College of Dental Surgeons of Alberta

Standard of Practice:

Patient Records

2015

The Alberta Dental Association and College is now operating under the name College of Dental Surgeons of Alberta. This name will become official when Alberta's *Health Professions Act* is amended.

A. Introduction

All regulated members (dentists) of the College of Dental Surgeons of Alberta (CDSA) are required to create and maintain accurate patient records.

Professional, ethical, and legal responsibilities dictate that a complete patient chart and record containing all aspects of each patient's dental care must be created and maintained by dentists. The creation and maintenance of clear and comprehensive patient records have many purposes, including:

a. Facilitating the provision of effective clinical care

b. Ensuring the continuity and comprehensiveness of oral/dental health services

c. Satisfying a dentist's professional, ethical and legal obligations

Dentists will be required to comply with all relevant privacy legislation that applies to patient records. In the Standards, the term "patient records" is any item of information, regardless of form or medium that is created by a dentist, dental office or professional corporation that is created and maintained to provide care to patients and conduct business.

B. Standards for Patient Records

2. The dentist is responsible and accountable for ensuring that they document and retain a record of treatment plan or treatment provided to a patient.

3. The dentist must ensure that:

    a. all entries on a patient record are dated

    b. all entries on a patient record are signed, initialled, or are otherwise attributable to the writer and treatment provider

    c. all paper-based entries on a patient record are recorded by hand in permanent ink, typewritten, or printed from a digital file

    d. all entries on a patient record include sufficient information to meet all Standards of Practice relating to privacy and management of health information, and comply with all requirements in applicable health information legislation, including the *Health Information Act* (Alberta)

4. The *Health Information Act* defines "record" to mean health information in any form and includes notes, images, audiovisual recordings, x-rays, books, documents, maps, drawings, photographs, letters, vouchers, papers, and other information about an individual that is collected when a health service is provided to the individual, that is written, photographed, recorded, or stored in any manner. The dentist must ensure that all entries in a patient record are complete, clear, legible and in English.

5. The dentist must ensure that the patient record contains sufficient information to provide a record of informed consent, diagnosis, treatment plan, care provided and postoperative instructions such that another health care provider can continue care. The requirements may vary depending on circumstances related to whether the care is provided in public health, institutional, research, educational, community or clinical practice settings.

6. The dentist in providing care to a patient through delivery that generally occurs in a clinical practice setting needs to ensure the patient record contains the following at a minimum:

    a. Patient name, address, telephone numbers, and date of birth, gender

    b. Weight and height

    c. Primary care physician, if applicable

    d. Emergency contact name and telephone number

    e. Insurance information and/or Alberta Personal Health Number (PHN), if applicable

    f. Dates seen and identity of dentist and other health providers attending the patient on those dates

    g. Medical and dental history, including medical conditions, illnesses, disorders, prosthetic devices, drug or alcohol dependency, pregnancy

    h. Current medications, treatment regimes, allergies, and drug sensitivities

    i. Chief complaint or reason for examination or appointment

    j. Findings on examination

    k. Diagnoses, whether tentative, differential, or established

    l. Documentation of informed consent

m. Treatment advice, treatment provided, complications and outcome

n. Medication prescribed, including:

   i. the name of the medication

   ii. the dose of medication and route of administration to be taken at each administration

   iii. the frequency of administration

   iv. the duration of the period for which the patient is to take the medication, and

v. whether or not refills have been issued

o. Radiographic and other imaging results and interpretation

p. Instructions or treatment provided, including instructions for follow-up care

q. Documentation of any refusal to follow advice or instructions

r. Letters of referral or other referral documentation, and

s. Laboratory, imaging, pathology, consultation, or other reports received or sent relating to dental care

7. The dentist must comply with CDSA Standards of Practice relating to the provision of specific health services that may create additional patient record requirements.

8. The dentist must keep accurate financial records relating to the date of service, the type of health service, fees charged for the service, the treatment provider and relevant payment information.

9. The dentist must take reasonable steps to ensure that patient records are accessible for continuity of care for patients. The dentist must determine appropriate retention periods for patient records, considering that patient records for adults must remain accessible for a minimum period of ten (10) years following the date of last service, and patient records for minors must be accessible for a minimum period of ten (10) years past the patient's age of majority. In the event of a patient becoming deceased, the retention period is not changed.

10. A dentist must keep a record of appointments showing for each day the names of patients who received professional services for a period of at least two (2) years.

11. When information in a patient record is updated, added to, or corrected, the following information must be maintained on the patient record:

    a. the original entries

    b. the identity of the person making the update, addition, or correction and

    c. the date of the update, addition, or correction

12. These Standards must be followed by dentists who are members of the CDSA. Failure to do so constitutes unprofessional conduct and may result in disciplinary action by the College of Dental Surgeons of Alberta.

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