The College of
Dental Surgeons
of Saskatchewan

CDSS PATIENT RECORDS STANDARD

November 2021 PROPOSED DRAFT

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Dental Surgeons
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1. All professional corporations and all regular members, practicing life members, and faculty members licensed by the College shall keep full and complete clinical dental records on behalf of themselves and all other dentists and allied dental personnel in their employ or under their supervision, which records shall include as a minimum core set of information, of which the complexity increases with the complexity of the treatment.
2. The information must be readily accessible to the patient and other authorized persons.
3. The following information must be included in the patient record:
    I. Patient identification data, demographics
    II. Chief complaint
    III. Medical history
        A. Including names and contact number of physicians for consulting purposes.
        B. Must be updated at regular intervals to provide support for the clinical examination, treatment planning, sequencing and performance of emergency, urgent, necessary, and elective dental care.
        C. The dated signature of both parties is required.
        D. Drugs prescribed name – brand name & generic, category or action, why it was prescribed, potential interactions with epinephrine, antibiotics, analgesics, sedative hypnotics, oral manifestations, and side effects.
    IV. Clinical examination findings
        A. Vital signs, extra oral evaluation, intra oral evaluation.
        B. Evaluation of arch relationship, evaluation of growth and development.
        C. Diagnostic and consultation reports must present an accurate description of the patient's initial and ongoing status.
        D. Problem list and groups, treatment options, recommended treatment plan.
        E. Informed consent, accepted treatment plan, sequencing of care.

V. Each treatment prescribed pertaining to the patient.

VI. Each treatment rendered pertaining to the patient.

VII. Each date that the patient is seen in the dental office.

VIII. All medications given or prescribed to the patient, including the amount, instructions and date provided or prescribed; and

IX. All radiographs, images and models which are clearly labeled and dated with interpretation.

X. Administrative and financial records.

4. Where a patient has attended a member's office for the purpose of receiving a treatment from any allied personnel, and such allied personnel has recommended a dental examination by the dentist, the dentist shall ensure that such recommendation (and any refusal) shall be noted in the patient's records. No further action is required of the member once such notation has been made.

5. All records shall be in an intelligible form, and shall be written, typed, or stored in electronic form with one or more backup copies.

6. Daily entries must be signed, initialed, or otherwise attributed to the individual(s) delivering care or service.

7. General legal responsibility:

I. Pursuant to the Health Information Privacy Act HIPA (website) there is legal responsibility to:

A. Take reasonable measures to protect confidentiality, privacy, access.

B. Get consent to share information with other people who need to know – the Privacy commissioner will help with compliance.

II. Pursuant to the Freedom of Information and Privacy Act (FOIPA) (website):

A. Patients own their record, have a right to see their record.

B. Patients have right to know who their record is shared with.

III. Security of records transfer must be considered - by CDA/Itrans, Secure Send or other secure method.

IV. Pharmacy Information Program (PIP/SK Health) information must be secured to authorized persons only.

8. **Extra oral and Intra-oral findings**

- Head and neck
- Lymph nodes

- TMJ
- Soft tissue - lips, cheeks, tongue palate, gingiva and floor of mouth, hard tissue

9. **Periodontal screening and recording**

I. **Treatment sequencing**

Disease management – Primary prevention, Rehabilitation – Secondary & Tertiary prevention + Primary prevention, Maintenance & recall - Primary prevention

- Caries Risk Assessment
- Establishes caries activity and caries risk status
- Caries management by risk assessment (CAMBRA)

10. **Radiographic Examination**

- Refer to radiograph and imaging standard.
- Recall and/or post-operative radiographs should only be taken on a patient-by-patient, *as-needed* basis not as a routine.
- Prescription of recall radiographs (number & frequency) is based on:
  - Patient's age
  - General/systemic condition
  - Dental history
  - Current status
  - Risk status
  - Clinical signs and symptoms
  - Balance between minimizing exposure and obtaining an adequate number of radiographs for a complete diagnosis
- Radiographs should never be taken solely for administrative purposes.
- Note a patient's refusal to have radiographs in the chart.

a. **New Patien**t

- Whenever possible, obtain previous radiographs from other practitioners and assess them prior to prescribing new radiographs.
- Conduct a clinical exam before prescribing radiographs to assess existing disease and disease risk.
- Use the above information to decide if a larger number of films are required to aid in diagnosis.

b. Recall Patient

- Radiographs should never be prescribed based on set time periods alone (e.g., Bitewing films every six months).
- The number and frequency of radiographs must be prescribed based on existing disease and disease risk.
- Prescribe radiographs after your clinical examination.

c. Emergency Patient

- Use a minimum number of radiographs to obtain accurate diagnosis.

11. **Progress Notes**

- Progress notes describe the treatment provided for a patient.
- They should be well-organized, legible, (written, 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.
- It is also advisable to record on the patient record whenever a discussion of possible limitations of treatment was held with the patient.

12. **Electronic Record Keeping**

- Provides an accurate visual display of the recorded data and is capable of retrieving and printing the data in a timely manner and in chronological order.
- Records the date of each entry for each patient.
- Provide access to the clinical and financial records of each patient by name.
- Be password/security enabled to protect integrity of data and unauthorized access.
- Have file backup/data recovery to prevent data loss.

13. **Financial Records**

The patient's financial records must include:

- A copy of any written agreement with a patient
- Date and amount of all fees charged
- Date and amount of all payments made
- An itemized listing of all commercial lab fees
- Copies of all dental claim forms

14. **Third Party Consults**

- Patient consent – preferably in writing – is required prior to consulting another practitioner regarding that patient.
- Create a record of any inter-practitioner communication including letter, notes of telephone conversations, consultation/lab reports.

15. **Confidentiality**

- All members of your dental team must be up to date with Federal and Provincial privacy legislation including release of patient information/records to a third party.
- 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.
- Careful understanding of how and when to discuss patient information inside and outside of the practice.

16. **Integrity of the Clinical Data**

- Complete your charting at the end of the appointment; do not leave charts until the end of the day – memory fades.
- Especially important with a difficult patient. When you review the chart ensure that:
  - All clinical data is accurately recorded
  - There is a signed treatment plan
  - Financial calculations match the services delivered
  - The next appointment has been scheduled
  - Do not complete a chart if angry or stressed
  - Calm down first and record information objectively not subjectively
  - Routinely altering charts should not be your record keeping norm but if it does have to be done document it properly
    - *Late entry* + date and signature
    - Strike out amended entries
    - If there is a significant addition or change, discuss it with the patient. Call them and discuss at the next appointment.

17. **Retention of Records**

A member shall retain patient records for six (6) years after the date of the last entry in the records.

A member shall retain the records of pediatric patients until two (2) years past the age of majority

(age 18); or six (6) years after the date of the last entry in the records; whichever may be the later date. Age 24 would be the maximum age in this category.

This policy applies to all patient information including:

- All radiographs

Pre-treatment and post treatment models, for major treatment, by specialists or general members, must be kept for six (6) years after satisfactory delivery and appropriate adjustment and/or follow up. Major treatment would include but not be limited to the following cases:

- Multiple veneers (more than 4)
- Full mouth reconstruction involving most posterior teeth
- Multiple implants
- Alteration of posterior vertical dimension
- Implant supported removable prosthesis
- Orthognathic surgery
- Orthodontics - the appropriate models must be kept for the greater of six (6) years or the age of majority plus two (2) years after satisfactory completion of treatment and appropriate retention.

Appropriate disposal should ensure compliance with HIPA which states: [17(1) (2)(b)] “personal health information is destroyed in a manner that protects the privacy of the subject individual.”

A member is obligated to retain records of deceased patients for two (2) years from the date of the last entry in the records. (Discoverability Principle - The Limitations Act)

19. **Release of Records Policy**

Members shall provide within a reasonable time any report or certificate requested by a patient or his or her authorized agent in respect of an examination or treatment performed by a member.

A dentist must establish and maintain adequate records of medical-dental history, clinical findings, diagnosis, and treatment of each patient. Such records or reports of clinical information must be released to the patient or to whomever the patient directs, when requested by the patient. Original records should be retained, and a duplicate provided.

Reference to the patient's right to obtain copies of their dental records were strengthened following a unanimous ruling of the Supreme Court of Canada wherein the Court found that, due to the patient's vital interest in the information contained in the records, the patient has the right to inspect the records and obtain copies of the records. Subsequent decisions have been made by dental regulatory bodies stating that to withhold the release or transferring of a patient's dental records due to an outstanding account is not permissible, as there are alternate methods available to collect such accounts.

Upon a written request from a patient or legal guardian a dental office should:

1) Forward the requested records directly to another dental office or to the patient where so requested.

2) Record the written request and the date of transfer.

3) Receive confirmation, in writing, that the other dental office, or the patient, have received the record.

This protocol respects the patient's rights, the Bylaws, and the Code of Ethics. However, in a situation where a practitioner is retiring or closing a practice there is no need to retain the original record, provided that the original record is forwarded securely to the patient's dental office of choice and confirmation of this transfer should be sent to the originating dentist. Copying the file is not necessary. One may want to retain records for legal purposes.

A provider may charge for this service and the following codes in our fee guide relate to this matter:

93211 Patient File Management

92911Radiographs, Duplications

92912Radiographs, Duplications

92913Radiographs, Duplications

20. **Informed consent**

Members may wish to consult with their personal legal counsel to address their specific circumstances.

1. **General Consent**
   Members must obtain general consent to gather and maintain personal health information. In Saskatchewan, The Health Information Privacy Act legislates the gathering, maintenance, storage, use, sharing and disposal of personal health information.

2. Members must obtain general consent for the gathering of other personal information and electronic data. The Personal Information and Protection of Electronic Data Act (PIPEDA) governs the gathering, maintenance, storage, use, sharing and disposal of personal information and electronic data (basic personal data, billing information and data).

3. **Informed Consent**
   Informed consent is a principle based on good communication of appropriate information and the right of each person to determine what will be done to his or her body and by whom. Informed consent guarantees each person the right to refuse treatment, to consent to treatment, and to withdraw consent to treatment.

4. **Informed Consent Process**
   Dentists have a legal and moral responsibility to act in the best interests of their patients.

This includes providing advice to patients in an appropriate and understandable manner given the patient's capacity and respecting the patient's right to self-determination of their health through consent. Informed consent is a continual process, not a single event, a signature, or a form letter.

5. There are two types of consent that occur within the profession of dentistry:
    a) Implied consent
        i. Implied consent is sufficient in the following situations:
            1. Emergency situations where a delay could be hazardous to a patient's life.
            2. Examinations (not including radiographic imaging)
            3. A dental procedure that the patient has previously had performed on him or her if the following conditions are met:
                a. The patient has previously had documented informed consent for this type of procedure at the same dental office
                b. The risks, limitations, and benefits for the planned treatment are the same as for the previous treatment for which informed consent was obtained.
    b) **Express or informed consent**
        i. Given after disclosure of all information reasonable under the circumstances, which allows a competent person to make an intelligent decision on their future treatment. The level of disclosure by a dentist to a patient is measured by the patient's informational needs meaning what they believe they need to make a proper choice for themselves. Since different patients have different needs for information, the scope of disclosure will vary even among patients with the same condition. An example is a procedure beyond a simple examination such as imaging procedures, surgery, extractions, fixed and removable prostheses, orthodontics, implants, sedation, endodontics, and non-surgical procedures that may cause change or harm to the body. All experimental procedures.

6. Patients are entitled to know whether the provider is or will be a General Dentist, Specialist, Dental Assistant, Dental Hygienist, Dental Therapist or other.

7. Oral and written consent are legally acceptable, however, oral consent should be confirmed in writing and documented in the patient's chart. Signatures on forms have no meaning if the information on the forms has not been clearly articulated and understood by the patient. Consent forms do not absolve a dentist from liability when the dentist feels it is against his/her better judgment, but the patient is insisting that this is the way they want it done. A consent form by itself is insufficient to ensure informed consent has been given.

8. Not all patients have the capacity to provide consent, so consent should be obtained from someone legally allowed to do so and consent should include the articulation and understanding of the costs involved.

9. There is no current authority in Saskatchewan, Statutory or Regulation, which bases consent on age. If a patient is capable of understanding the appropriate information provided to them, they can provide consent regardless of age. Thorough documentation of the process

is prudent. Furthermore, if a parent or other party will be implicated as a ‘payer' for the services proposed for consent, it would be prudent to obtain permission to approve the payment.

10. Further documentation beyond a consent/disclaimer form is required when patients choose not to accept or receive treatment. A disclaimer form could be useful when patients refuse to have recommended appropriate imaging performed or when they refuse to accept antibiotic prophylactic treatment.

11. Consent forms should include the following information:
    a) Patient's name, address, and age
    b) Language and terminology that your patients will understand
    c) General description of the condition
    d) Specific, potential or Differential Diagnosis
    e) Reasonable options for treatment that may include no treatment
    f) Nature and purpose of recommended treatment
    g) Risks, benefits of proposed treatment and consequences of no treatment
    h) Realistic outcome of treatment (aesthetic, functional or limitations)
    i) Estimated costs of proposed treatment
    j) Who will provide the treatment and follow up
    k) Signatures of the patient and a witness.

12. The dentist should be certain that the patient has consented to treatment.

13. Members must not make a misrepresentation respecting a remedy, treatment, or device.

14. Members must provide patients or their legal guardian with the opportunity to have their questions answered.

15. Members should be aware of the adage ‘before treatment it's an explanation; after harm happens, it's an excuse'.

16. Members are prudent to document the discussions with patients including your patient's consent to treatment - “if it is not written, it never happened”.

17. Members are ultimately responsible for appropriate informed consent process. Trained staff may be utilized to perform appropriate informed consent process.

18. Display on the outside of the premises the name and phone number of the dentist(s) connected to the practice.

Repercussions of failing to obtain informed consent

When the College receives a complaint, the Professional Conduct Committee investigates the matter and determines if proper informed consent process occurred and if not, determine the appropriate resolution of the complaint.

A Civil statement of claim by the patient may allege that if they had known the risks prior to actions, they would have avoided the harmful outcome. To determine in favor of the patient, the court must be convinced that a reasonable person in the patient's circumstances would not have consented to treatment if the risks were disclosed. If a reasonable person would have consented,

even with the risks, then the dentists may be able to avoid civil liability.

Adults (18 years and older)

- Adults or their substitute decision maker (SDM) must provide informed consent prior to treatment.
- Adults or their SDM have the right to refuse or revoke consent for treatment.

Mature Minors (13-17 years)

- Health care directives can be given at the age of 16 years.
- There is no legal age of consent for health care in Saskatchewan. Children aged 13 years and older can legally consent to, refuse, and revoke treatment on their own behalf if they demonstrate capability and understanding of the standard information.
- Mature minors have the authority to give, refuse, or revoke consent for their own treatment when the health care provider feels they have demonstrated capacity to make that decision.

Children (12 years and younger)

- All biological and adoptive parents have the authority to give, refuse and revoke informed consent for their children's treatment, except when their decision-making rights have been legally revoked and another legal guardian has been appointed (e.g., social worker) or when their child has self-consented as a mature minor.
- Foster parents, relatives who have temporary day-to-day guardianship (by court order or by an informal consensual arrangement) or a social worker may sign the consent for treatment. Parents who have temporarily relinquished the custody of their children, whether voluntarily or involuntarily, to the Ministry of Social Services or to a First Nations Child and Family Services should be encouraged, if they are available and willing to do so, to sign the consent as well.
- If a parent has sole custody and the other parent has some access, only the primary custodian may provide consent for immunization.
- If a practitioner becomes aware of a situation where both parents have custody and have opposing views regarding treatment, defer treatment pending joint consultation with parents. The onus is on the parent to bring forward information regarding custody arrangements.
- If there is any dispute between the parents regarding which has the authority to sign the consent, a copy of the custody order or agreement should be requested.
- If the parent who originally provided consent is no longer the legal guardian or is deceased, obtain a new consent from the current guardian. Retain both consents.

The College cannot endorse or recommend any particular form because each one should be unique unto itself and meet the patient's needs. Oral and written consent are legally acceptable, however, oral consent should be confirmed in writing and documented it the patient's chart where risks are significant.