STANDARDS OF PRACTICE: RECORD KEEPING

Standards of Practice are a validated set of expectations that contribute to public protection. The Standards define the expectations for the profession, communicate to the public the Denturists' accountability and guide the Denturist's practice. The College or other bodies may use the Standards of Practice in determining whether appropriate standards and professional responsibilities have been met. In the event of any inconsistency between this Standard and any legislation that governs the profession, the legislation prevails.

Introduction

Documentation and maintaining records is a key component of a Denturist's practice. Documentation whether paper, electronic or digital is used to provide evidence of service, monitor treatment plans, support recall of information, and identify who did what, and when.

This Standard of Practice explains the regulatory expectations for documentation and record keeping. It takes into account applicable legislation and regulations that impact denturism practice. To help Denturists understand their legal and professional obligations, the content is presented as a set of standard statements which describe a broad practice principle. Each standard statement is followed by a corresponding performance indicator that explains how a Denturist would meet the standard when documenting and maintaining records.

Purpose of Record Keeping

The patient record should provide a clear understanding of the patient goals, plan of care, services provided, cost of services, evaluation and outcomes. Information captured in the record can be used for many purposes: 1) to determine the care and services provided; 2) to evaluate professional practice as part of quality assurance requirements; 3) for Denturists to reflect on their practice; and 4) to provide evidence in a court of law or College tribunal.

The physical patient record is owned and held by the Denturist (known as the custodian and/or agent) but information contained in the record is owned by the patient. Therefore Denturists are highly accountable to ensure information is accurate, secure and kept from unauthorized access. Denturists also have an obligation to know the patient's rights with regards to accessing records in accordance with applicable laws.

Failing to keep records as outlined in the Standard, falsifying a record, signing or issuing a document that the Denturist knows is false or misleading, collecting, using, and disclosing information without patient consent and failing to make arrangements for the timely transfer of a patient's record when required all constitute professional misconduct under the *Denturists Act, 1991* and may result in College proceedings.

Glossary

Agent	Any person who is authorized by a health-information custodian to perform services or activities on the custodian’s behalf.
Confidentiality	A set of rules or a promise that limits access to or places restrictions on certain types of information. Patient confidentiality is based on the principle that information should not be revealed to any third party without the patient’s consent.
Attestation (to attest)	The process of assigning responsibility and authority for an activity, usually by applying a signature.
Record	A record may include the patient’s medical record, an appointment book, video recordings, photographs, dentures, rough notes that might not be

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	kept with the record, invoices, billable receipts, consent forms, release forms, patient education materials and information sheets, a master signature list, a laboratory script, and any other documentation relevant to the patient's treatment and/or interaction with the Denturist and others.
Custodian (health information custodian)	A person or organization with custody or control of personal health information as a result of or in connection with performing the person's or organization's power or duties.
Information	Information includes both personal non-health (e.g. phone number, email address, address, birth date) and personal health information.
Encryption	Coding that protects access to electronic data. Encryption is the most effective way to achieve data security. To read an encrypted file, the individual must have access to a security key or password that removes the encryption.
Lock Box	The term adopted by the health-care community to refer to the situation when a patient shares information but asks that it be kept out of the patient record. Individuals may also provide instructions to health-information custodians not to use or disclose their personal information for health-care purposes. The health information custodian is required to respect the request of the individual and ensure that no unauthorized collection, use or disclosure of the information occurs. The custodian records such expressed instructions or limitations on the consent to collect, use or disclose personal health information. When a lock box has been triggered the Denturist can advise any third party that personal health information has been lock boxed. The specifics of the lock boxed information must remain confidential and not be disclosed to a third party.
Security	The degree of protection from loss, damage, disclosure, or misuse.
Substitute Decision-Maker (SDM)	A person described in the *Health Care Consent Act, Substitute Decision-Maker Act* or *Personal Health Information Protection Act* as a person who is authorized under these acts to consent on behalf of the individual.
Unique Identifier	An identifier includes the date of birth, the patient's name, or the unique alpha-numeric code assigned to a record to ensure that information belonging to a patient exists in only one patient profile.

The Standard

Standard Statement	**Performance Indicators**
Documentation is accurate, clear, concise, and presents a comprehensive picture of provided services.	1. Maintains records in an organized, logical and systematic fashion to support ease of retrieval of information.
	2. Ensures documentation is legible and written in either English or French.
	3. Ensures the patient health record contains the following: a. the patient's name, address and date of birth; b. dental and relevant medical history; c. name of emergency contact person and contact information; d. name of the primary-care physician and any referring health professional; e. medication and supplement use; f. information obtained during the examination performed by the Denturist; g. clinical findings and professional opinions of the Denturist; h. when a Denturists either refers a patient or accept a referral the records include the reason for the referral, and name of the professional accepting or referring; i. information about advice provided and patient education

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Standard Statement	Performance Indicators
	that occurred; j. the date and nature of all patient's interactions, including patient services related to any repairs and/or adjustments made; k. information about any procedure that was commenced but not completed and the reason for the non-completion; l. documentation of a refund and the reason for the refund; m. a unique identifier on every part (or page) of the patient record; n. a copy of the external laboratory design prescription; o. a notation documenting the informed consent process according to the Standards for Consent; and p. a copy of the signed consent form, if obtained.
	4. Clearly notes the unique identifier and date on all multi-media data (e.g. pictures of the patient, images of teeth /oral cavity, dentures, email messages, video tapes).
	5. Maintains a master signature list if initials are used to attest the records.
	6. Documents in a timely manner and completes documentation during or soon after the services or event.
	7. Corrects and initials errors while ensuring the original information is visible or retrievable.
	8. If the only service a member provides is a repair of dentures that the member did not fabricate, the record for the repair need only contain: a. the patient's name, address, birth date and contact information; b. the date and nature of the repair; c. the name of the treating Denturist(s); d. advice given to the patient; e. clinical findings and professional opinions; f. a notation of the assessment if conducted; and g. a notation documenting the informed consent process according to the Standards for Consent.
	9. Patient requests for a change in the record can be made in writing or requested orally. a. The Denturist makes changes to the record if he/she agrees the information is incomplete or inaccurate, within thirty days from the receipt of request. b. The Denturist documents the request and the rationale for the change. c. The Denturist is not obligated to make changes to records he/she believes are accurate or complete. This is particularly true when the entry contains an evaluative component or an expression of the professional opinion. d. In the event a change is not made, the Denturist attaches a statement of disagreement reflecting the correction requested. e. The Denturist gives notice of every correction made and every statement of disagreement attached to the patient record to every person and organization to which the record was disclosed during the 12 months preceding the date the correction was requested.

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Standard Statement	Performance Indicator
Records maintained in electronic form meet the Standard of Practice, regulations and legislation.	10. Ensures individual patient records are easily retrievable.
	11. Takes reasonable steps to ensure that records maintained in electronic form are secure from loss, tampering, interference or unauthorized use or access.
	12. Confirms the system maintains an audit trail that, at a minimum, records the date and time of each entry of each patient, shows any changes in the record, and preserves the original content when a record is changed, updated or corrected.
	13. Ensures regular off-site back-up and/or automatic back-up for file recovery to protect records from loss or damage.
	14. If documents are scanned and maintained in an electronic form, the original paper copy may be securely destroyed.

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Records are collected, maintained, shared and disclosed in a secure and confidential manner in accordance with applicable legislation and regulations.	15. Denturists who act as the custodian: a) ensure physical security of all records and personal information (including staff human resource files); b) put in place security systems on electronic devices (e.g. passwords, user IDs, encryption, firewall and virus scans); c) display the privacy and confidentiality policy and ensure it is visible to the public; d) train staff on security and confidentiality policies; e) act as or appoint a privacy officer; f) regularly audit the practice for compliance with security policies and confidentiality agreements; and g) notify patients whose personal health information has been compromised (stolen, lost, or accessed by an unauthorized person).
	16. Take reasonable steps to transfer patient records before resigning as a member or selling practice in accordance with the Standards for Professional Communications.
	Denturist:
	17. Collects and stores only necessary information that pertains to the services provided.
	18. Obtains and documents patients' informed consent prior to the collection, use, storage and release of information, digital images and impressions, according to the Standards for Confidentiality and Privacy.
	19. Retains patient records for a period of seven (7) years, either in paper or electronic form, from the date of the last entry.
	20. Maintains draft notes as a component of the patient record until such time as the notes are transcribed into the record and ensures all data is captured in the record before destruction of the notes.
	21. Ensures the maintenance of multi-media data (pictures of the patient, images of patient's teeth or oral cavity, patient's dentures, email messages, or other digital images or recordings) comply with the same collection, retention, use and disclosure legislation and standards as paper notes.
	22. Maintains a daily appointment record which sets out the name of each patient seen by the Denturist.
	23. Shares information and/or allows access to the patient record only for the purpose of providing services or assisting in the provision of care; for the purpose of seeking legal counsel or insurer advice being sought by the member or required by the member's policy of insurance; as ordered by a subpoena; or to

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	comply with the *Regulated Health Professions* Act, (e.g. release patient records for the purpose of College Quality Assurance program or College investigation).
	24. Facilitates the right of patients and/or substitute decision-makers to access, inspect, and/or obtain a copy of the patient record, unless the Denturist reasonably believes there is serious risk of harm to the care of the patient or serious physical or emotional harm to the patient or another person.
	25. Provides a report or certificate relating to an examination or treatment performed by the Denturist within thirty days of a request from the patient or his or her substitute decision-maker.
	26. Provides patient records to the patient within a reasonable time on request, though a reasonable fee for the copying of a patient record may be collected first. (Denturists may refuse to release the record until such fees are paid, unless there is risk of harm to the patient if the information is not released.)
	27. Takes measures to ensure all information is kept secure and access is limited to authorized personnel only. (e.g. password protect documents, use of encryption, log off computer, lock filing cabinets, computer back-up).
	28. Respects patient requests to withhold information in the record (See glossary "Lock Box").
	29. Notifies the patient of a breach of security via unauthorized access, loss or theft of information.
	30. Obtains patient's informed consent before communicating by email and/or sending information electronically, explaining the potential risk of another person's access to information.
	31. Ensures the intended recipient of a facsimile is named on the document and places a confidentiality statement on the bottom of the facsimile.
	32. Takes reasonable steps to ensure security of information when transporting patient records or information (e.g. moving from one office to another, bringing patient files home).

Standard Statement	Performance Indicators
Records eligible for destruction are destroyed in a secure and confidential manner.	33. Ensures all information is permanently destroyed or erased in an irreversible manner making sure the record cannot be reconstructed in any way.
	34. Maintains a copy of the destruction date and the names of the individuals whose records were destroyed.
	35. Seeks consultation on the secure destruction of multi-media and computer files from a field expert.

Standard Statement	Performance Indicators
Financial records are kept as part of the patient record or linked by the unique identifier.	36. Maintains an account of all charges for services, which accurately reflects services provided.
	37. Issues an invoice which Includes the following: a) the Denturist's company name, address and phone

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	number; b) the patient's/recipient's name and address; c) the cost of the item/services; d) the date and method of payment received; e) balance due or owing; and f) if applicable, the fees charged by commercial laboratory.
	38. Issues a receipt for all payments received and a credit receipt for all refunds.
	39. Ensures a process is in place to provide upon request, an itemized account of fees charged for professional services, using terminology understood by the public.

Standard Statement	**Performance Indicators**
All services to, maintenance for and inspection of equipment and/or instruments are tracked.	40. Maintains an up-to-date record of service to and maintenance for equipment and/or instruments (e.g. safety datasheets, autoclave testing).
	41. Maintains equipment records for a minimum of seven (7) years from the date of the last entry, even if the equipment has been discarded.

Standard Statement	**Performance Indicators**
Takes reasonable steps when closing the clinic and/or resigning registration to ensure patients have access to their records.	42. Makes appropriate arrangements with the patient for the transfer of the patient's records when the member ceases practice, or when the patient requests the transfer.
	43. Makes reasonable efforts to notify patients before transferring records to a new custodian, or as soon as possible thereafter.
	44. Makes reasonable efforts to inform patients of the intent to close the clinic and/or resign, and provides information on how to access and /or obtain a copy of the record.

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