COLLEGE OF
DENTURISTS
OF ONTARIO

Guide to the Standard of Practice: Record Keeping

The College's Standard of Practice: Record Keeping explains the regulatory expectations for documentation and record keeping. This Guide to the Standard offers further information regarding record keeping legislation and regulations that impact denturism practice and how to apply the Standard in practice. The Guide includes frequently asked questions and Practice Scenarios that illustrate elements of the record keeping process.

Retention

Why is the retention period 7 years for patient records?

Through the mandatory 60 day consultation process, the profession validated that a retention period of 7 years is sufficient for patient records.

Can records be kept for longer than 7 years?

Yes, records can be kept for longer than 7 years.

If a patient has not been to a clinic for 2 years and the file is transferred to another denturist (say, in the sale of the clinic), does the new denturist have to keep the record for another full 7 years? Or just the remaining 5?

The denturist would have to keep the record for a total of 7 years from the date of the last visit. Therefore, in this example, the denturist would keep the record for the remaining 5 years.

If I find out that one of my patients is deceased, do I still have to keep their record for 7 years?

Yes. The estate trustee of the deceased patient may request access to the personal health information.

How long do I have to keep the record of destruction for patient files that have been securely destroyed?

The record of destruction should be kept indefinitely. If the practice is transferred to another practitioner, the record of destruction should also be transferred.

For which equipment do I have to maintain records?

The denturist must maintain records for all equipment utilized in the practice (including technological and laboratory equipment).

What is the time frame for maintaining financial records?

Financial information that is part of the patient record, such as invoices and receipts, should be kept for the duration that the patient record is active.

Denturists should seek advice from Canada Revenue Agency and accounting or legal professionals to determine the retention requirements for other financial records such as tax returns and audits.

Should denturists keep the models or any other physical items related to a patient record?

Denturists can keep the models and other physical items related to the patient record. If storage space is a concern, denturists may consider documenting the materials (i.e. through notation and photographs) and keep that documentation in the patient record.

If a document is scanned into a patient file, can the paper copy be destroyed or does it have to be kept for 7 years as well?

Once a physical document is scanned into a patient file and marked with the unique identifier, it can be securely destroyed.

What happens in the event that a denturist dies and no one purchases the practice? What happens with the files?

Upon the death of a custodian, the estate trustee or the person who assumed responsibility for the administration of the estate becomes the custodian, until custody and control passes to another person who is legally authorized to hold the records. A custodian may divest itself of responsibility for the record by transferring them to an archive.

Reference: https://www.ipc.on.ca/wp-content/uploads/Resources/phipa-faq.pdf

What happens in the event that a clinic is being closed and not sold or transferred to another registered practitioner?

A custodian remains the custodian in respect to a record of personal health information until complete custody and control of the record passes to another person who is legally authorized to hold it. Therefore, the denturist who is the custodian of the records must remain as such until the period of retention has passed for all patients and the records can be securely destroyed.

Reference: https://www.ipc.on.ca/wp-content/uploads/Resources/phipa-faq.pdf

Can I store records in my home or in a storage unit?

Yes. However, it is very important to keep in mind that wherever you are storing records must be secure. In other words, only authorized individuals should have access to the patient records, regardless of where the documentation is stored.

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Charting

Does the commercial laboratory fee need to be given to the patient or kept in the patient's file?

The commercial laboratory fee information should be provided to the patient and kept in the patient record.

Why can't a Date of Birth (DOB) serve as a unique identifier?

The DOB can serve as part of a unique identifier. However, it is not uncommon for patients to have the same name and possibly the same birth date. To avoid confusion and reduce the risk of error, it is recommended that the denturist select another way to uniquely identify patient records.

Would the master signature list require a signing at each appointment?

The master signature list is a tool designed to specify the names of the individuals that accessed and/or amended the patient record. This list should be kept in the denturist practice and made available upon request if a patient record is needed for review. If someone new has amended or accessed a record, their name and initials should be added to the master list.

Can I make up my own patient charts? Or do I have to use the chart created from one of the associations?

The College does not require that denturists use templates from any organization, including the associations. It is important to remember that the responsibility of adhering to the Standard of Practice for Record Keeping is the onus of the denturist. Therefore, denturists must ensure that any template they use is in accordance with the Standard.

Clarify what is required for the following performance indicator "must contain information about advice provided and patient education given."

A denturist who provides advice or patient education should note the conversation in the patient record and can include, but is not limited to, the following information: the date, the advice/education provided, the reason for providing the information, and any questions that the patient asked.

How do I acknowledge in the record that the patient understood my advice?

A denturist should note that the patient indicated their understanding of the information being provided to them. When the level of risk warrants it, the denturist should obtain written informed consent through the informed consent process. See the Standard of Practice: Informed Consent and the Guide to the Standard of Practice: Informed Consent for more information.

If someone discloses a lock-box item, does it actually have to be written into the file somewhere? Like on a separate piece of paper?

If a patient discloses a lock box item, the denturist should create a written account of the conversation so that the information can be recalled if/when necessary. However, this document (physical or electronic) should be kept separate from the patient record. The unique identifier should be present so that the documentation can be matched up with the correct patient.

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The notation in the patient record should indicate that information was shared but not disclosed in the record, at the patient's request.

Can I record patient visits on video? Is that sufficient for record keeping?

Denturists who operate video and/or surveillance equipment in their offices must ensure that visitors are aware that they are being recorded through the posting of noticeable signs, particularly in public areas, such as waiting rooms and operatories. Patient appointments may be recorded upon receipt of informed consent by the patient. Patient records should be transcribed after each appointment, either in hardcopy or electronically.

Do I have to transfer my old patient charts to a new chart form?

If you start to use a new chart template or form, you may consider transferring existing patient information to the new form to ensure that all of the required information is now being captured. Alternatively, you can start a new chart for an existing patient using the new template and include the old version of the chart as an appendix to the record.

Does the College recommend any specific software for patient record keeping?

No. The College does not provide recommendations for software or hardware systems. It is suggested that denturists speak to their colleagues and membership associations to inquire about various options, prices and features.

Patient-Related

If the patient refuses to provide any information about his or her medical history, should I treat this patient?

Denturists must be able to assess the patient's suitability for various treatment options. Refusing to provide information about medical history could put the patient at risk of harm. If there is something in the medical history that the patient does not want disclosed on the record, the denturist can make note that a disclosure was made but cannot be shared (the information was "lock boxed").

If the patient still refuses to provide this information, the denturist can refuse treatment.

If we are given fraudulent or incorrect info from patient, can we be accountable?

Denturists can include a disclaimer on their intake forms that requires patients to provide true, honest and accurate information and that assessment and treatment will be delivered based on the information that the patient provides. Denturists who receive fraudulent or incorrect information from a patient or on behalf of a patient should immediately note this in the patient record and consult a legal professional for further advice.

What are my mandatory reporting obligations to report any type of abuse to authorities when the patient has shared information they do not wish to be disclosed (i.e. "lock boxed").

If the patient is under the age of 18, the Child and Family Services Act (CFSA) could apply and permit the denturist to report to the police. However, that will only be triggered if the abuser is the child's parent.

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If the CFSA does not apply, the denturist must comply with the Personal Health Information Protection Act (PHIPA).

If the denturist believes that the disclosure to the police or parents is necessary to eliminate or reduce a significant risk of serious bodily harm to the patient, then he/she will not be breaching PHIPA. This is in light of s. 40(1) of PHIPA which states the following:

> 40. (1) A health information custodian may disclose personal health information about an individual if the custodian believes on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons. 2004, c. 3, Sched. A, s. 40 (1).

We strongly suggest that the denturist consult with a lawyer to see if he/she has the requisite belief in order to justify the disclosure.

If the patient has capacity (as set out in the Health Care Consent Act) he/she is authorized to provide instructions as to who can and cannot access their personal health information (PHI).

The "lock box" provision normally speaks to sharing PHI with other health care providers. For example, a health care provider is permitted to share PHI with health care providers who are within the circle of care. Express consent is not required for this disclosure. However, the "lock box" provision allows the patient to withhold or withdraw consent or may prohibit or place conditions on the disclosure.

According to PHIPA, once a patient says the PHI is to go in the lock box, it must remain there unless:

- The patient changes their mind and advises the denturist; and/or
- The denturist believes on reasonable and probable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons.

The denturist should still record the information provided to them by the patient. If using paper files, the information can be kept separately and securely away from the main chart with clear indications that part of the record has been removed under the lock-box provision.

The denturist may wish to ask the patient if he/she is still intent on keeping this information confidential. If they change their mind, this would permit the denturist to disclose the information. The denturist will likely want to provide the patient with resources so that he/she can obtain help.

How do I inform my patients if I am leaving or selling my practice? Can I inform them via an ad in the newspaper? I have seen thousands of patients and sending out a mailing would be costly and time consuming.

Denturists may consider sending an electronic communication such as an email message to patients who have provided an email address. Those without email addresses can be sent paper letters. Denturists can also place notices in newspapers to advise their patients if the clinic is being sold or transferred, is closing or is moving locations.

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If someone purchases a clinic and then is asked by the College to submit a file, should the patient be informed of the file being sent to the College?

If the College is requesting a patient record for an investigation, the denturist must release the record to the College. Denturists should advise patients that their record may be disclosed to the College, as part of their privacy policy and form.

The Personal Health Information Protection Act, 2004 (PHIPA) allows for disclosures related to that Act or others, such as the Regulated Health Professions Act, 1991 (RHPA). For more information, please review the Standard of Practice: Confidentiality & Privacy and the Guide to the Standard of Practice: Confidentiality & Privacy for more information.

What do I do if a patient record goes missing?

If personal health information has been stolen or lost or if it has been used or disclosed without authority (this includes the unauthorized viewing of health records):

- The health information custodian must notify the individual about whom the information relates at the first reasonable opportunity. The notice has to inform the individual that he or she is entitled to make a complaint to the Information and Privacy Commissioner of Ontario.
- As of October 1, 2017, health information custodians will also have to notify the Information and Privacy Commissioner directly of certain privacy breaches.
- An agent that handled the information must notify the responsible health information custodian at the first reasonable opportunity.

Health information custodians have additional reporting obligations to regulatory Colleges (which include the Colleges under the Regulated Health Professions Act, 1991 and the Ontario College of Social Workers and Social Service Workers) if the custodian takes disciplinary action against a member of a College for the unauthorized collection, use, disclosure, retention or disposal of personal health information.

For more information, please review the Standard of Practice: Confidentiality & Privacy and the Guide to the Standard of Practice: Confidentiality & Privacy for more information.

Multi-Disciplinary Practice:

Can we use the same record as other health care practitioners in the office? Or do we have to keep separate records?

Several professions acknowledge that in multi-disciplinary practices, it makes sense to have one record. This is likely more efficient and ensures that all members of the patient's team are aware of the care provided. Each regulated health professional will want to ensure that they comply with their respective college requirements when making such entries. Ideally, the organization who operates the multi-disciplinary practice will take all such requirements into account when stipulating how employees are to document in the record. The Personal Health Information Protection Act (PHIPA) and College standards must be complied with irrespective of the employer requirements. It is important to remember that each individual amending the record must be able to be identified (i.e. through a master signature/initial list).

With respect to billing and appointments, the same principle would apply. As long as the patient knows who provided the treatment on the common invoice, the College will likely be satisfied. The only caveat is if the denturist is practising through a professional corporation. IF that is the case, and the professional corporation is providing the invoice, no other regulated health professionals can bill from that denturist corporation.

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There are certain colleges who mandate that dually registered members (i.e. members who are registered in more than one regulated health college) must maintain separate records and issue separate receipts for each separate profession. The College of Denturists of Ontario is not one of them.

Who do the charts belong to if a denturist works for a dentist office as an associate?

Health professionals have different levels of responsibility depending on whether they are the health information custodian or an agent. If you are a regulated health professional or you operate a group practice, and you have custody and control of personal health information in connection with your duties, then you are a health information custodian for purposes of the Personal Health Information Protection Act (PHIPA).

However, even if you fall under the definition of a health information custodian, if you work for or on behalf of another custodian (such as another regulated health professional, a group practice or a hospital), then you are considered to be an agent of that health information custodian.

A health information custodian is ultimately responsible for the personal health information in his or her custody or control, but may permit an agent to collect, use, disclose, retain or dispose of the information if certain requirements are met.

For more information, please review the Standard of Practice: Confidentiality & Privacy and the Guide to the Standard of Practice: Confidentiality & Privacy for more information.

Practice Scenarios

Record Keeping No. 1

John, a denturist, owns a denture clinic. Carl, another denturist, is an associate of this clinic and therefore an agent of the records. Carl has been working in John's clinic for a number of years but has decided to open his own. Carl never signed a non-competition agreement. Can Carl notify the patients that he treats at John's clinic about his departure?

John is the custodian of the records and Carl is an agent. Carl and John need to have a professional conversation regarding how this change will be communicated to the patients. The denturists need to evaluate how the patients will be best served and work out the business details secondary to that. If the patients provide consent to release their information to Carl, and John agrees, copies of the records could be transferred to Carl's clinic.

Record Keeping No. 2

Debbie, a denturist, has been practising for 45 years in the same clinic, and has built up a busy and successful practice. She decides she is ready for retirement but wonders what she is supposed to do with her patient records. Does she have to retain them herself? Ordinarily she would have to retain patient records for seven years from the last interaction with the patient. But in this case Debbie may be selling her practice to another practitioner to take over the business and patients. If this is the case, she does not have to retain the records herself, but needs to notify the patients of the transfer of their patient records. This can be done through a combination of telling patients on their next visit, sending out letters and placing a notice in the local newspaper. All three of these strategies should be followed unless every patient has been reached in person and by letter.

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