



Denturist Society of Saskatchewan

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Patient Recordkeeping Guidelines

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OVERVIEW

The Society's Standard of Practice: Record Keeping articulates the regulatory requirements for documentation and record keeping. It is important for registrants to maintain patient records in an organized, logical, and systematic fashion to facilitate adherence to the requirements set out in the Health Information Protection Act (HIPA). These guidelines offer further clarity regarding record keeping retention, patient charting, and disclosure of records.

The HIPA fully applies to denturists in Saskatchewan, as they are considered "trustees" under the legislation when they have custody or control of personal health information. This means denturists have a legal duty to protect the privacy and confidentiality of their patients' health records. For more information regarding your role as a trustee, please visit the Office of the Saskatchewan Information and Privacy Commissioner website.

1) Confidentiality and Patient Information

Registrants are required to comply with the HIPA and the Personal Information Protection and Electronic Documents Act (PIPEDA). Patient information must be treated as confidential, and registrants must obtain the patient's consent before using or disclosing such information.

- **Contact with Other Practitioners:**

When it is necessary to consult with another practitioner regarding a patient's treatment, registrants must ensure compliance with the requirements of the HIPA.

- **Staff Awareness:**

All staff members must be informed of their duty to maintain confidentiality and the legal requirement to obtain patient consent before transferring or releasing any patient information to a third party. The registrant is responsible for ensuring that employees adhere to the requirements of HIPA.

- **Record Storage:**

Patient records must be stored in a secure location and maintained in a manner that protects confidentiality and prevents unauthorized access.

2) Patient Charts/Records

- **Patient Chart:**

A *Patient Chart* is the collection of patient-specific information and documentation 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 the patient's treatment;
- All written or electronic information, notes, records, or documents regarding the financial, insurance, and/or business matters associated with the patient's treatment;
- All radiographs.

- **Patient Record:**

A *Patient Record* is the broader compilation of materials and includes:

- The patient chart; and
- Other pertinent information such as diagnostic models, impressions, and the appointment book/schedule (collectively, not separated per individual).

- **Legal Documents:**

Patient records are legal documents and must be maintained to prevent misinterpretation.

- **Entries should demonstrate:**

- Legibility – clear handwriting or computer print, correct spelling, grammar, punctuation.
- Consistency – systematically organized.
- Accuracy – factual, truthful, without bias or exaggeration.
- Brevity – concise, succinct sentences.
- Clarity – meaning immediately understandable.
- Chronology – dated and recorded in order of occurrence.
- Signature – signed by the registrant (and intern if applicable), including digital signatures where software permits.
- Use of standard medical/dental terminology.

- **Use of symbols/abbreviations** should be recognized, limited, and supported by clarity to avoid misinterpretation. If used, they must be:
 - Consistent across all patient records.
 - Industry-accepted (e.g., WNL, CUD/CLD, URPD, LRPD, ↑TC, ↓TC).
 - Supported by a secure, accessible “legend” defining each abbreviation or symbol.
 - Under HIPA, practitioners must be able to explain any term, code, or abbreviation upon request.
- **Recommended practices** include:
 - Using the FDI System for charting natural dentition.
 - Employing an anatomical Odontogram to record tooth presence or absence.
- **Electronic record systems** should include spell-check capability and allow for dictionary supplementation.

3) Consent in Patient Care & Record Keeping

- **Patient Rights:** Every competent patient has the right to make decisions about their health care.
- **Nature of Consent:** Consent is more than signing a document; it requires discussion of the treatment plan so the patient can make an informed choice.
- **Types of Consent:**
 - Implied Consent – granted through patient actions or words (e.g., attending treatment and not objecting).
 - Expressed Consent – clear, verbal or written agreement to treatment (e.g., stating or signing approval).
 - Informed Consent – requires full disclosure of treatment details (refer to standard of practice).
- **Special Circumstances:**
 - Dependent Adults – consent must come from a verified legal guardian if the patient cannot make decisions.
 - Minors (<18 years) – consent typically comes from parents or legal guardians; registrants must confirm guardianship.
- **Patient Signatures:** Patient signatures, dated and recorded in the patient record, are essential for significant matters, including:
 - Initial and updated medical and dental histories.
 - Consent to treatment and associated fees.
 - Acknowledgment of instructions for major procedures or treatments.
 - Financial arrangements.
 - Consent to obtain or release patient information (as required by law, e.g., HIPA), including transfers of records to other practitioners.
 - Documentation of any patient refusal of recommended treatments or referrals.
- **AI-Supported Note Tracking or Documentation Assistance:** Registrant must obtain informed patient consent prior to using these tools during the provision of care.
 - The patient must be advised that the tool is used solely to assist the Registrant in generating or organizing clinical notes, that the Registrant remains fully responsible for the accuracy and completeness of the patient record, and that no identifiable patient information will be transmitted, stored, or used beyond the purposes of documentation unless otherwise authorized by the patient.

- Consent must be documented in the patient record, including the patient's acknowledgment of the tool's purpose, limitations, and privacy safeguards.
- Consent may be withdrawn at any time, and the Registrant must discontinue use of the tool immediately upon withdrawal.

PATIENT CHARTING

1) Basic Information

All patient records must be complete, accurate, and regularly updated. All entries must be dated, signed, and corrected appropriately when needed. Each record should contain the following information:

General Information:

- Patient's name, gender, date of birth, home/mailling address, phone numbers.
- Emergency contact details.
- Legal guardian/responsible individual (if applicable).
- Insurance and account information.

Health & Clinical Information:

- Medical and dental history (initial and updated).
- Primary-care physician, family dentist, previous denturist, and referring health professionals.
- Medications and supplements.
- Examination findings, diagnoses, treatment plans, and progress notes.
- Advice provided and patient education.
- Documentation of procedures (including incomplete ones with reasons).
- Referrals made or accepted, with names of professionals involved.

Consent & Privacy:

- Signed consent forms (treatment, fees, release of information).
- Documentation of informed consent process.
- Consent to collect, use, and disclose patient information (HIPA/PIPA compliance).

Financial & Supporting Records:

- Financial records, including fees, payments, refunds (with reasons).
- External laboratory prescriptions.
- Radiographs, diagnostic models, impressions, and other supporting materials.

2) Medical History Information

- **Initial Appointment:** Medical history must be obtained, reviewed with the patient, and initialed by the registrant. The form must be signed by the patient or responsible guardian.
- **Purpose:**
 - Identify significant medical conditions, drug interactions, or side effects to assess treatment risk.
 - Evaluate patient stress levels and their impact on treatment.
 - Ensure treatment can be provided safely.
- **Charting:** Pertinent conditions must be clearly noted. Responses should use closed (yes/no) questions.
- **Updates:** Medical history must be updated:
 - Annually (if patient attends yearly).

- After an absence of more than one year.
- Whenever the patient reports changes.
- **Review & Signatures:** Updates must be reviewed jointly by the denturist and patient, dated, and signed/initialed by both. Records must allow space for entries and required signatures.

3) Dental History Information

- **Purpose:** Dental history complements the clinical examination, helping the registrant develop treatment plans and determine prognosis.
- **Goals:**
 - Provide additional context for examination findings and treatment planning.
 - Document prior dental experiences and patient knowledge.
 - Assess patient concerns and awareness of oral health.
- **Updates:** Dental history must be updated:
 - Annually (if patient attends yearly).
 - After an absence of more than one year.
 - Whenever the patient reports changes.
- **Forms:** Standard dental history forms often focus on natural dentition. Denturists must ensure their forms capture information specific to patients with or requiring dental prosthetics.

4) Patient Clinical Examination

- Patient records must include a Clinical Examination chart documenting conditions observed during the initial exam.
- Findings must be recorded by the registrant (or staff under their direction).
- The initial record must remain unaltered to preserve accuracy and integrity.

5) Information Presented to Patients

- All information provided to patients must be documented in progress notes.
- When appropriate, a written copy of the information should also be included in the patient record.
- If standardized letters or brochures are used, the record must specify which was provided, and examples of all standard materials should be securely maintained and accessible.
- For complex or critical information, a comprehensive discussion with the patient is required, and the information should also be presented in writing.
- Examples of written materials include:
 - New Dentures instructions
 - Immediate Dentures instructions
 - Cleaning instructions
 - Bleaching instructions

6) Progress Notes

- **Purpose:** Progress notes are a required descriptive record documenting treatment progression, clinical events, and related technical details.
- **Content:** Notes should include:
 - Patient's subjective information.
 - Registrant's objective assessment/analysis.

- Treatment provided.
- Prognosis.
- Planned future procedures.
- Name of the providing Registrant.
- **Documentation Standards:**
 - Every appointment (clinic, home, nursing home, hospital) must be recorded.
 - Relevant correspondence must also be documented.
 - Entries should be made the same day, ideally immediately after the appointment or review of correspondence.
 - Discussions of treatment limitations must be recorded.
- **Methodology:**
 - Multiple Appointment Procedures:
 - *Initial Note* – entered at first appointment.
 - *Ongoing Treatment Note* – entered at each subsequent appointment.
 - *Final Treatment Note* – entered at the last appointment.
 - Single Appointment Procedures:
 - *Initial Note* – records planned treatment at the start.
 - *Final Note* – records treatment provided and information shared at the end.

7) Documentation of Referrals & Conversations

- **Referrals:** All referrals to other health care providers must be documented in the progress notes, including:
 - Name of the provider.
 - Date and purpose of the referral.
 - Description of information disclosed.
- **Consent:** Patient consent must be obtained before sharing information and should be recorded in the patient record.
- **Correspondence:** Referral letters, reports, and electronic communications from other providers must be retained in the patient record.
- **Conversations:** Any discussions with other providers about the patient must be documented in progress notes.

8) **Refusal of Referral:** If a patient refuses a recommended referral, the refusal must be recorded, and whenever possible, signed by the patient to acknowledge the refusal.

9) Continued Care

- Registrants must use a systematic approach to notify patients about follow-up care, checkups, and recall appointments.
- Patient records must include:
 - The recommended recall date and purpose of the appointment.
 - Documentation of missed or cancelled recalls, whether initiated by the patient or practitioner.

- Recall appointments must be recorded in the patient record, noting:
 - Updated medical and dental histories, signed by the patient and reviewed with the registrant (with signatures/initials of the attending member or provisional/student where applicable).
 - The type of examination performed and the findings.

RECORDS FOR DENTURE REPAIRS

If the only service provided is a repair of dentures that the Registrant did not themselves fabricate, the record for the repair may only contain the following:

- 1) the patient's name, address, birth date and contact information;
- 2) the date and nature of the repair;
- 3) the name of the treating Denturist(s);
- 4) advice given to the patient;
- 5) clinical findings and professional opinions;
- 6) a notation of the assessment if conducted;
- 7) a notation documenting the informed consent process according to the Standard of Practice: Informed Consent.
- 8) a notation documenting the consent to collect, use and disclose patient information in accordance with the clinic's privacy policy and according to the Standard of Practice: Confidentiality & Privacy; and
- 9) copies of the signed consent forms.

FINANCIAL RECORDS

- **Importance:** Financial arrangements and transactions are an integral part of the patient record.
- **Documentation:**
 - Financial records must be separate from progress notes but form part of the overall patient record.
 - Must identify who is responsible for the patient's account.
 - Written and signed financial agreements (e.g., payment schedules) must be retained.
- **Required Contents:**
 - Copies of all written financial agreements.
 - 1) Dates of services, procedures, and/or codes.
 - 2) Fees charged.
 - 3) Dates, amounts, and methods of payments.
 - 4) Itemized external invoices (e.g., lab fees).
 - 5) Copies of dental insurance claim forms (retained for at least 7 years).
 - 6) Signature/initial of the person making each entry.
- **Financial Ledger:**
 - Patient financial information must be recorded permanently on a separate ledger form.
 - Copies of insurance claims, statements, and related financial documentation must be retained.
- **Best Practice:** Provide patients with a written financial terms agreement.

ELECTRONIC RECORDS

- **Equivalency:** Electronic records are approved but must meet the same standards as paper records.
- **System Requirements:**
 - Accurate visual display and ability to retrieve/print information.
 - Audit trail that preserves original entries, records changes, and date-stamps all clinical and financial entries.
 - Digital signature of the individual making entries.
 - Patient records accessible by name, viewable/printable in chronological order.
 - Password protection or other access controls.
 - Regular backups with recovery methods to prevent data loss or corruption.
- **Confidentiality & Security:**
 - Computer screens positioned to safeguard patient information.
 - Access restricted to authorized individuals; use of passwords and screen savers required.
- **Best Practices:**
 - Daily encrypted backups, with copies stored off-site.
 - Maintain a hard copy in chronological order.
 - Protect equipment against hazards (electrical surges, theft, fire, water damage).

FORENSIC MATTERS

- **Forensic Dentistry:** Combines dental and legal professions.
- **Common Role for Denturists:** Providing antemortem patient records to help identify deceased individuals.
- **Useful Records for Identification:**
 - Diagnostic models and impressions.
 - Charted examination findings.
 - Digital photographs and radiographs.
 - Records of denture teeth used.
 - Records of natural dentition.
- **Access Requirements:** Forensic investigators must present formal authority to access patient records; informal requests are insufficient.

PATIENT RECORDS

1) Requested Changes to Records

Patients may request changes to their records in writing. The registrant must document the request along with the rationale for any changes made. It is important to note that registrants are not obligated to alter records they believe to be accurate and complete. The patient's request and the registrant's response should be clearly documented.

2) Access to Records

- **Ownership & Release:**
 - The record itself belongs to the denturist, but the information belongs to the patient.
 - Records are held in trust for the patient's benefit.

- Must be maintained in a form that allows access and copying (including electronic).
- Information may only be released with patient/legal representative consent, unless required by law.
- Signed written consent is recommended before releasing information.
- Originals must never be given; only copies should be provided to preserve integrity.
- **Right of Access:**
 - Patients may review or request a copy of their full record.
 - Requests should be in writing, with photo ID verification if needed.
 - Access may only be denied if it could harm the patient or a third party.
 - Embarrassment or fear of litigation is not valid justification for denial.
- **Documentation & Safeguards:**
 - Patient access must be recorded in progress notes.
 - Reviews should occur with a registrant/staff member present to explain terminology and protect record integrity.
 - Safeguards must prevent alteration, damage, or removal.
 - Reasonable duplication fees may be charged and must be documented in the financial record.
- **Special Cases:**
 - Dependent Adults: Access requests must be in writing, signed by the legal guardian, legally permitted, and recorded in progress notes.
 - Minors: Access requests must be in writing, signed by a parent/legal representative, legally permitted, and recorded in progress notes.

3) Disclosure of Records

- **Distribution/Sharing:** Patient information may only be shared with patient consent, for continuity of care, or as required by law.
- **Transfer:** Records may be transferred between practitioners only when legally required or during the sale of a practice.
- **Safeguarding:**
 - Records must be kept in environments that maintain integrity.
 - They must not be visible to the public or other patients.
 - They must not be left unattended in public areas.

4) Records Storage, Security & Retention

- **Physical Protection:**
 - Records must be safeguarded against hazards (e.g., fire, damage, loss).
 - Missing records may indicate poor management, carelessness, or intentional concealment.
- **Security of Records:**
 - Patient records must be protected from unauthorized access, modification, or destruction in compliance with privacy legislation.
- **Storage of Active Files:**
 - Records must not be left unattended in public areas.
 - Access restricted to authorized individuals only.
 - Staff should sign confidentiality agreements and be reminded of obligations when leaving employment.

- **Storage of Inactive/Archived Records:**

- Off-site storage must ensure security and integrity in a controlled environment with restricted access.
- Clinics must maintain a log of stored files and their location for tracking and reference.

- **Retention:**

- **Minimum Retention:** All patient records must be kept for at least 7 years after the last service, in a safe and protected environment.
- **Extended Retention:** Recommended beyond 7 years to meet legislative, insurance, hospital, business, tax, accounting, or legal requirements.
- **Special Situations:**
 - **Sale of a Practice**
 - Seller must inform the new owner of retention requirements and how much of the 7-year period has elapsed.
 - Patients should be notified of the sale, who holds their records, where they are stored, and contact details.
 - **Closure of a Practice:**
 - Records must still be retained for 7 years in a protective, accessible environment.
 - Registrar must be notified of closure and record storage location.
 - Patients should be informed of who holds their records, where they are stored, and how to contact them.
 - **Deceased Patients:**
 - Records must be retained for 7 years after last treatment.
 - Legal guardians should be notified of record storage location.
 - **Appointment Schedule Records:**
 - Appointment books or electronic schedulers must also be retained for at least 7 years.

5) **Records Destruction & Disposal**

- Records may only be disposed of after the retention period has expired.
- Disposal must ensure confidentiality is safeguarded.
- Approved methods include:
 - Returning records confidentially to the patient.
 - Physical destruction (e.g., shredding or incineration) through controlled processes, including bonded disposal services.
 - Rendering information permanently unidentifiable.
- Clinics must maintain a log of disposed files, including the date and method of disposal, at the clinic location.

6) **Recordkeeping for Unique Patient Situations & Appointment Management**

- **Refusal of Treatment/Referral:**
 - Record refusal in progress notes.
 - Obtain patient/legal representative signature when possible.
- **Dissatisfied Patient:**
 - Document all interactions and resolution attempts in progress notes.
 - If legal action is anticipated, seek advice from Professional Liability Insurance Provider and record related correspondence.

▪ **Termination of Treatment:**

- Record justification and steps taken to fulfill legal obligations.
- Complete ongoing procedures.
- Notify patient formally (e.g., registered mail) advising them to seek another practitioner; provide emergency care for two months.
- Copies of records may be transferred with written patient consent—originals must never be sent.

▪ **Appointment Schedule Records**

- Appointment schedules form part of the patient record.
- Must be retained for **at least 7 years**, ideally indefinitely.
- Hard copy or encrypted backup of electronic schedules should be maintained for security and accessibility.