



POLICY AND PROCEDURE: POLICY NO. #22

DENTAL RECORDS

References:

Privacy Act 1988 (Commonwealth) and associated National Privacy Principles
Health (Drugs and Poisons) Regulation 1996
Powers of Attorney Act 1998
Freedom of Information Act 1992
Guardianship and Administration Act 2000

Scope:

This Policy and its Appendix document the Dental Board of Queensland's (the Board's) expectations with respect to recording, use and maintenance of dental records by dental practitioners (dentists, dental specialists, dental therapists and dental hygienists) as well as defining what constitutes a dental record.

Dental practitioners should ensure that all aspects of record keeping comply with the principles espoused by and the legislation referred to in this Policy and its Appendix.

Background:

An accurate record of each patient encounter is an essential part of the practice of dentistry, enabling complete delivery of care by all treating clinicians. Dental records are necessary for forensic patient identification, for evidentiary use in the case of disputes and as a repository of valuable information that forms the foundation for teaching, education and research.

Requirements:

The following topic areas cover minimum expectations of the standard to which an informed and competent dental practitioner will record, use and maintain records. Detail on each topic area can be found in the Appendix to this Policy.

- What constitutes a dental record
- The way in which information is recorded
- Initial charting
- Recording of subsequent treatment
- Recording of treatment on referral
- Recording of patients seeking emergency care
- Obtaining and recording consent for treatment
- Privacy Act 1988 (C'wth)
- Health information
- National Privacy Principles
- Advice to patients about information collection
- Consent to collect, use or disclose health information
- Ability to collect information without consent
- Restrictions on the collection of information
- Use of health information
- Prevention of breaches of data security
- Use of standardised forms
- Obligation to provide access to dental records
- Granting patients access to their health information
- Handling a patients request for information
- Treating patients anonymously
- Retention of dental records
- The duty to keep patient information confidential

Non-compliance:

The Board may take disciplinary action against dental practitioners who fail to comply with this policy.

Approval Date: 5 August 2008

Review date: August 2010

Appendix to Dental Board of Queensland Policy #22 Dental Records

This appendix is designed to be read in conjunction with the Dental Board of Queensland Policy # 22 'Dental Records'. It provides expanded information on topic areas specified within the Policy.

1. What constitutes a dental record?

All of the following whether kept physically or electronically constitute a dental record:

- Notes made by dental practitioners, other clinicians and staff;
- Completed medical history questionnaires;
- Consent documents obtained for treatment;
- Copies of correspondence relating to the patient;
- Radiographs, tracings and measurements;
- Diagnostic casts;
- Special test findings;
- Photographs;
- Records of financial transactions;
- Any treatment advice that the patient was unwilling to accept;
- Drugs prescribed or administered (name, quantity, dose, instructions);*
- Unusual sequelae to treatment reported by patient;
- Estimates or quotations of fees;
- Relevant comments by patients on concerns over offered treatments;
- Any comments or complaints by patients about treatment provided; and
- Annotations by staff following telephone conversations.

(* Refer to the Health (Drugs and Poisons) Regulation 1996.)^a

a Legislation is available at www.legislation.qld.gov.au

2. The way in which information is recorded

- Dental records should be legible, accurate and concise. They should be readily understood by any third party (particularly another dental practitioner) accessing the record.
- The dental record should identify the person about whom it is written and include surname, given name(s), date of birth, gender, address, telephone number and parent or guardian details for minors or other patients under a legal disability.
- For each entry in a dental record, the person making the entry should be easily identifiable.
- Entries should be made in chronological order.
- All comments should be couched in objective, unemotional language.
- The record should contain an adequate medical history which is updated regularly.
- The record should contain the patient's medical practitioner's name and contact details.
- The record should describe the presenting complaint, relevant history, clinical findings and diagnosis.
- The record should list the date of each visit and note any appointment which the patient failed to attend.
- Paper records should be hand written in ink or typed. The treating dental practitioner is responsible for the accuracy of medical and dental information, even if the record is made by another person.
- Where corrections are necessary, liquid paper products or erasable pens should not be used. Corrections should be undertaken by the person striking out the incorrect words and rewriting the correct words. If the document is being rewritten the original document should be kept as a reference.
- The principles applying to hand written records also apply to electronic records. Computer records should be time logged and, if codes are used they should be readily convertible to conventional language. Corrections to electronic records should not delete or remove the original (uncorrected) record.

3. Initial charting

On first attendance, subject to patient consent, a complete and thorough oral examination should be carried out on the teeth and oral soft tissues, and the findings recorded using an odontogram and/or text.

Minimum Suggested Requirements of a Dental Chart.

The World Dental Federation (FDI) system of charting is recommended.

If an odontogram is used, the following items should be indicated:

- Treated teeth
 - ~ tooth code, surface(s)
 - ~ material used - gold, amalgam, synthetic, other;
- Teeth present and sound or missing;

- Hard tissue abnormalities;
- Soft tissue abnormalities;
- Occlusion, including tooth mobility;
- Periodontal status
 - ~ Presence of any periodontal diseases
 - ~ Periodontal pocket depth
 - ~ Supra-gingival calculus
 - ~ Sub-gingival calculus
 - ~ Oral hygiene status; and
- Prosthetic appliances present, including materials used, teeth replaced.

If an odontogram is not used, the above items should be addressed in the text.

4. Recording of subsequent treatment

Textual description of treatment should include:

- Tooth code (FDI notation);
- Surface(s) of the tooth;
- Material used;
- Australian Dental Association Inc. item number; and
- Prosthetic appliances including partial and full dentures, bridges and pontics, implants.

It is recommended that the odontogram, if used, be updated after completion of treatment.

5. Recording of treatment on referral

The Dental Specialist or Dentist to whom the patient has been referred should complete a full examination, and record that aspect of the patient's management pertinent to the area or areas.

6. Recording of patients seeking emergency care

When patients attending for the first time require emergency treatment and the treatment is limited to addressing the immediate problem, dentists should at least record all information relevant to the emergency and its treatment.

7. Obtaining and recording consent for treatment

In order to practise in a professionally responsible manner, a dental practitioner must assist patients to make well informed decisions about treatment procedures.

- By the action of consulting a dental practitioner, consent for examination is implied.
- For more complex procedures, express consent (which may be verbal or written) is required.
- For consent to be valid, information about the proposed procedure and its risks and consequences must be provided and the patient must understand what it is he or she is voluntarily consenting to.
- Advice given on treatment options, likely outcomes, including advantages and disadvantages of treatment and consequences of no treatment, pre- and post-operative instructions should be recorded.
- Dental practitioners should give information about the material risks of any intervention. Material risks are those that are likely to influence the patient's decisions. Known risks should be disclosed when an adverse outcome is common even though the detriment is slight, or when an adverse outcome is severe, even though its occurrence is rare. A dental practitioner's judgement about how to convey risk will be influenced by:
 - ~The nature of the intervention;
 - ~The likelihood of harm and the degree of possible harm;
 - ~The questions the patient asks;
 - ~The patient's temperament, attitude and level of understanding; and
 - ~Current accepted dental practice.
- Any other advice given to a patient which may influence their treatment choice should be recorded.
- A decision by a patient to withdraw consent for a treatment plan or procedure should be documented.
- In the case of minors and other persons with a legal disability, the consent of the parent, guardian^b or Adult Guardian^{b**} should be obtained if possible.

(**The Adult Guardian (Tel. (07) 3234 0870 or 1300 653 187 <http://www.justice.qld.gov.au>) is a person appointed by the State. Refer to the Powers of Attorney Act 1998.)

Note that consent to dental treatment is different from consent to the use of information under the Privacy Act. Please see further below.

Where adults are incapable of providing consent, the Guardianship and Administration Act 2000 outlines the substitute decision making process:

- If possible follow an Advance Health Directive ("AHD");

- If there is no AHD, follow the direction of a guardian appointed by the Guardianship and Administration Tribunal ("the Tribunal") or any order of the Tribunal;
- If the Tribunal has not made a ruling obtain consent from an attorney appointed under an Enduring Power of Attorney;
- If there is no appointed attorney obtain consent from the statutory health attorney; or
- If there is no readily available, culturally appropriate statutory health attorney, contact the Adult Guardian who may provide consent as the decision-maker of last resort.

8. Privacy Act 1988 (C'with)

Since 21 December 2001 the Privacy Act 1988^c ("the Act") has applied to private sector health service providers, including dental practitioners. Because health service providers and dental practitioners deal with health information, the Act applies to them regardless of turnover.

The Act is designed to balance the protection of a person's health information with a practitioner's need to share information, where necessary, for the provision of quality health care, including dental care.

b Any appointed guardian should be contacted

c Legislation is available on www.comlaw.gov.au

9. Health information

Health information is personal information:

- about an individual's health or disability at any time (i.e. past, present and future);
- about an individual's expressed wishes regarding future health services;
- about health services provided, or to be provided, to the individual;
- collected whilst providing a health service; or
- collected in connection with the donation or intended donation of body parts and substances.

Health information includes any information collected by a health service provider during the course of providing treatment and care to an individual, including:

- medical information;
- personal details, such as a name, address, billing information and Medicare number;
- information generated by a practitioner or assistant, such as notes and opinions about an individual and his or her health; and
- information about physical or biological samples, where it can be linked to an individual (for example, where a name or identifier is attached).

The Act applies to health information held in any form, including paper, electronic, visual (x-rays, videos and photos) and audio records.

10. National Privacy Principles

The Privacy Act established ten National Privacy Principles ("NPPs"), which set the minimum standard for privacy in the private health sector. The NPPs may be summarised as follows:

NPP 1: Collection and NPP 10: Sensitive Information

These NPPs require practitioners:

- to collect only the information necessary to deliver dental services;
- to collect lawfully, fairly and not intrusively; and
- to obtain a person's consent to collect health information about them.

Practitioners must ensure that patients are well informed about why their health information is being collected, who is collecting it, how it will be used, to whom it may be given and that they can access it if they wish.

NPP 2: Use and Disclosure

This NPP sets out how health information, once collected, can be used within an organisation or disclosed to third parties outside the organisation. Health information may only be used or disclosed:

- for the main purpose for which it was collected; or
- for directly-related secondary purposes, if the consumer would reasonably expect it to be used for such purposes; or
- if the consumer gives consent to the proposed use or disclosure; or
- if one of the other provisions under this principle applies.

Practitioners must ensure that the practice's expectations of what will happen with health information align with the expectations of the patient.

NPP 3: Data Quality and NPP 4: Data Security

Health service providers are required to take reasonable steps to keep information up-to-date, accurate and complete, as well as to protect and secure information from loss, misuse and unauthorised access.

NPP 5: Openness

Health service providers need to be open about how they handle health information. Practitioners must develop a document for consumers which clearly explains how his or her practice handles health information. The document must be made available to anyone who asks for it.

The Board endorses the ADAQ privacy policy document, "We Respect Your Privacy".

NPP 6: Access & Correction

Patients have a general right of access to their own health records. Access can only be denied in certain circumstances. Patients also have a right to have information corrected, if it is inaccurate, incomplete or out of date. Practitioners must take reasonable steps to correct information when requested by patients.

NPP 7: Identifiers

There are limits on the use of Commonwealth government identifiers (such as a Medicare number or a Veterans Affairs number). Practices cannot adopt these identifiers for their own record keeping systems. They may only be used by providers for the reasons for which they were issued.

Practitioners must have their own system for identifying patients, which does not involve the use of the patients' Medicare, Veterans Affairs or Health Care Card numbers.

NPP 8: Anonymity

Where lawful and practicable, patients must have the option of using health services without identifying themselves.

NPP 9: Transborder data flows

If health information needs to be transferred out of Australia, this may occur if laws (or a scheme) with similar privacy protection to the NPPs binds the recipient of the information. Otherwise, health information should only be transferred with the patient's consent or if other provisions of this principle apply.

11. Advice to patients about information collection

It is important to advise patients on how their information will be handled. It is best for this to occur when the information is being collected. For example, practitioners may prepare and display a brochure containing the information at their reception or another location easily accessible by patients.

Alternatively, when asking patients to complete forms, practitioners may include a notice outlining the reasons for collecting the information.

The brochure or form should include information such as:

- the reasons types of information are collected;
- routine procedures for collecting, holding and disclosing information, including if the provider contracts out services;
- any laws that require the provider to disclose information to other organisations, such as government authorities;
- how requests for information are handled;
- the procedures the practitioner has in place for dealing with complaints about breaches of privacy under the Act; and
- the practitioner's contact details.

The Act gives a patient the right to ask for more information about the above matters. Practitioners can either talk to the patient or provide them with more written information.

12. Consent to collect, use or disclose health information

Once a practitioner has his or her patient's consent to collect, use or disclose health information, the practitioner may work within that consent.

However, should a practitioner wish to do anything with the information outside the consent, he or she must speak to the patient, obtain a new consent or come within one of the exceptions in the NPPs referred to in section 13.

As mentioned above, the consent is different from the consent which patients provide for dental treatment. This is the case even if both consents are provided at the same time.

The consent given must be:

- voluntary;
- given after the patient is adequately informed; and
- given by a patient who has the capacity to understand, provide and communicate his or her consent.

Even if a patient does not have the capacity to give consent, he or she must still be involved in the decision making process. Privacy issues must be discussed with the patient in a manner that he or she will understand.

The Privacy Act does not set an age at which children or young people may exercise their privacy rights. When competent to do so, a child or young person should make his or her own decisions. Otherwise, a practitioner may discuss the health information with a parent or guardian.

Practitioners should use some discretion - if a child asks that some information be kept confidential, the request should be seriously considered before speaking with the child's parent or guardian.

13. Ability to collect information without consent

NPP 10 allows information about an individual to be collected without consent in limited circumstances:

- where the health information is necessary to provide a health service and the collection is carried out according to particular kinds of professional rules of confidentiality, or as required by law;
- where there is a law requiring collection of information (e.g. where a person has a disease such as Legionnaires or HIV / AIDS);
- where there is a serious and imminent threat to life or health; or
- where information is required for management, research or statistical purposes and it is impracticable to obtain the consent of the individuals in question.

14. Restrictions on the collection of information

Information must be collected lawfully, fairly and not intrusively.

It is intrusive to collect information by asking an individual to disclose sensitive information in circumstances where he or she might be easily overheard.

15. Use of health information

Once information has been collected from an individual, there are restrictions on the way in which it may be used or disclosed.

Generally, the consent and reasons for which the information was given will dictate to what can be done with it.

If compelled by law to use or disclose information, for example in response to a subpoena, practitioners must disclose the information. However, if practitioners have any concerns about the information sought, they should speak to a Court Officer, obtain legal advice or speak to an Officer of the Dental Board.

Information may also be disclosed to a law enforcement body, if the disclosing body has a reasonable belief that the information is necessary for the functions or activities carried out by, or on behalf of, the law enforcement body. In determining whether a belief is reasonable, practitioners should consider the seriousness of the situation and the balance between the patient's confidentiality and the need for investigation and enforcement of the law.

If information is disclosed, a written record of the disclosure should be kept.

Health information can be disclosed to a responsible person:

- if it is necessary for the provision of appropriate care or treatment to the individual; or
- for compassionate reasons.

16. Prevention of breaches of security data

Practitioners should not engage in any actions which may lead to breaches of security, such as:

- leaving dental notes unattended at a public counter;
 - disposing of health records in a non-secure manner;
 - maintaining inadequate controls on staff access to health information; and
 - storing sensitive data on a laptop computer that is taken 'off-site' and not stored securely.
- Practitioners should consider taking steps to physically secure information, such as:
- introducing password access to computer systems;
 - providing lockable security for physical records;
 - only transferring information by secure means (e.g. practitioner's should not use non-secure emails to send sensitive information); and
 - introducing monitoring systems to check data security.

17. Use of standardised forms

When collecting information, practitioners must be careful to only collect the information necessary.

Practitioners should segment forms and ask patients to only complete the relevant sections. Also, they should consider introducing particular forms for particular purposes.

18. Obligation to provide access to dental records

The common law provided that dental records were kept primarily for the benefit of the patient, but the dental record was actually the property of the practitioner (*Breen v Williams*, (1996) 138 ALR 259).

Previously, patients did not have a right of access to dental records maintained by private practices.

However, this changed with the introduction of the Privacy Act. In the public sector, patients may access their dental records by administrative access or by applying under the Freedom of Information Act 1992 to the institution currently providing the dental care.

Before the introduction of the Privacy Act, there was no obligation to transfer information to another dentist; merely an expectation that this would be done. Now, the transfer of information is regulated by NPPs 6 and 8 (see above).

19. Granting patients access to their health information

There are a number of ways a patient can access his or her health information. They may:

- look at the information and talk through its contents with a staff member;
- obtain a copy of the information (for example, a photocopy or copy of an x-ray);
- take notes about information;

- listen to an audio recording or watch a video recording; or
- obtain a print-out or get an electronic copy of information stored.

A request for access does not have to be in writing. However, in the case of a complex request, it is preferable that it be in writing to avoid misunderstanding and provide the practitioner with a record of the request for his or her file.

20. Handling a patients request for information

A guide for handling requests for information is to:

- check the identity of the person making the request;
- acknowledge the request within 14 days. If any costs are to be charged (see further below) list these costs;
- collate the information;
- ensure that the information does not include any details which should not be disclosed;
- detail or remove any information to be withheld;
- provide the information to the patient in the most appropriate form.

The total time to process a request should not be longer than 30 days and, in many cases, should be somewhat shorter.

Practitioners cannot charge a patient for making a request for access. However, it is permissible to charge someone for the administrative costs involved when access is provided. The rates listed in the Freedom of Information Acts should be used as a guide.

A request for access can be denied if (and to the extent that):

- the request would infringe upon another person's privacy;
- the request is frivolous or vexatious (caution should be taken when deciding what is frivolous or vexatious);
- the information relates to existing or pending legal proceedings and it would not be discoverable in those proceedings;
- access to the information would prejudice negotiations with an individual;
- access would be unlawful;
- denying access is required or authorised by or under law;
- law enforcement or national security authorities would have an interest in the information; or
- the information is commercially sensitive evaluative information.

If a practitioner decides to withhold information, he or she should consider using an intermediary to liaise with the patient. Practitioners should obtain the patient's written consent to disclose personal information to the intermediary.

The patient must be told why he or she has been denied access to information.

21. Treating patients anonymously

If a patient asks to be treated anonymously, he or she should be treated without knowledge of his or her name, if possible. If this is not possible (e.g. because the practice needs an identifier for its records or for other reasons), practitioners should afford the patient an opportunity to seek treatment under a pseudonym.

22. Retention of dental records

- All dental records should be kept for at least ten years after the final entry.
- Records in relation to the treatment of minors should be retained for at least ten years after the minor has attained majority (18 years of age).

23. The duty to keep patient information confidential

In addition to NPPs 3 and 4, the practitioner has an ethical duty to keep patient information confidential. Also, there is a contractual obligation (which can be either express or implied) owed by the dental practitioner to the patient to keep the patient's records confidential. The nature of the professional relationship imposes a duty on the dentist to keep patient records confidential. A breach of this professional duty may amount to professional negligence.