/initialed by the Regulated Member.
(Example in PDF)

iv.) Radiographs

Regulated Members **should** use their professional judgement when considering the necessity and benefit of prescribing radiographs.
The number, type and frequency of the radiographs should be determined on a case-by-case basis, with consideration to the patient's clinical signs, symptoms and past dental history.
As well, an appropriate referral is **required** when ordering radiographs and a copy of that referral **should** be retained on the patient's record.
Radiographs form an important part of the patient record and as such, they need to be of acceptable diagnostic quality, be clearly labeled and dated.
With digital radiography, a digital record of the unaltered original exposure **should** be maintained along with any enhanced or altered views of the original image.

v.) Periodontal Screening Record & Tooth Mobility Measurement Record

When **appropriate** and applicable, and specifically, when providing a patient with partial denture treatment(s), a current periodontal probing record or periodontal screening & record (PSR), and tooth mobility measurement record **should** be incorporated into a patient's record.
Such records can be made by the attending Regulated Member, if he or she is adequately trained to conduct periodontal screenings and tooth mobility measurements. Alternately and with the consent of the patient, a copy of the current periodontal screening record should be obtained from the patient's dentist or hygienist.

These records are to be recorded permanently, updated periodically, (once per calendar year or upon patient's return to your office). Updates **must** be recorded onto a new form. The original probing record or PSR **should remain unaltered.**

vi.) Partial Denture Prescriptions

Partial denture prescriptions **should** be recorded permanently on a separate form, utilizing either a laboratory prescription pad or a Regulated Member's customized prescription form. A copy of the prescription form **should** be retained as part of the patient record.

vii.) **Financial Ledger**

The financial information pertaining to a patient **must** be recorded permanently and on a separate form such as a financial ledger. In addition, copies of insurance claim submissions, statements or other documentation related to the financial aspects of a patient's treatment **must** be retained with the record.
It is **prudent** to provide patients with a written financial terms agreement.

V. Progress Notes

Progress notes are a **required** descriptive record of the progression of treatment, both what happened clinically at the appointment or interaction, as well as any related technical events that require documentation.
Progress notes generally include:

- The patient's subjective information;
- The Regulated Member's objective assessment/analysis;
- The treatment provided to the patient;
- The prognosis;
- Planned future procedures; and
- The name of the providing Regulated Member

Every appointment that a patient attends (whether in your clinic or at an external location such as at a private residence, nursing home or hospital) **should** be entered into the patient's progress notes by the Regulated Member or staff member recording on instruction from the Regulated Member. Any correspondence you receive that relates to the patient **should** also be recorded in the patient's progress notes.
Progress note entries **should** be made on the day the appointment occurred. The amount of information recorded will be dependent on the treatment being provided. It is **prudent** to

record the entry immediately upon competition of the appointment, or upon the completion of the review of the received correspondence.
If any limitations of the treatment(s) are discussed with the patient during an appointment, details of the discussion **should** be recorded.

W. Progress Notes Methodology

Although the style and content of progress notes will vary from Regulated Member to Regulated Member, it is essential that the information recorded in the Progress Notes meet the criteria described herein.

i.) **Multiple Appointment Procedures**

When treatment requires that a patient attend multiple appointments, such as in the case of new dentures, the progress notes will be one of three types:

1. **Initial Note:** The initial note is entered during and/or upon completion of the first appointment with the patient, whether that appointment is for a consultation, an examination, or for other procedure.
2. **Ongoing Treatment Note:** An ongoing treatment note is entered during and/or upon completion of each and every appointment in a series of treatments for the patient.
3. **Final Treatment Note:** The final treatment note is entered during and/or upon completion of the final appointment in a series of treatments for the patient.

ii.) **Single Appointment Procedures**

When a patient is attending for a single appointment procedure treatment, such as an adjustment or a repair, then the progress notes for the single appointment would consist of two entries as follows:

1. **Initial Note:** The initial entry is done at the start of the appointment/procedure, and indicated what treatment is planned.
2. **Final Note:** It is possible that issues may arise during the appointment that necessitates a change/addition to the planned treatment. The final note is done at the end of the appointment/procedure, and indicates what treatment was provided and what information was presented to the patient.

X. Documentation of Referrals & Conversations

Any referral to another health care provider **should** be recorded in the progress notes by the Regulated Member or staff member recording on instruction from the Registered Member.

Because you are disclosing personal information about the patient, your entry **should** include the name of the person to whom the referral was made, the date and purpose of the referral, and a description of the information disclosed in the referral. Be reminded that you **should** obtain patient consent prior to discussing the patient's condition with any other practitioner or third party, and it is prudent that this consent **should** be recorded into the patient record.
Any referral letters, reports and/or other correspondence, including electronic correspondence, received from the referred to practitioner, **should** be retained within the patient record.
In addition, any conversation with other providers regarding the patient **should** be duly recorded into the progress notes in the patient record.
Finally, if you have recommended a referral **and the patient refuses the referral**, it is **pertinent** that you record this refusal and whenever possible, and have the patient sign the charting entry acknowledging refusal of the referral.

Y. Recall – Continued Care

It is **prudent** that Regulated Members adopt a systematic methodology for patient notification regarding necessary post-insertion follow-up care, checkups, and general monitoring (recall). Regulated Members **should** enter into the chart the recommended date for the patient to be recalled and the purpose of the recall appointment. Additionally, it is **prudent** to record missed or cancelled recall appointments, whether practitioner or patient initiated, in the progress notes section of the patient record.
Recall appointments **should** be recorded in the patient record by the Regulated Member or staff member recording on instruction from the Regulated member. The record should document:

1. **Patient Updated Medical & Dental Histories**- complete with patient signatures. In addition, the Regulated Member must note that the updated medical and dental histories were reviewed with the patient. The attending Regulated Member, or if applicable, the Provisional Regulated Member/student with the Regulated Member's initial, must sign/initial the entry.
2. **The type of Examination** provided, and findings of the examination.

Z. Electronic Recordkeeping

Electronic computer recordkeeping is a viable and approved method of patient recordkeeping. It should be noted however, that electronic records **should** comply with the same requirements as paper-based records.
An electronic computer recordkeeping program should support basic functions in order to meet the required guidelines of record keeping. The system should ensure:

1. There is an accurate visual display of the information recorded.
2. The information recorded can be retrieved and clearly printed.
3. The original entered information is unaltered after a short time period of the entering of information, and that a continuous audit trail is maintained which:
    - Indicates any changes to the recorded information;
    - Maintains an original content record when information is changed, updated, or deleted;
    - Date-records every clinical entry for each patient; and
    - Date-records every financial entry for each patient.
4. It reveals the digital signature of the individual who made the entries.
5. There is access to each patient's clinical and financial records by the patient name.
6. There is the capability to visually display and print clinical and financial information for each patient in a chronological order, for specified dates and/or periods of time.
7. Access is password protected or has another form of unauthorized access prevention.
8. Date is backed up to a removable recording media, and includes a method for data recovery, protection against loss, damage, corruption and/or inaccessibility to any or all patient information.

Computer screens **should** be placed so as to ensure safeguarding of confidential information. Access to computers within a facility or to portable computers containing practice-related data **must** be restricted to authorized individuals, and the use of screen savers, passwords, etc., is **required**.

It is **prudent** to perform a daily **encrypted** backup of the records and to remove a copy of the backup from the premises. Further, it is **recommended** that a hard copy of the data be maintained in a systematic chronological manner. All necessary steps **must** be taken to maintain security of the copy and the information contained therein.

Regulated Members **must** take all necessary steps to ensure the safeguarding of computer equipment from electrical failures or fluctuation (surges), theft, fire, water damage or any other hazard.

AA. Financial Records

Financial arrangements and transactions form an important and integral part of the patient record.

The patient record **must** provide details of financial arrangements and agreements with the patient, and must indicate who is responsible for the patient's account. When a financing

agreement or payment schedule is in effect, a separate written and signed financial terms agreement form **should** be completed and retained in the patient record.

A financial record is a distinct document that **must** be separate from the patient progress notes. It forms part of the patient record.

The financial record for each patient **must** contain:

1. A copy of all written financial agreements with the patient.
2. The dates of services, procedures and/or codes.
3. The amounts of all fees charged.
4. The dates, amounts, and method of all payments made.
5. An itemized list of external invoices, such as fees from commercial laboratories.
6. Copies of all dental insurance claim forms, including forms from the preceding seven years.
7. Signature/initial of the individual who made each entry into the financial record.

BB. Forensic Matters

Forensic dentistry is an overlap of dental and legal professions.

The most common element of forensic dentistry that a denturist is likely to encounter, is the request for an antemortem (before death) patient record to aid in identifying a deceased individual who has not otherwise been identifiable.

The Regulated Member's patient record can provide invaluable information to assist in the identification of such an individual. The retained diagnostic models, impresssions, charted examination findings, digital photographs, radiographs, records of denture teeth used, and record of natural dentition, can all aid a forensic investigator to identify an individual.

In such a case, the forensic investigator **must** provide you with their formal authority to access your records. Note that a simple "*I am investigating matter and need your chart*" is not sufficient proof of authority to access a patient record.

CC. Retention of Patient Records

Any and all patient records **must** be maintained for a minimum of **Seven (7) years** after the date service(s) were last provided to the patient, in a safe, protected environment that protects the integrity of the record.

The DSS also recommends that its members consider maintaining records beyond the **Seven (7) year** period mentioned above, in order to:

1. Comply with legislative requirements;
2. Fulfill the requirements of a public or private health insurance plan;
3. Satisfy any applicable requirements for record retention established by a hospital or other publicly funded healthcare entity in which the denturist provided treatment;
4. Meet business, tax, or accounting requirements; and
5. Have access to records in the event of legal recourse.

i.) Sale of a Practice

If a member or other individual who owns a clinic sells it, he/she is responsible for ensuring that the new owner is aware of the requirements for patient record retention. It is appropriate that the seller provide indication to the new owner of how much of the minimum **Seven (7) year** retention period has elapsed in for each patient record.

Further, it is **prudent** that the seller provide notification of the sale of the practice to all present and former patients, and to advise them of who is in possession of the practice's records, where the records will be located, and the contact information of the record holder.

ii.) Closure of a Practice

If a member or owner closes a practice, the member, owner, **must** maintain the patient records for the minimum **Seven (7) year** period.

Further, these records are **required** to be:

1. Retained and maintained in a protective environment to prevent damage; and
2. Easily accessible should record retrieval be necessary.

The D.S.S. **requires** that notification of the closure of the clinic be provided to the Registrar in a timely manner, with a written indication of the location of stored patient records.

It is **prudent** that a notice of the closure of the clinic, the name of who is in possession of the patient records, the contact information for that individual, and the location where patient records will be stored be provided to the patients.

iii.) Deceased Patients

It is **prudent** to retain a deceased patient's record for a minimum of **Seven (7) years** from the date on which treatment was last provided to the patient.

If the patient had a legal guardian, it is **prudent** to provide notice to the legal guardian as to where the record is being retained.

iv.) Appointment Schedule Records

The member or individual who owns the clinic is required to retain the Records of Appointments, whether a hard copy appointment book or an electronic scheduler, for a period of at least **Seven (7) years.**

DD. Security, Storage & Disposal of Patient Records

1. Security of Records

Patient record security relates to the methods used to protect patient information from unauthorized viewing, modification and/or destruction, whether accidental or intentional. Privacy legislation has detailed **requirements** for the securing, storage and disposal of patient information.

i.) Current Patient Records – Active Files

Patient records **must** be handled appropriately within the clinic. The following apply:

- Records are **not** to be left unattended in public areas of the clinic.
- **Only** authorized individuals may access the records.

In addition, it is **prudent** to have all employees execute an ***Oath of Confidentiality*** to protect patient information, and that employees leaving a practice are reminded that continued confidentiality is required.

ii.) Physical Protection and Security

Appropriate storage and protection of patient records will reduce the possibility of their misplacement, damage, and/or loss. Reasonable precautions **should** be employed to safeguard records from damage due to fire and other hazards.

Missing records may be indicative of poor record management or carelessness by the Regulated Member and/or their staff, or worse, the purposeful concealment or elimination of records.

2. Storage of Inactive/Archived Records

If patient records are to be removed from the normal clinic location for storage at an "off-site" location, the security and protection of the integrity of the records **must** be ensured. A secure controlled environment with restricted access is **recommended.**

A record of which files have been stored and the location of the storage **must** be maintained at the normal clinic location, for tracking and reference.

3. Disposal

If the patient record information is no longer required and the retention period has expired, the record may be disposed of in a manner that will ensure that confidentiality is safeguarded.

Suitable methods of disposal include:

- Confidential return of the record to the individual patient.
- Physical destruction such as shredding or incineration in controlled process whereby any residual material does not contain any readable personal information. (This may include the use of bonded commercial companies that provide information disposal services).
- Rendering the personal information into a form which can no longer be identifiable.

It is **required** that a record of which files have been disposed of, and the date and the method of their disposal be maintained at the normal clinic location.

EE. Access to Recorded Information

A patient record is the possession of the denturist; however, the information in the patient record **belongs to the patient, not the denturist**.

The information is held "***in trust***" by the denturist, for the benefit of the patient in the delivery of health services.

You **must** maintain the patient records in a form that allows for access and for the ability to make a copy; this includes electronic data.

As such, any release of this information **must** have prior consent from the patient, or the legally authorized representative of the patient, except in specific situations where required by law.

Before a Regulated Member releases information from a patient record with an existing patient consent, it is **prudent** to obtain signed written consent from the patient or legally authorized representative to release the information.

Any **original**, referral or correspondence letter, radiograph, or other retained item/document, should **never** be given to the patient. Rather, the patient should be provided with a copy of the documents, even if the patient is merely requesting to examine the record. The integrity of the original record **should** be maintained.

i.) Patient Access

Patients have the right to review or request a copy of their patient record in its entirety. It is **prudent** that such a request be in writing from the patient and, if being dealt with by a staff member who is not familiar with the patient, that government issued picture identification be presented to verify the identity of the requester.

Regulated Members **must** provide access to records, expect in a situation where the Regulated Member believes that there would be significant likelihood of an adverse effect on the patient's physical, mental or emotional health, or that granting access would likely result in harm to a third party. Regulated Members **must** have adequate justification for refusing to provide examination and/or a copy of the patient chart. A regulated Member's fear of embarrassment of litigation arising from remarks entered into the patient record by the Regulated Member is **not** adequate justification!

When a patient has accessed his or her record, an entry reflecting this access **should** be made in the progress notes of the patient record by the Regulated Member of staff member recording on instruction from the Regulated Member.

As well, it is **prudent** to only allow the patient to review his or her record while you or a staff member- who can interpret and explain the terminology, symbols, and/or abbreviations contained in the record is in attendance.

Again, the integrity of the original record **should** be maintained and precautions taken to prevent the patient from altering, damaging, removing or destroying any part of the record.

It is at the Regulated Member's discretion as to whether to charge the patient a fee for duplication of part or all of the record. If a fee is charged, it **must** be reasonable and appropriate and the transaction **must** be recorded in the financial record contained in the patient record.

ii.) Dependent Adult Patient Access

Access to a dependent adult patient's record **must** be requested in writing and must be signed by the authorized legal guardian.

Further, such access to information **must** be legally allowed and **should** be recorded into the progress notes in the patient record by the Regulated Member or staff member recording on instruction from the Regulated Member.

iii.) Minor Aged Patient Access

Access to a minor aged patient's record **must** be authorized by the responsible parent or by the legally authorized representative of the minor aged patient, and requests to access **must** be in writing and signed by the responsible parent or legally authorized representative.

Further, such access to information by legal guardians **must** be legally allowed and **should** be appropriately recorded in the progress notes in the patient record by the Regulated Member or staff member recording on instruction from the Regulated Member.

FF. Specific Situation Considerations

In the course of providing services to the public, Regulated Members have specific situations arise that do not afford a smooth provision of services.

The following provides guidelines for dealing with some such situations.

i.) Refusal of Treatment and or Referral

If a patient or the legally authorized representative refuses to consent to a recommended treatment of referral to another practitioner, this refusal **should** be recorded into the progress notes in the patient record by the Regulated Member or staff member recording on instruction from the Regulated Member.

Whenever possible, it is **prudent** to have the patient or legally authorized representative provide their signature at the end of the entry documenting the refusal.

ii.) Dissatisfied Patient

In the event of confrontation with a patient dissatisfied with services provided, it is **prudent** that any interaction, including any and all attempts to resolve the issues of the patient's dissatisfaction, be recorded in the progress notes in the patient record by the Regulated Member or staff member recording on instruction from the Regulated Member.

If a Regulated Member becomes aware that the patient is planning to or has initiated legal action, it is **prudent** that you seek the advice of your Professional Liability Insurance Provider, and record such correspondence into the patient's record.

iii.) Termination of Treatment

If you chose to terminate treatment, the justification(s) for the termination and any steps taken to ensure that all legal aspects of the practitioner/patient relationship have been fulfilled **must** be recorded into the progress notes in the patient record by the Regulated Member or staff member recording on instruction from the Regulated Member.

Such steps include:

1. Completion of any procedures which are in progress.
2. Formal notification to the patient via registered mail, (or other confirmable delivery method), indicating the need for the patient to find another practitioner, and to advise the patient that you will provide him/her with

only emergency treatment for a period of two months from the date of the letter.

3. Finally, indicate that if the patient wants a copy of his/her patient record transferred to a new practitioner, the patient will have to provide written consent before the copied records can be transferred. Such correspondence **must** be recorded in the patient record. **Do not send the original patient record.**

II. Appointment Schedule Record

In addition to appropriate individual patient records, the Appointment Schedule Record must be retained as it forms part of a patient record.
Whether the appointment records are kept in a hard copy appointment book or are computer generated, appointment schedule records **must** be maintained for a minimum of **Seven (7) years**, with consideration of indefinite retention if possible.
For generated appointment schedules, it is **prudent** that a hard copy be printed and maintained, or at minimum, a separate encrypted backup of the electronic record of the appointment schedule is maintained.