

GUIDELINES

Issued February 2008*
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Dental Recordkeeping

*(Replacing those originally issued in June 1995 and reprinted in January 2002)

The Guidelines of the Royal College of Dental Surgeons of Ontario contain practice parameters and standards which should be considered by all Ontario dentists in the care of their patients. It is important to note that these Guidelines may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

INTRODUCTION

Professional, ethical and legal responsibilities dictate that a complete chart and record documenting all aspects of each patient's dental care be maintained. Patient records must be 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.



Royal College of
Dental Surgeons of Ontario

Ensuring Continued Trust

6 Crescent Road
Toronto, ON Canada M4W 1T1
T: 416.961.6555 F: 416.961.5814
Toll Free: 800.565.4591 www.rcdso.org

USE OF THIS DOCUMENT

These Guidelines are designed to help practitioners meet the legal requirements for dental recordkeeping. They also may have application in several areas of responsibility of the College regarding standards of practice and quality assurance. The statutory committees of the Royal College of Dental Surgeons of Ontario (RCDSO) that consider allegations of professional misconduct – Executive, Complaints and Discipline Committees – may use this document as a reference when considering a particular case.

It is important, therefore, that members of the College carefully read this document and take the necessary action to ensure that their dental record-keeping complies with the recommendations contained in these Guidelines. Once a practitioner has determined that the dental record form that is being used, or intended to be used, in the office does allow for the collection and retention of the required patient information, all that would be required to comply with the regulation is that the records be updated at subsequent appointments.

It is the College's opinion that practice guidelines should be sufficiently flexible to allow practitioners to exercise their judgement with respect to particular situations. Accordingly, the terms "appropriate" and "pertinent" have been used throughout these Guidelines to indicate where professional judgement is expected to be used.

RECORDKEEPING BASICS

The extent of the 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. However, certain baseline data should be common to all dental patients.

This information includes:

- accurate general patient information;
- a medical history 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;
- a record of the significant findings of all supporting diagnostic aids, tests or referrals such as radiographs, study models, reports from specialists;
- a diagnosis and treatment plan;
- a notation that informed consent was obtained from the patient for treatment and, where appropriate, such informed consent appears in writing;
- assurance that patient consent was obtained for the release of any and all patient information to a third party;
- a description of all treatment that is provided, materials and drugs used, and where appropriate, the outcome of the treatment;
- an accurate financial record.

GENERAL RECORDKEEPING PRINCIPLES

Patient records must provide an accurate picture of the conditions present on initial examination as well as the clinical diagnosis, treatment options, the proposed and accepted treatment plan, a record of the treatment performed, details about any referrals, and the prognosis and/or outcome of the treatment where applicable. 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 should be signed, initialled or otherwise attributable to 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:

- name
- address
- telephone numbers – home and work
- date of birth
- insurance information, if applicable
- name of the person or agency responsible for payment
- name, address and telephone number of the patient's primary care physician, if obtainable
- name and address of any referring health professional, if applicable
- emergency contact name and telephone number

MEDICAL HISTORY

A general medical history should be reviewed and initialled by the treating practitioner and dated at the initial examination. Some dentists may choose to have the patient or responsible adult sign the completed medical history. This history should be updated at regular intervals and this fact noted in the patient record.

In taking a medical history, dentists must ensure that all necessary and relevant medical information is obtained in order to allow for the provision of safe dental care now and in the future. In doing so, the following key areas must be addressed for all patients and both positive and negative responses recorded:

- presence of heart conditions
- ever had or been tested positive for any immuno-compromising disease

- any allergies
- a listing of all medications currently being taken
- details of past hospitalizations and/or serious illnesses, conditions or adverse reactions

It is important that the collection of necessary medical history information be done in a systematic manner. In determining, for example, if a particular patient has had any serious illnesses, conditions or adverse reactions that might impact on the provision of safe dental care, the following checklist may be helpful:

- history of infective endocarditis
- significant respiratory diseases, e.g. asthma, emphysema, tuberculosis etc.
- any known allergies
- peculiar or adverse reactions to any medicines or injections, e.g. penicillin, aspirin or local anaesthetics
- heart disease, heart attack, blood pressure problems or stroke
- epilepsy or seizures
- blood disorders, bleeding or bruising tendency
- endocrine disorders, e.g. diabetes
- cancer/radiation treatment/chemotherapy
- hepatitis A/B/C, jaundice, liver disease or gastrointestinal disorders
- kidney disease
- immuno-compromising diseases, e.g. HIV positive status, AIDS, leukemias etc.
- nutritional status/eating disorders i.e. anorexia nervosa, bulimia etc.
- any prosthetic joints
- pregnancy
- psychiatric disorders/treatment
- drug or alcohol dependency
- any other conditions or problems of which the clinician should be made aware

Any drug allergies, medical alerts or conditions pertinent to the patient's care should be conspicuously noted in the patient record.

Medical questionnaires, once completed, should be reviewed, dated and signed by the treating dentist and regularly updated.

Some practitioners may choose to have the completed medical history signed by the patient, parent or legal guardian.

CHOOSING A MEDICAL HISTORY FORM

In evaluating the medical history protocols and/or forms that are currently being used, or in choosing a new medical history system, it is important that there be sufficient space available for the recording and updating of relevant patient information.

If a medical questionnaire is used, it is important that the design allow for a positive/negative response to the various questions. By using such a format, the practitioner will be able to clearly demonstrate that the important questions were asked, and that a systematic review of the patient's past medical history and present state of health took place. The sample adult medical history questionnaire (Fig. 1) provided is as an example only of this format.

RECALL HISTORY

On a regular basis, the patient's medical history should be updated to ensure that the information remains accurate. One method is to have the patient review the information previously obtained and advise the dentist of any changes. Alternatively, the dentist may ask specific questions of the patient. In either case, the results of the inquiry must be documented in the chart records.

Appropriate questions could include:

- Has there been any change in your health, such as any serious illnesses, hospitalization or new allergies? If yes, please specify.
- Are you taking any new medications or has there been any change in your medications? If yes, please specify.
- Have you had a new heart problem diagnosed or had any change in an existing heart problem?
- When was your last medical checkup?
- Were any problems identified? If yes, please explain.
- **For women only:** Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?

FIG. 1 - SAMPLE ADULT MEDICAL HISTORY QUESTIONNAIRE

This form is available on the College's website at www.rcdso.org under the heading of Publications & Resources/Practice Resources.

MEDICAL HISTORY QUESTIONNAIRE**MEDICAL ALERT:**

NAME: MR./MISS/MRS./MS./DR.

DATE OF BIRTH (DAY/MONTH/YEAR): / /

ADDRESS (HOME):

PHONE:

ADDRESS (BUSINESS):

PHONE:

OCCUPATION:

WHO REFERRED YOU TO OUR OFFICE?

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME:

RELATIONSHIP:

DAY-TIME PHONE:

NAME OF FAMILY DOCTOR:

PHONE OR ADDRESS:

(1) NAME OF MEDICAL SPECIALIST:

AREA OF SPECIALITY:

PHONE OR ADDRESS:

(2) NAME OF MEDICAL SPECIALIST:

AREA OF SPECIALITY:

PHONE OR ADDRESS:

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?

☐ YES ☐ NO ☐ NOT SURE/MAYBE

2. When was your last medical checkup?

3. Has there been any change in your general health in the past year? If yes, please explain.

☐ YES ☐ NO ☐ NOT SURE/MAYBE

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.

☐ YES ☐ NO ☐ NOT SURE/MAYBE

5. Do you have any allergies? If you answered yes, please list using the categories below:

☐ YES ☐ NO ☐ NOT SURE/MAYBE

- a) medications
- b) latex/rubber products
- c) other (e.g. hayfever, foods)

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.

☐ YES ☐ NO ☐ NOT SURE/MAYBE

FIG. 1 - SAMPLE ADULT MEDICAL QUESTIONNAIRE (CONT'D)

7. Do you have or have you ever had asthma? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

8. Do you have or have you ever had any heart or blood pressure problems? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

10. Do you have a prosthetic or artificial joint? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

11. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

12. Have you ever had hepatitis, jaundice or liver disease? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

13. Do you have a bleeding problem or bleeding disorder? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain. ☐ YES ☐ NO ☐ NOT SURE/MAYBE

15. Do you have or have you ever had any of the following? Please check.

<input type="checkbox"/> chest pain, angina	<input type="checkbox"/> rheumatic fever	<input type="checkbox"/> pacemaker	<input type="checkbox"/> steroid therapy	<input type="checkbox"/> seizures (epilepsy)	<input type="checkbox"/> osteoporosis
<input type="checkbox"/> heart attack	<input type="checkbox"/> mitral valve	<input type="checkbox"/> lung disease	<input type="checkbox"/> diabetes	<input type="checkbox"/> kidney disease	medications
<input type="checkbox"/> stroke	<input type="checkbox"/> prolapse	<input type="checkbox"/> tuberculosis	<input type="checkbox"/> stomach ulcers	<input type="checkbox"/> thyroid disease	(e.g. Fosamax,
<input type="checkbox"/> shortness of breath	<input type="checkbox"/> heart murmur	<input type="checkbox"/> cancer	<input type="checkbox"/> arthritis	<input type="checkbox"/> drug/alcohol dependency	Actonel)

16. Are there any conditions or diseases not listed above that you have or have had? If so, what? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

17. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) ☐ YES ☐ NO ☐ NOT SURE/MAYBE

18. Do you smoke or chew tobacco products? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

19. Are you nervous during dental treatment? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

20. **For women only:** Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

To the best of my knowledge, the above information is correct:

PATIENT/PARENT/GUARDIAN SIGNATURE:

DATE:

DENTIST SIGNATURE:

DATE:

DENTIST'S NOTES

DENTAL HISTORY

In addition to clinical findings, the patient record must contain a notation of any significant dental history. Information obtained regarding a patient's dental history can supplement the clinical examination, and assist in the planning and sequencing of dental care that is necessary and appropriate to improve the patient's dental health status. As with the sample adult medical history questionnaire that appears in these Guidelines, the dental history questionnaire (Fig. 2) below is provided as an example only since it is possible to obtain an adequate dental history using a variety of formats.

CONFIDENTIALITY

If it is necessary to contact any other practitioner about a patient, consent, preferably written, must be obtained from the patient. Or, if you judge that the patient is incapable of granting consent, from a substitute decision-maker such as a parent, legal guardian or government-appointed advocate.

A record of any inter-practitioner communication, such as letters, notes of telephone conversations, reports, must be retained as part of the permanent patient record.

Dentists should also ensure that members of their office staff are aware of the confidentiality rules and need for patient consent regarding the release and transfer of any patient information and dental records to any third party.

FIG. 2 - SAMPLE DENTAL HISTORY QUESTIONNAIRE

> When was your last dental visit?	_____		
> When did you last have dental x-rays?	_____		
> How often do you brush your teeth?	_____		
> How often do you floss your teeth?	_____		
	YES	NOT SURE/ MAYBE	NO
> Have you been seeing a dentist regularly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> Do any of your teeth ache?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> Have you ever been advised to take antibiotics before dental appointments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> Do your gums bleed when you brush?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> Do you have any pain when you chew?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> Do you feel that you have bad breath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> Have you ever been in a vehicle accident or experienced any blows to your jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> Have you ever had any implant surgery in one or both of your jaws or jaw joints?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> If you answered "yes," to the last question, who performed the surgery and when was it done?	_____		
> Are you being followed up by a dental specialist?	_____		
> Please list anything else not mentioned above regarding your past dental history.	_____		

Records should be stored securely, not left unattended or in public areas of the office, and destroyed effectively at the end of the required retention period.

Impact of Privacy Legislation

On November 1, 2004, Ontario's Personal Health Information Protection Act (PHIPA) came into effect. All members must comply with the requirements of this legislation regarding records, and transfer and release of patient information. The College provided all members with a special publication called, *5 Easy Steps – The Guide for Dentists to Implement Ontario Health Privacy Requirements and Policies*, as a supplement to the October/November 2004 issue of *Dispatch*, the College's membership magazine. This document is available on the College's website at www.rcdso.org under the heading Publications & Resources/ Practice Resources.

Health information custodians are required to:

- Put in place information practices.
- Prepare and make available a written public statement about the custodian's information practices.
- Prepare a notice to post or make available describing the purposes of the custodian's collections, uses, and disclosures of personal health information.
- Designate a contact person to perform the functions set out in the Act. This is unnecessary if the custodian is a "natural person," for example an individual health-care practitioner, and is acting as the contact person.

- Ensure that employees and all other agents of the custodian are appropriately informed of their duties.
- Take reasonable steps to ensure personal health information in the custodian's custody or control is protected against theft, loss, unauthorized use, disclosure, copying, modification, and disposal.
- Ensure that personal health information records in the custodian's custody or control are retained, transferred, and disposed of in a secure manner and in accordance with the regulations.

For more details, please refer to the Personal Health Information Protection Act, 2004, and any regulations made under the Act at www.ipc.on.ca.

Patient consent, preferably signed, should be obtained for the release of any patient information to or the obtaining of any patient information from another dentist, the patient's physician or authorized representative. There may be situations where verbal consent is acceptable provided such consent is recorded in the patient record.

A record of any oral or written communication with the patient's primary care physician, medical specialist, previous dentist or dental specialist should be retained as part of the permanent file.

COMPREHENSIVE DENTAL EXAMINATION

The patient records should include chart recordings, written and/or electronic descriptions of the conditions that are present on examination of the patient. See Fig. 3. This information can be categorized as follows:

Extra-Oral Evaluation

Soft Tissue Evaluation

Dentition Evaluation

Vital Signs – The necessity of this information depends on the complexity of the dental treatment required, the medical history and present state of health of the patient, and whether or not sedation or general anaesthesia will be used.

Periodontal Evaluation – This may be carried out in two stages, namely a recognized periodontal screening examination for adolescent and adult patients [i.e. Periodontal Screening Record (PSR), Community Periodontal Index of Treatment Needs (CPITN)] and a complete periodontal examination for those whose screening results warrant in-depth follow-up.

Arch Relationship and Growth/Development Evaluation – Where appropriate.

As part of a complete oral examination, it is important to show in the patient record that each of these areas has been addressed during the examination. For those patients with little or no history of dental disease and a relatively healthy mouth, this can be accomplished with a notation such as “within normal limits” for most of the areas.

While the choice of patient record or chart form is left to the individual practitioner, it is important that there is sufficient space to record all relevant information and to update it whenever necessary.

The odontogram must be large enough to allow for the charting of all pertinent clinical findings. To allow for a permanent record of the patient's initial conditions, the charting of existing conditions should not be altered.

Changes in clinical findings noted at subsequent re-examination or emergency appointments should be recorded in writing in the patient records or noted on a separate odontogram.

FIG. 3 - SAMPLE CHART AND TREATMENT RECORD

POCKET DEPTH

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	DATE
4	4	5	4	3	3	3	3	3	2	3	3	3	3	3	3	1 29/3/05
																2
																3

FACIAL

FMC

POCKET DEPTH

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	DATE
4	4	5	4	4	3	3	3	3	3	3	3	3	3	3	3	1 29/3/05
																2
																3

CR

CR

MOBILITY (0-3)

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	DATE
																1
																2
																3

POCKET DEPTH

48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	DATE
4	4	4	5	4	4	3	3	3	3	3	3	3	3	3	3	1 29/3/05
																2
																3

FACIAL

POCKET DEPTH

48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	DATE
5	4	5	5	4	4	3	3	3	3	3	3	3	3	3	3	1 29/3/05
																2
																3

LINGUAL

MOBILITY (0-3)

48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	DATE
																1
																2
																3

Periodontal Screening

3	1	3
3	2	3

Sextant Score

27	03	05
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Day Month Year

Diagnosis & Clinical Findings

- heavily restored dentition
- moderate adult periodontitis (right molars)
- 36 temp
- 21 chipped DI
- Rt. mand. and max. molars
- 4-5 mm pockets

Treatment Plan

1. Full mouth periodontal charting
2. Scaling and prophylaxis
3. 21 DI comp
4. Scaling and root planing under L.A.
 - Rt. max. molars
 - Rt. mand. molars
5. 36 core buildup
6. 36 Crown (FMC or PFM?)
7. Check OH and re-evaluate molars

RADIOGRAPHIC EXAMINATION

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. This means that the number, type and frequency should be based individually for each patient's clinical signs, symptoms and past dental history. Radiographs should never be taken solely for administrative purposes.

Initial Examination for New Patients

- Where possible, previous radiographs should be obtained from other practitioners and these should be assessed before prescribing new radiographs.
- A clinical examination should be performed before prescribing radiographs to assess existing disease and the expected occurrence of disease.
- If indicated after these two points have been considered, it may be necessary to prescribe an appropriate radiographic survey to aid in making the initial diagnosis.

Recall or Returning Patients

- Radiographs should never be prescribed based on inflexible time periods alone, e.g. bitewing films every six months.
- Both the number and frequency of radiographs must be prescribed based on existing disease and the expected occurrence of disease.
- At recall appointments, a clinical examination should be performed before prescribing radiographs.

Patients Requiring Emergency Treatment

- In emergency situations, the minimum number of radiographs necessary to obtain an accurate diagnosis should be taken.

These general radiographic principles are in keeping with the ALARA principles (As Low A Dose As Reasonably Achievable) as outlined in the Healing Arts Radiation Protection (HARP) Act and the HARP Dental Guidelines.

RADIOGRAPHIC QUALITY

Radiographs are an important part of the patient record. They should be clearly labelled, dated, and be of acceptable diagnostic quality. The following factors may influence the diagnostic quality of radiographs:

- film fog
- stain, discolouration or foreign marks
- inadequate image density
- elongated or foreshortened images
- overlapping of interproximal surfaces
- inadequate view of the apex or apices

The number and type of radiographs prescribed for new patients should be appropriate to the age, oral health status and dental history of the patient.

The decision to take recall radiographs should be based on the patient's age, general or systemic condition, dental history and current status. Recall and/or post-operative radiographs should only be taken when judged necessary, not on a routine basis.

Whenever a patient, patient's guardian or authorized representative refuses recommended radiographs, such refusal should be noted in the patient record.

DIAGNOSIS AND TREATMENT PLANNING

The patient record should contain statements that identify the immediate need or chief complaint as presented by the patient; and, other than for emergency or single appointment situations, the overall condition of the teeth and supporting structures.

The **diagnosis** that has been made from a review of the baseline data that was collected and recorded during the clinical examination, supplemented by necessary radiographs and/or diagnostic study models and/or the results of any tests or consultations, should be recorded in the patient record.

The **treatment plan** should list the services to be performed for the patient and should be based on the medical and dental history, clinical examination and diagnosis. It should have as its objectives where possible:

- the achievement and maintenance of dental/oral health for that particular patient in his or her particular circumstances;
- the prevention or monitoring of malocclusion;
- the prevention of recurrent disease and future degenerative changes.

The treatment plan should be supported by a complete and accurate clinical record and take into account the relative urgency and severity of the patient's condition. Treatment alternatives should be discussed.

For extended or complex treatment, the treatment plan should also include a schedule of visits, estimated timeline, and provide a brief description of the services to be performed at each appointment. Any conditions that are being monitored should be noted, as well as the fact that the patient was informed accordingly. The extent to which the patient has accepted or rejected the recommended treatment should also be recorded, where applicable.

INFORMED CONSENT

Informed consent is based on the right of each person to determine what will be done to his or her own body. Informed consent guarantees each person the right to refuse treatment, to consent to treatment, and to withdraw consent to treatment.

Consent may be either implied or express. Implied consent is usually ascertained by the actions of the patient – as with the patient who opens his or her mouth for an examination. Express consent may be oral or written.

Informed consent is not an event or specific form but rather an ongoing dialogue with your patients that begins at the first visit to the office and continues as treatment progresses.

Implied consent may be sufficient if:

- The patient voluntarily comes to the dentist's office.
- Simple examinations or non-invasive procedures pose no risk of harm to the patient.

Express consent should be obtained when:

- The procedure is beyond a simple examination or procedure, e.g. oral surgery, extraction or bridge work.

Guidelines for Obtaining Express Consent

- The standard for obtaining informed consent used to be what a reasonable prudent practitioner would disclose. In the early 1980s, the standard changed to a more patient-centered view. Now, the standard is what a reasonable person, in the patient's position, would need to know to make a decision. This makes it imperative that dentists know their patients and that they tailor the information that is provided to the needs of each particular patient.

- In order for consent to be informed, the dentist must provide the patient with certain information: the diagnosis or problem noted, nature and purpose of the proposed treatment, the risks and benefits of the proposed treatment, the treatment alternatives available (not just the ones that the dentist provides), the likely consequences of not having the treatment, and the cost of each option.
- The dentist should be certain that the patient has consented to the procedure(s).
- Although both oral and written consent are legally acceptable, oral consent should be confirmed in writing where risks are significant.
- Regardless of whether the patient consents in writing or orally, the dentist should keep a record of the nature of the conversation, the information provided, and the patient's decision.

Other Significant Consent Information

- There is no age of consent in Ontario. If the dentist is of the opinion that a patient is capable of providing his or her own consent, then the dentist can rely on that consent.
- A legal guardian or other substitute caregiver must consent to dental procedures for incompetent patients or children, who are not capable of understanding information that is relevant to making a decision about the treatment and not able to appreciate the reasonable foreseeable consequences of a decision or lack of a decision.
- Consent is not required in emergency situations defined under the Health Care Consent Act, 1996, as circumstances where the patient is apparently experiencing severe suffering or is at risk of sustaining serious bodily harm if the treatment is not administered promptly.

PROGRESS NOTES

Progress notes describe the treatment rendered for the patient. They should be well-organized, legible (handwritten, typewritten or an acceptable electronic format), and provide a complete and comprehensive description of the patient's ongoing care. They should also indicate the reason for the particular treatment, if it is not apparent from the record, i.e. loose or fractured restoration, and the tooth/teeth or area of the mouth being treated. It is also advisable to record on the patient record whenever a discussion of possible limitations of treatment was held with the patient.

The progress notes for each visit should provide a concise and complete description of all services rendered and include:

- the date of treatment;
- the treating clinician's identity;
- the type and quantity of local anaesthetic used;
- the materials and methods used;
- any other drugs that are prescribed, dispensed or administered and the quantity and dose of each;
- all recommendations, instructions, advice given to the patient and any discussion with the patient regarding possible complications and/or outcomes.

As care is provided to the patient, circumstances may change and require alterations to the initial and/or recommended treatment plan. Such alterations should be clearly documented, along with a notation that they were discussed with and agreed to or declined by the patient.

FIG. 4 - SAMPLE CLINICAL RECORD

Date	Clinical Record/Treatment Performed
March 15/05	New pt attends for emerg exam. Pt says pain LL quad to H + C for 1 mos, short/sharp, occ to biting. Pt points to 36. Med hx OK. EO/IO tissues WNL. 36 MOD amalgam fx @ distal. Perc/palp -ve. EPT = 45 (46 control = 60). DL pocket = 4 mm. 1 BW + 1 PA taken, demo deep distal decay, but no PA radio. Rec temp for today, but pt adv may need RCT or ext. LA = 1.8 ml lido, 1:100. Decay removed + pinpt exposure @ DL. Placed CaOH + IRM. Pt adv re exposure and call if pain persists. Pt to return for complete exam (booked). Last dental visit = 3 yrs and FMX was taken. Pt signed request for copies of records from prev dentist (Dr. Brown). J.D., DDS
March 23/05	Pt called in morning for appt same day → says LL constant throbbing pain, awake all last night. Disc pros/cons/costs 36 RCT vs. ext. Pt wants RCT and aware will need crown. LA = 3.6 ml lido, 1:100. RD applied, access and instr ML and D canals to #15 @ 21 mm, irrig w RC prep and NaOCl, 1 PA taken. File separated MB canal and pt adv. Rec referral to endo to remove file and complete RCT. Pt adv if cannot remove file, may need surg. Pt agrees. Refer to Dr. Percha. J.D., DDS
March 24/05	Called pt → says RCT went well, feels much better now, has 2nd appt w Dr. Percha for obt, will keep appt for complete exam. Mary Brown
March 27/05	Complete exam. Charting and PSR done. 1 BW + 6 PA's taken. Heavily restored dentition, but no decay and serviceable. OH only fair. Disc dx/tx plan, incl costs. Pt aware of perio concerns and will return for full mouth perio charting and initial scaling w J.W. Pre-determination for 36 PFM crown sent to ins. J.D., DDS
March 29/05	Complete perio charting. 3 u scaling + 1/2 u polish by standing order. Mod calc/bleeding, esp UR + LR molars. OH re brushing tech (modified Bass) + floss (showed w mirror). J.W., RDH
April 3/05	36 RCT completed by Dr. Percha → nice fill! Pt says tooth comfy now. No LA. 36 amalgam core + 1 pin @ DL. Reminded re crown → pt wants tooth coloured, aware ins. only covers metal, agrees to cover diff. J.D., DDS
April 17/05	2 u scaling/root planing LR molars w LA (1.8 ml lido, 1:100 given by J.D.). ↓ plaque/bleeding. OH improved, but stressed daily floss. J.W., RDH
April 24/05	21 DI comp. LA = 1.0 ml lido, 1:100. a-e, Scotchbond MP, Z100 A2. J.D., DDS 2 u scaling/root planing UR molars w LA (1.0 ml lido, 1:100 given by J.D.). LR tissues much better now. J.W., RDH
May 3/05	36 prep PFM crown. LA = 1.8 ml lido, 1:100. Md Reprosil, mx alg, bite reg w Blu-Mousse, shade D3. Temp w ProTemp and TempBond. J.D., DDS
May 10/05	36 insert PFM crown. No LA. Try-in → margins + contacts excellent, sl adj to occl. Pt okay w shade. Cem w Fuji. Pt to return for perio check in 3 mos. J.D., DDS
Aug. 11/05	Missed appt. Called pt → says slept in, very sorry. Rebooked appt for next week. Mary Brown
Aug. 17/05	Perio check. All pockets ≤ 3mm, except 47 ML = 4mm. OH good → min plaque/bleeding. Again stressed daily floss. 2 u scaling → lt calc, lgly md ant. Okay 6 mos. Pt asks about veneers 11/21 → gave info sheet and adv to disc w J.D. if interested. J.W., RDH
Feb. 21/06	Recall exam w J.D. MH no Δ's. EO/IO tissues WNL. OH good + flossing most days → min plaque/calc. All pockets ≤ 3mm. No decay obs + 36 very comfy. J. D. disc info sheet + pros/cons/costs re veneers → pt says can't @ this time as no \$. 2 u scaling + 1/2 u polish. Okay 6 mos. J.W., RDH

Helpful Tips for Chart Entries

- When composing chart entries, adopt a methodical style. For example, the individual steps for each service may be documented in the order that they were performed.
- Abbreviations and short forms are commonly employed for brevity. This is an acceptable practice, but they should be easily decipherable and used in a consistent fashion.
- For various reasons, many dentists rely on office staff to document their chart entries. This too is an acceptable practice, but the dentist should review each entry for accuracy and completeness to ensure that it captures the necessary information.
- Any complication and/or adverse outcome should be well documented. The chart entry should specifically note the patient was advised about the incident and the available options to address it.

The sample clinical record (Fig. 4) contained in these Guidelines shows examples of the minimum level of detail required in the progress notes.

REFERRAL DOCUMENTATION

Notations of referral to a specialist, as well as copies of any reports/correspondence to and from specialists should be kept on file. A summary of any oral conversations with another dentist or specialist about a patient should also be noted in the chart.

A patient's consent must be obtained before his or her dental conditions and/or treatment needs are discussed with any third party.

It is also important to record patient refusal of a referral recommendation.

PATIENT FOLLOW-UP AND RECALL EXAMINATIONS

It is advisable to have a systematic notification procedure for the ongoing care of patients, especially as it relates to the completion of treatment, post-operative checks and treatment follow-up. The recommended return date, if applicable, should be noted on the chart. It is also advisable to keep a record of missed appointments or cancellations. When patients are seen on a recall or episodic basis, the chart entries should include:

- the type of examination conducted (recall, emergency, specific area);
- a notation that the medical history was reviewed and/or updated;
- the findings of the examination;
- the details of any treatment recommended and rendered.

ELECTRONIC RECORDKEEPING

The use of electronic recordkeeping by dentists, including digital radiography, has grown substantially in Ontario, and the sophistication of hardware and software has also evolved significantly since the College's Guidelines on Dental Recordkeeping were originally issued in June 1995. 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

The proposed regulations on prescribed records passed by the RCDSO Council in February 1995, and addressed in detail in the College's Guidelines on Dental Recordkeeping, allow dentists to make and keep records in an electronic computer system.

When it comes to accuracy, the most important feature of electronic recordkeeping is an audit trail so that 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.

It is important that any electronic recordkeeping system employed in a dental practice:

- Has a login and password to access the data, or otherwise provide reasonable protection against unauthorized access, and can authenticate all entries.
- Provides an accurate visual display of the recorded information and is capable of retrieving and printing this information within a reasonable time period.
- Has the ability to maintain or has an audit trail which:
 - Preserves the original content of the recorded information (text, image or chart) in a read-only format, when changed or updated, and when doing so tracks the author, time, date, and workstation (for networked systems) of the modification.

- Records the author, time, date, workstation (for networked systems) of each entry for each patient in respect to the financial or clinical data entry, and is capable of being printed separately from the recorded information for each patient.

- Provides a means of access to the clinical and financial records of each patient by patient name and is easily printed or transferred in its entirety, with the inclusion of all of the original and modified entries, and the dates, order of entry and authors.
- Is capable of visually displaying and printing the read-only recorded clinical and financial information for each patient in chronological order and can print this information without unreasonable delay.
- Stores the original data in a read-only format from within the dental program itself, but protects the data files from entry and alteration from the database.
- Backs up files on a removable media and allows the data recovery or provides by other means, reasonable protection against loss, damage, and/or inaccessibility of patient information.
- Ensures the privacy of the patient's personal information is properly safeguarded in both the electronic recordkeeping and in the transfer of the patient's records.

The dentist and/or user staff also need to be properly trained and have technical competence with the computer program.

Summary

The College believes that it is important to address the effects and impact of technological changes on dental recordkeeping. These Guidelines are designed to provide assistance to members and comfort to the public that personal and other information of patients maintained in dental practice has the protection of the appropriate principles of accuracy and confidentiality.

FINANCIAL RECORDS

Another important facet of the patient record relates to financial arrangements. It is prudent to include in the patient record a note or notes about the financial arrangements and agreements made with the patient and/or guardian concerning the settlement of accounts.

The financial record for each patient must include:

- a copy of any written agreement with a patient;
- the date and amount of all fees charged;
- the date and amount of all payments made;
- an itemized listing of all commercial laboratory fees that were incurred in respect to prosthetic, restorative or orthodontic services;
- copies of all dental claim forms for the preceding two years.

If dental treatment is provided for a patient on a basis other than fee-for-service, or where the responsibility for payment is with a person other than the patient or patient's guardian, you should be aware of the following recordkeeping requirements. Any such agreement with a patient must:

- be in writing;
- be maintained as part of the patient record;
- identify the person or persons entitled to dental services under it;
- the dental services to which they are entitled;
- state the period of time it will be in force;
- specify the obligations of the parties in the event the member is unable to provide covered services, including the obligations to make further payments and the application of payments that were previously made.

If payments for dental services are made on behalf of a patient by a third party, the financial record must include the identity of the person or agency making such payment (XYZ Insurance Company, Workplace Safety and Insurance Board, local welfare agency, CINOT etc.).

RETENTION OF DENTAL RECORDS

In general, clinical, financial and drug records, and radiographic and consultant reports that are made in respect to an individual patient must be maintained for at least 10 years from the date of the last entry in that record. In the case of a minor, these records must be kept for at least 10 years after the day on which the patient reached the age of 18 years. This includes appointment records, lab prescriptions and invoices.

Two exceptions to this requirement involve working models and copies of dental claim forms.

FIG. 5 - SAMPLE DRUG REGISTER FOR NARCOTICS, CONTROLLED DRUGS, BENZODIAZEPINES AND TARGETED SUBSTANCES

Drug:	TYLENOL® NO.3	DATE	PATIENT	QUANTITY	BALANCE
Purchase Date:	April 1, 2007	2/4/07	J. Brown 23 North Street	12	88
Purchased From:	DrugRite Pharmacy, Main and Centre Streets	15/4/07	K. Green 14 South Road	8	80
		3/5/07	P. White 1 East Lane	10	70
Invoice #:	94-32411 (\$24.00)	10/6/07	B. Green 28 West Street	12	58
Quantity Purchased:	100 tabs	15/7/07	T. White 35 Centre Road	12	46

1. 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 judgement of the individual practitioner. Diagnostic or study models are considered part of the permanent patient record and must be kept for the period prescribed by the regulations.
2. Copies of dental claim forms must be maintained for at least two years from the date the claim was provided to the patient or submitted on the patient's behalf. An electronic copy of claim forms on a properly backed-up system would be acceptable. Other material from insurance companies, e.g. predeterminations and cheque stubs, are not required to be retained but often are useful until final settlement of account.

access. A drug register must record and account for all narcotics, controlled drugs, benzodiazepines and targeted substances that are kept on-site. The register should also be kept in a secure area in the office, preferably with the drugs.

- Whenever drugs in the above-mentioned classes are used or dispensed, a record containing the name of the drug, number dispensed, name of the patient and date should be entered in the register. Each entry should be initialled or attributable to the person who made the entry. In addition, this same information should be recorded in the patient record along with any instructions given. See Fig. 5 above.
- Prescription pads should never be pre-signed. They should be kept out of reach of patients, prospective patients or visitors to the office.

DRUG RECORDS

- Dentists must take adequate steps to protect narcotics and controlled drugs in their possession from loss or theft. It is recommended that narcotics and controlled drugs be kept in a locked cupboard out of sight and reach of patients or prospective patients. Dentists must store benzodiazepines and targeted substances in a place used for the purpose of conducting their professional practice and in an area in that place where only authorized employees have

Drugs may only be provided or dispensed to dental patients of record and for dental conditions being treated and according to accepted dispensing protocols.

There is no provision for dentists or their staff, professional or non-professional, to access in-office supplies of narcotics, controlled drugs or other drugs that normally require a prescription, for their own personal use or use by their family members.



**Royal College of
Dental Surgeons of Ontario**

Ensuring Continued Trust

6 Crescent Road
Toronto, ON Canada M4W 1T1
T: 416-961-6555 F: 416-961-5814
Toll Free: 1-800-565-4591
E-mail: info@rcdso.org www.rcdso.org