Clinical examination & record-keeping: Part 1: Dental records

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In brief

Describes what constitutes dental records.

Discusses the statutory requirements pertaining to dental records.

Highlights the importance of security in dealing with and storing patient records.

This article forms part of a *BDJ* series of Practice papers on the subject of clinical examination and related record keeping. The series is taken from the Faculty of General Dental Practice UK (FGDP[UK]) 2016 Good Practice Guidelines book on this topic, edited by A. M. Hadden. This particular article, the first in the series, describes what constitutes dental records. The principles are applicable to electronic and handwritten records. Records will fall below acceptable standards when it is not clear to another clinician what was found, planned, discussed, and what treatment carried out.

Introduction to FGDP(UK) guidelines

Guidelines are systematically developed statements designed to assist the clinician and patient in making decisions about appropriate healthcare for specific clinical situations. They are not intended to be a rigid constraint on clinical practice, but rather, a description of the general approach against which the needs of the individual patient can be considered. These guidelines, for clinical examination and associated record-keeping, are intended to help practitioners assimilate, evaluate and implement the ever-increasing amount of evidence and opinion on how dentistry should be practised and recorded.

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Clinical Examination & Record-Keeping*

Part 1. Dental Records

Part 2. History Taking

Part 3. Electronic Records

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Guidelines are often used by dental advisers and experts, in courts and/or General Dental Council (GDC) Fitness to Practise proceedings, for defining a required standard. However, it is important to emphasise that the purpose of these articles (and in the FGDP[UK] CERK book) is to promote good clinical examination and relevant record-keeping aimed at enhancing clinical performance.

Throughout this series (and of course the associated book), the specific guidelines will be marked as follows:

A: Aspirational
B: Basic
C: Conditional.

- **A** recommendations represent the 'gold' standard. Anything graded A is included for completeness, but is not essential
- **B** recommendations represent basic or baseline information that should normally be recorded, or actions that should normally be undertaken, unless in the clinician's opinion there is a strong clinical reason for not doing so. In such an instance the clinician should record details of their rationale in the patient record
- **C** recommendations do not apply in every circumstance. Where they are relevant, actions labelled C should be considered to be B grade actions. In all other circumstances no action is required.

These guidelines cover the collection and recording of information which enables a diagnosis to be made and then allows appropriate treatment options to be discussed with a patient enabling them to choose a treatment plan or, sometimes, make a decision to refer for care. These guidelines should inform the clinician; however, they are not a substitute for professional judgement.

Please note that each clinical discipline has its own record-keeping requirements, which the guidance introduces but does not detail.

It is hoped that clinicians will review their current practices against these guidelines and, if necessary, modify their practice to ensure better patient care.

For more detailed information on the FGDP (UK) Guidelines discussed in this series, please see chapter 1 of the Clinical Examination & Record-Keeping (CERK) book which can be found online at: https://www.fgdp.org.uk/publication/clinical-examination-and-record-keeping-0.

What constitutes dental records?

Records comprise

- Personal information

- Medical history
- Note of initial discussion with patient (reason for attendance)
- Charting
- Examination notes (including findings from special tests/investigations etc)
- Radiographs
- Photographs
- Study models
- Audiovisual recordings
- Note of diagnosis
- Treatment options, discussion with patient, and treatment options offered but declined
- Evidence of consent
- Treatment plan
- Treatment notes (including sedation notes, anaesthetic charts, etc)
- Laboratory prescriptions
- Prostheses, statements of manufacture (medical device certificate and patient statement)
- Correspondence (incoming and outgoing)
- Payment history.

Files of formal complaints made by patients and other bodies

Details, such as documents relating to a patient complaint, should be kept in a separate file, and referenced in the clinical notes (eg 'see complaints file'). As this is beyond the scope of this book, the reader is advised to contact their indemnity organisation for further details about maintenance and retention of a patient's complaint file.

Other files/documents not regarded as part of the 'dental records'

- Medical reports, eg for insurance cover
- Medico-legal report for purpose of litigation eg negligence claims or GDC proceedings
- Correspondence with solicitors
- Correspondence with indemnity organisation/insurer.

These are prepared from information in the records, and may be supplemented by additional interview with the patient. They will often contain opinion about treatment and/or cause of injury, and the report is confidential between the party instructing the report and the clinician.

Basic information about records

All records should be written contemporaneously, and be accurate, complete, logical, clear, concise, legible, and easily understood by a third party. They should be made in ink or ballpoint pen in a colour that can be reliably scanned or photocopied. It should be possible to identify the person carrying out the consultation or treatment, and relevant support staff.

If errors in records are identified, appropriate amendments should be made to the record, and annotated to clearly indicate the amendment. Errors on paper should be scored out using a single line and initialled. The corrected entry should be written alongside it, dated, timed if appropriate (eg If the error is discovered on the same day that the original entry was written), and signed. Any additions should be made as separate entries, and should be dated and cross-referenced to the original note they replace. For electronic records, it may be possible to make an amendment correcting any errors before the entry is locked in the system prior to 'backup'. If that is not possible, then an entry should be inserted as soon as any error is discovered, drawing attention to the original entry and error.

To summarise:

- Be factual, consistent and accurate
- Write legibly in ink that can be accurately scanned and copied
- Date, time (where relevant) and sign all entries ensuring the clinician is identifiable
- Print your name and designation where such additional clarification is necessary to distinguish the clinician from other individuals
- Make any alterations by scoring out with a single line; date, time and sign
- Avoid abbreviations unless there is a previously agreed list
- Demonstrate the chronology of events
- Identify each page with the patient's name, date of birth and unique number (NHS number, CHI number, etc)
- Secure all papers within the record folder
- For electronic records, the same principles apply. See Part 3 of this series (or chapter 8 in the FGDP[UK] book) for further information.

Box 1 Remember

Good record-keeping is an integral part of your professional practice and a mark of the skilled and safe clinician. It is important to record the salient points of any visit or consultation.

Statutory requirements

Information on the records is personal to a patient and is therefore confidential. Patient access to records is enshrined in law, and statutory requirements include:

- Data Protection Act 1998 (DPA98)[1]
- Access to Health Records Act 1990[2]
- Access to Health Records (Northern Ireland) Order 1993[3]
- Freedom of Information Act 2000[4]
- Freedom of Information (Scotland) Act 2002.[5]

The Data Protection Act 1998 (DPA98)

This Act governs how public bodies may handle and process personal data, including health records (dental practices are classified as public bodies under the Act, whether they are NHS or private). It provides that where personal data is held, it must be:

- Fairly and lawfully processed
- Obtained only for a specified and lawful purpose
- Adequate, relevant and not excessive in relation to the purpose for which it is processed
- Accurate and up to date
- Not kept for longer than is necessary for the stated purpose
- Processed in accordance with the patient's rights
- Stored securely
- Not transferred to another country which does not offer an adequate level of data protection.

DPA98 also gives patients the right to apply for access to any information held about them. Any request should be in writing and, on receipt of such a request and any applicable fee, the relevant data (copy of records) should be forwarded to the applicant within 40 calendar days. The applicant is not required to give a reason for the request. The practitioner is advised to retain the original records.

When a third party, such as a patient's solicitor or a relative, seeks access to the information, the request must include a mandate signed by the patient authorising release of the information.

There are circumstances in which a request may be refused, and the Act also provides for a number of exemptions. A comprehensive guide to data protection is outside the scope of this book. Readers are advised to consult their indemnity organisation for further advice should a request for records be received where

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the clinician is concerned that they have potential vulnerability to complaints or a claim.

Access to Health Records Act 1990, and Access to Health Records (Northern Ireland) Order 1993

These only apply to records of deceased patients. If a request is received, advice should be obtained from your indemnity organisation or insurers.

Freedom of Information Act 2000, and Freedom of Information Act (Scotland) 2002

These Acts place obligations on public bodies to release information to the public, and NHS dental practices are considered public bodies under Freedom of Information Act (FOIA) as they are publicly funded. However, it should be noted that FOIA relates to government activity only, and personal information about patients or employees must be kept confidential. Several other exceptions apply under the Act, and readers should seek advice from their indemnity organisation.

Box 2 Scenario

Note recording of an adverse event, and records retention

The dentist was surprised to receive a letter from solicitors about a patient whom he had not seen for at least 10 years. The solicitors sought the record cards, and alleged that there would be a claim in negligence for fracturing an endodontic file and leaving it within a tooth during root canal treatment.

The patient had recently attended a dentist, as she had an abscess from a tooth, upper left 4. The new dentist had taken a radiograph and seen that within the radiopaque root filling material there were what appeared to be the remnants of a broken instrument in the tooth. He had informed the patient (wrongly) that this was the cause of her symptoms.

The dentist who had received the solicitor's letter had long since removed this former patient's records from his record stock, and stored it elsewhere. It was retrieved, and when he checked the records he was relieved to see there was a full account of the difficulties with carrying out the root treatment. His notes confirmed that part of a file had 'become separated' within the canal, and that despite his attempts to remove it, he had been unable to do so. The patient had been fully informed of the situation, and advised of several treatment options, which included specialist referral, or filling the root canal system as well as possible and monitoring the situation, or extracting the tooth. All this had occurred 12 years earlier. The records confirmed the patient opted to have the dentist fill the root canal system as well as possible. They also recorded she had returned on several occasions during the subsequent two years, and noted there were no symptoms from upper left 4.

A patient has three years from the date of any incident, or from the date of knowledge of any incident, in which to raise a negligence claim. In this case, the patient's solicitors had taken the date of knowledge as the time of the patient's recent attendance at a new dentist who had commenced treatment of the abscess, as the patient had forgotten about the tooth being previously root treated. The records showed that the date of knowledge was a considerable time earlier, and the claim could not be pursued.

Summary

If something untoward happens during treatment it is important that this is noted on the records, including that the patient has been informed. The records should be adequately complete to allow full recollection of the incident by the dentist. In this case, it was clear that the patient had been fully informed and advised of her treatment options. Records should ideally be retained for up to 30 years, and for a minimum of 11 years after the completion of treatment.

Confidentiality

All patients are entitled to confidentiality, and it is therefore essential that all members of the dental team understand the importance of this duty. A confidentiality statement should be included in staff employment contracts. There are many instances when confidentiality can be breached unintentionally, such as telephoning to change an appointment and leaving a message with a third party, or discussing personal information in the waiting room in front of other patients. It is vital that all information maintained is kept confidential. Team members must ensure that they are familiar with current guidelines published by the Department of Health[6] and the General Dental Council.[7] There are some rare circumstances where confidentiality must be breached, for example where safeguarding issues have arisen or where it is necessary for the detection and investigation of a serious crime. It is wise to discuss any situation where there is a need for a deliberate breach of confidentiality with your indemnity organisation.

Retention of records

The Data Protection Act states that records should be 'not kept longer than is necessary'.[1] The Department of Health guidance suggests this is no longer than 30 years.[8] For adults it is recommended that treatment notes, radiographs, study models and correspondence be kept for minimum of 11 years after the completion of treatment. For children, records should be retained until the patient is 25 years old, or for 11 years after the completion of treatment, whichever is longer.[9] It is recognised that there are often practical difficulties in storing study models or working models, surgical guides or wax ups, and it reasonable to make a decision to retain these for a shorter period of time. It would be prudent to consider retaining models where complex treatment (eg restorative, implant or orthodontic) has been carried out, or if treatment has not gone to plan; initial and final models should then be retained as a minimum.[9]

The scenario provided in Box 2 demonstrates why records should be accurate and retained.

Security of records

Patient records, whether paper or electronic, must be stored in a manner that protects their security.[10] The security of electronic records is considered in Part 3 of this series (or chapter 8 of the FGDP[UK] book).

Records must be secured against unauthorised access. For paper records this would require the use of lockable storage, in an area that is not accessible to the public without staff supervision. This also means that records should not be left out in a surgery overnight where they can be viewed by anyone entering the building out-of-hours. Archived records held off-site should be in lockable storage within a lockable area of a secure archive storage facility.

Security of communications

All communication channels have security vulnerabilities. As a general principle, the more open the communication channel, the less information you should send. The clinician must assess the risks associated with any form of communication and restrict the patient data sent, accordingly. Ideally you should reach an agreement with each patient about which channel(s) of communication you may use for confidential information. This agreement should be documented in the record.

For example, confidential personal data should not be included within the subject line or body of an email message without permission. You should bear in mind that an email to

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a patient's work or family email address may be seen by any number of people who have access to that patient's inbox. When dealing with voicemail, you should be aware that family members may listen to the messages left. Therefore it is best practice to simply leave a message inviting the patient to return your call. Letters to a patient should be marked 'Private and Confidential' and addressed to the individual patient concerned. This is particularly important when sending treatment planning letters and estimates. Letters of referral which inevitably contain significant personal medical and dental information should be marked in the same way.

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3. Access to Health Records (Northern Ireland) Order 1993. Available at www.legislation.gov.uk/nisi/1993/1250 (accessed November 2017).
4. *Freedom of Information Act 2000*. London: HMSO, 2000. Available at www.legislation.gov.uk/ukpga/2000/36 (accessed November 2017).
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6. Department of Health. *Good practice in consent implementation guide: consent to examination or treatment*. London: DH, 2001. Available at www.dh.gov.uk/consent (Accessed December 2015).
7. General Dental Council. *Standards for Dental Professionals*. London: GDC, 2005.
8. Department of Health. Records Management: NHS Code of Practice Part 2, Annex D1. London. DH. 2009. www.gov.uk/government/uploads/system/uploads/attachment_data/file/200139/Records_Management_-_NHS_Code_of_Practice_Part_2_second_edition.pdf.
9. Advice from Medical and Dental Defence Union of Scotland (MDDUS).
10. https://digital.nhs.uk/data-security-information-governance.

Faculty of General Dental Practice - Good Practice Guidelines

The Faculty of General Dental Practice (FGDP[UK]) provides evidence-based guidance and standards for the whole of the dental profession in order to promote high quality practice and patient care. Their publications are available in variety of formats including hard copy, e-books, and free of charge online as part of the Open Standards Intiative.

Clinical Examination and Record-Keeping is a complete reference guide to record-keeping and examination, and is available in hard copy and free of charge online. The hard copy includes scenarios to put the guidance into context, as well as a series of extensive appendices, diagrams, charting notes and template forms which dental and professionals may adopt for use in their practice.

The FGDP(UK) published its newest guidelines, Dementia-Friendly Dentistry: Good Practice Guidelines in October 2017.

For more information about all FGDP(UK) standards and guidance, visit: www.fgdp.org.uk/guidance-standards

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