COLLEGE OF DENTURISTS OF ONTARIO

# *Guidelines for Record Keeping*

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## Overview

The College's Standard of Practice: Record Keeping articulates the regulatory requirements for documentation and record keeping. It is important for Registered Denturists to maintain patient records in an organized, logical, and systematic fashion to facilitate adherence to the requirements set out in the *Personal Health Information Protection Act, 2004* (PHIPA).

This Guideline offers further clarity regarding record keeping retention, patient charting, disclosure of records, and working in a multi-disciplinary practice.

## Retention of Records

In general, a patient's clinical and financial records must be kept for at least seven years from the date of last entry in that record. Other records such as equipment records including maintenance and inspections should also be retained for a minimum period of seven years.

### *Closing, Leaving, or Selling a Practice:*

Denturists must notify their patients if they are closing, leaving, or selling a practice. They should consider sending an electronic communication such as an email message to patients who have provided an email address. Those without email addresses should be sent paper letters. Denturists can also place notices in local newspapers to advise their patients that the clinic is being sold, transferred, closing, or moving locations.

A Health Information 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.

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

The College has published a separate guideline regarding the important topic of closing, leaving, or selling a practice. Please review those guidelines for further information.

For more information regarding your potential role as a Health Information Custodian, please visit the Information and Privacy Commissioner of Ontario's website.

### *Records Eligible for Destruction:*

Records must be retained for the minimum seven-year period. After the expiration of this retention period, records may be eligible for secure destruction. If a patient has filed a complaint to the Information Privacy Commissioner, those records should be kept until the patient has completed the process of the investigation.

When destroying eligible patient records, Registered Denturists need to ensure that all information is permanently and securely destroyed or erased in an irreversible manner and to ensure that the record cannot be reconstructed in any way.

The secure destruction of the patient record should be recorded in a separate record or log known as the Record of Destruction. This record of destruction should be kept indefinitely as proof that destruction took place, what records were destroyed, and when it was destroyed. If the practice is transferred to another practitioner, the record of destruction should also be transferred.

If the Registered Denturists use electronic records, they should seek consultation on the secure destruction of multi-media and computer files from a field expert.

## Patient Charting

### *Basic Charting Information:*

All patient records should contain the following information:

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;
g) clinical findings and professional opinions;
h) reasons for referring a patient or the patient accepting a referral, and the name of the professional accepting or referring;
i) information about advice provided and patient education 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 copy of the external laboratory design prescription;
n) a notation documenting the informed consent process according to the Standard of Practice: Informed Consent;
o) a notation documenting the consent to collect, use and disclose patient information in accordance with the clinic's privacy policy and according to the Standard of Practice: Confidentiality & Privacy; and
p) copies of the signed consent forms.

### *Records for Denture Repairs:*

If the only service provided is a repair of dentures that the Registered Denturist did not themselves fabricate, the record for the repair may only contain the following:

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;
g) a notation documenting the informed consent process according to the Standard of Practice: Informed Consent.
h) a notation documenting the consent to collect, use and disclose patient information in accordance with the clinic's privacy policy and according to the Standard of Practice: Confidentiality & Privacy; and
i) copies of the signed consent forms.

### *Financial Records and Invoices:*

Registered Denturists must maintain an account of all charges for services, which accurately reflects services provided and the amounts paid for the services.

Registered Denturists should issue an invoice which includes the following information:

a) the Denturist's name, as it appears on the Public Register, and registration number;
b) the Denturist's company name, address and phone number;
c) the patient's/recipient's name;
d) the cost of the item/services;
e) the date and method of payment received;
f) balance due or owing; and if applicable

If a payment is received or a refund is issued, documentation must be provided to the patient with a copy kept in or linked to the patient record.

As of July 1, 2024, Registered Denturists must provide an itemized receipt or invoice providing an account of fees charged for professional services regardless of if the patient requested it or not. Registered Denturist must also provide them with that information using terminology that they would understand.

### *Electronic Records:*

Registered Denturists that keep electronic patient records should keep the following in mind:

- Ensure individual patient records are easily retrievable and identifiable.

- Each individual patient should be assigned a unique identifier or patient ID. Registered Denturists are free to employ a method for assigning a unique identifier that works best for their record keeping processes. This may include the use of an electronic records management system or patient management system that assigns a unique identifier that is captured as metadata.

- Take reasonable steps to ensure that records maintained in electronic form are secure from loss, tampering, interference or unauthorized use or access.

- Confirm 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.

- Ensure regular off-site back-up and/or automatic back-up for file recovery to protect records from loss or damage.

- Securely destroy paper documents once they are scanned and maintained in electronic form.

Registered Denturists should maintain draft notes as a component of the patient record until the notes are transcribed into the record before they can securely destroy any draft notes. Once a physical document is scanned into a patient file, it can be securely destroyed. An official patient records can either be in electronic or paper format, once the Registered Denturist has selected a format for their practice, all copies can be securely destroyed.

The College does not provide recommendations for software or hardware systems. It is suggested that Registered Denturists speak to their colleagues or Denturism associations to inquire about various options, prices, and features.

### *Patients Requesting Changes to Patient Records:*

Patients can request changes to their patient records either in writing or making a request verbally.

The Registered Denturist must document the request and the rationale for the change. It is important to remember that a Registered Denturist is not obligated to make changes to records they believe are accurate or complete. This is particularly true when the entry contains an evaluative component or an expression of the professional opinion.

In the event a change is not made, the Registered Denturist must attach a statement of disagreement reflecting the correction requested. The Registered Denturist must also give 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.

### *Correcting Patient Records:*

From time to time, Registered Denturists may wish to correct or modify patient records when new circumstances change or to correct a mistake in the records.

When correcting a patient record, Registered Denturists should initial the error(s) while ensuring the original information is visible or retrievable. It is also advisable for the Denturist to note the date the

change was made. If the change is substantial, it is also advisable for the Denturist to make a note as to the rational for the change.

## Disclosure of Patient Records

Registered Denturist must facilitate 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 if the patient records are disclosed.
Additionally, copies of patient records must be provided 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.)

A Registered Denturist can share information and/or allow access to patient records for the purposes of:

- providing services or assisting in the provision of care;
- seeking legal counsel or insurer advice being sought by the member or required by the member's policy of insurance;
- complying with a subpoena; and/or
- complying with the *Regulated Health Professions* Act, (e.g. release patient records for the purpose of College Quality Assurance program or College investigation).

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.

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.

## Multi-Disciplinary Practices

Registered Denturists may practice in a variety of clinical settings including multi-disciplinary practices with several other health care professionals. In multi-disciplinary practices, it may make sense to have one shared patient record for the various health care professionals.

This is likely more efficient and ensures that all members of the patient's team are aware of the care provided. Each respective Regulated Health Professional will want to ensure that they comply with their respective regulator's requirements when making such entries.

Ideally, the organization who operates the multi-disciplinary practice will take all such requirements into account when stipulating how practitioners are to document in the patient record. The *Personal Health Information Protection Act, 2004* (PHIPA) and College's standards must be complied with irrespective of the employer requirements. It is important to remember that each practitioner 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. Patients and the patient record must clearly state who provided the treatment, the services rendered by each practitioner, and all other required information for invoices.

If the Denturist is practicing through a professional corporation, no other regulated health professionals can bill from that Denturist's corporation, and therefore shared invoices is not permitted.

There are certain health regulators who mandate that dual 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.

### *Health Information Custodians and Agents:*

A health information custodian is ultimately responsible for the personal health information in their custody or control, but may permit an agent to collect, use, disclose, retain, or dispose of the information if certain requirements are met. The agent must ensure that the collection, use, disclosure, retention, or disposal of the information is permitted by the custodian and is necessary for the purposes of carrying out the agent's duties. Such purposes must not be in contrary to the law and comply with any specific restrictions imposed by the custodian.

Health information custodians have the following additional administrative duties:

- to develop and comply with policies (known as "information practices") with respect to:
    - when, how, and the purposes for which the custodian routinely collects, uses, modifies, discloses, retains, or disposes of personal health information; and
    - the administrative, technical, and physical safeguards and practices that the custodian maintains with respect to personal health information.

- to designate a contact person to:

  - facilitate the custodian's compliance with PHIPA;
  - ensure that all agents are informed of their duties under PHIPA;
  - respond to public inquiries about the custodian's policies;
  - respond to requests for access or correction; and
  - receive public complaints about alleged privacy breaches.

- to display or make available a written public statement that:
  - provides a general description of the custodian's privacy policies (including the purposes for which personal health information is collected, used and disclosed);
  - describes how to contact the contact person or the custodian;
  - describes how an individual can seek access to or correction of a record; and
  - describes how an individual can make a complaint to the custodian and to the Information and Privacy Commissioner of Ontario.

Health information custodians must also notify the individual about whom the information relates if the individual's personal health information is used or disclosed in a manner that is outside the scope of the description set out in the written public statement.

## Example Practice Scenarios

### *Record Keeping Scenario 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 Scenario 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 notifying patients formally by email, at their next visit, sending out letters, and placing a notice in the local newspaper. All these strategies should be followed unless every patient has been reached in person and by letter/email.

## Frequently Asked Questions

### *Records 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 maintain multi-media such as patient pictures, old dentures, digital images, or recordings?**
Registered Denturists must ensure 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.

**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 models and other physical items related to the patient's 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 instead.

**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 it must be secure and meet the security requirements. In other words, only authorized individuals should have access to the patient records, regardless of where the documentation is stored.

## *Patient Charting*

**When should I do my charting?**
Registered Denturists should complete their charting during or soon after the services have been provided or events have occurred.

**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.

**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 from the Denturism 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.

**Can you clarify what is required for charting information regarding 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 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 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. The use of video surveillance must take into account the privacy of the patient.

Patient appointments may be recorded upon receipt of explicit consent by the patient. Special precautions must be taken to protect the privacy of video images and no covert surveillance should be conducted. Patient records should be transcribed after each appointment, either in hardcopy or electronically. For more information regarding the use of video surveillance please contact the Information and Privacy Commissioner of Ontario.

**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.

## *Patient-Related Questions*

**What are some best practices for sending patient information or documentation electronically?**
Registered Denturists should obtain the patient's informed consent before communicating by email and/or sending information electronically, explaining the potential risk of another person's access to information.

**I attend a lot of house call appointments and take patient records with me on these appointments. Is there anything special I need to do?**
Registered Denturists who transport patient files or information need to take reasonable steps to ensure security of information (e.g. moving from one office to another, bringing patient files home).

**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 a 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.

If the CFSA does not apply, the Denturist must comply with the *Personal Health Information Protection Act, 2004* (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 legal counsel to see if they have the requisite belief in order to justify the disclosure.*

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

The "lock box" provision normally speaks to sharing personal health information with other health care providers. For example, a health care provider is permitted to share personal health information 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 personal health information 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 they are still intent on keeping this information confidential. If they change their mind, this will permit the Denturist to disclose the information. The Denturist will likely want to provide the patient with resources so that they can obtain help.

**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 Practices:*

**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 their 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.

# Appendix

## List of Revisions

| Date | Revision |
|---|---|
| June 18, 2024 | • Updated guidance that all patients be provided with an itemized receipt or invoice.<br>• Updated guidance on unique identifiers and electronic records.<br>• The Denturists name and registration number is required on all receipts and invoices as it appears on the public register.<br>• Removal of requirement to list the patient's address on receipts and invoices. |
| June 14, 2024 | Updated template style guide, new headers, table of contents added. Approval of final draft by Council. |
| November 1, 2019 | First draft approval by the Quality Assurance Committee. |