Everything you need to know about dental records

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INTRODUCTION

Many practitioners, practice managers, and staff often have inquiries regarding dental records. They ask questions such as: "What is the retention period for patient records?" "Are study models included in dental records?" "Should we retain all records when our practice space is limited?" "Does the POPI Act apply to dental records?" At times, they also inquire about the possibility of disposing of records to free up space.

Nevertheless, many dentists, staff members, and managers lack clarity on how to manage these records and when it is appropriate to discard them.

The maintenance of dental records is fundamental for effective patient management and is regarded as both an ethical and legal responsibility of the dentist. Ethically, it fulfills the duty of care owed to the patient by the dentist, while legally, it serves as protection against potential medico-legal issues.

Dental records are classified as legal documents owned by the dentist, encompassing both subjective and objective information about the patient.

What is a dental record?

A dental record is a detailed document of the history of the illness, physical examination, diagnosis, treatment, and management of a patient. Dental professionals are compelled by law and ethics to produce and maintain adequate patient records.

The record comprises several elements including written notes, radiographs, study models, referral letters, dental charting, consultants' reports, clinical photographs, results of special investigations, drug prescriptions, laboratory prescriptions, patient identification information, and comprehensive medical history.

It includes subjective data (reasons for visiting the dentist, chief complaint, and symptoms), objective findings (obtained from clinical examination and diagnostic tests), assessments (diagnostic and therapeutic judgments based on the subjective data and objective findings), and treatment plans (various options and their costs, risks and benefits, time considerations, and so on).

A dental record usually comprises three sections:
patient information (see next);

- business information (billing details with date and amount, copies of claim forms submitted, information related to laboratory services used and their charges, scheduling of appointments); and
- drug record (condition being treated, dates and method of prescription, administration and dispensing of the drug including its name, strength, quantity, form, and directions of use).

A dental record may be used:

(i) for planning and maintaining continued patient care;
(ii) for documentary evidence of the evaluation and diagnosis of the patient'scondition, the treatment plan and informed consent, the treatment actually rendered, recalls and referrals made, and the follow-up care provided;
(iii) to monitor the success or failure of treatment carried out, as well as to monitor the patient's oral health and assist with oral health promotion and preventive practice;
(iv) to document all communications with the patient, whether written, verbal, electronic, or telephonic;
(v) as a record of communication regarding the patient and other healthcare providers, as well as interested third parties;
(vi) to protect the legal interests of all parties involved;
(vii) to provide data for continuing dental education, training, and research; and
(viii) for billing, quality assurance, and other administrative functions.

Records can also be used for communication with other practitioners or specialists for second opinions. They are indispensable as direct evidence against litigation or complaints lodged by patients in the event of malpractice lawsuits as well as medical scheme audits for utilization and clinical audits.

What makes a good record?

To keep things simple, try thinking in terms of the 4 Cs.

Contemporaneous: make a record as soon as possible after a patient interaction.

Clear: record your findings carefully (and legibly if not using a computer) so that they can be understood by anyone who may need to read and interpret them. For example, avoid abbreviations as far as possible and use one system of dental charting. It should be clear who made an entry and when.

Complete: It should where appropriate consist of all relevant clinical findings, including (but not limited to): -

- Who is making the notation in the patient health record (this is particularly important when multiple healthcare professionals are responsible for a patient health care record);
- The times of consultation and other clinical interactions;
- The full clinical history;
- The clinical examination;
- The differential diagnosis;
- The information and advice given to the patient;
- The clinical decisions made and when and who made such decisions;
- The decisions and actions agreed to and when these were agreed to;

- When required the written affirmation of such agreements (consent forms);
- The treatment administered (including detailed operation or invasive intervention notes when such a procedure has taken place):
- The drugs and doses of drugs given;
- The investigations ordered and their results and dates when ordered and when results have been received;
- Future appointments and referrals made;
- Any other documentation relevant to a patient's health.

The interactions that need to be recorded in a patient health record include (but are not limited to): -
- The face-to-face discussions between the patient and a health practitioner;
- Progress notes when a patient is seen for review regarding a specific episode of care (e.g. while a patient is in hospital or when a particular condition requires follow-up);
- Any virtual, telephonic or similar discussions and/or consultations with the patient and their relatives;
- Discussions with colleagues related to the patient;
- All correspondence related to the care of a patient.

The compulsory elements of a patient health record are: -
- The personal (identifying) particulars of a patient;
- The full biopsychosocial history of a patient, including allergies and idiosyncrasies;
- The time, date and place of consultation;
- The assessment of the patient;
- The proposed management of the patient;
- The medication and dosage prescribed;
- Details of referrals to specialists and other healthcare professionals;
- The patient's response to treatment, including adverse effects;
- Investigations ordered and their results;
- Details of the times that a patient was booked off work or similar activities and the relevant reasons;
- Written proof of informed consent when this is relevant.

Concise: records should be just long enough to convey the essential information. It should not contain superfluous personal comments or derogatory remarks regarding the patient.
that could backfire if someone else needs to access the record.

Alteration of patient health records

Late and additional entries must be dated and signed in full, when made in an electronic format, they must be fully attributable to the person making such a change. The reason for an amendment or error must be specified on the record.

Any error or incorrect entry discovered in the record may be corrected by placing a line through it with ink and correcting it. The date of change must be entered and the correction must be signed in full. The original record must remain intact and fully legible. Under no circumstances should the note simply be deleted or torn out and thrown away.

Privacy and security of patient health records

The National Health Act [1], imposes on the owner of a practice a duty to set up control measures to prevent unauthorised access to records including those in storage. This would apply to both paper and electronic records.

Electronic data must be managed, stored and backed up using internationally accepted standards.

The Protection of Personal Information Act (POPIA) is a robust data protection legislation that safeguards individuals' personal information and privacy. Practitioners are obliged to secure integrity and confidentiality of personal information and take necessary measures to prevent loss, damage or unauthorised destruction of personal information. They must take appropriate safeguards against all identified risks.take necessary measures to prevent loss, damage or unauthorised destruction of personal information. They must take appropriate safeguards against all identified risks.

Retention of records

What does the law say about retention periods of dental records?

Is there any law that prescribes the time that dentists need to keep their patient's clinical records in South Africa?

No legislation presently prescribes the length of time that dentists must keep their clinical records, there are, however, ethical guidelines published by the Health Professions Council of South Africa (HPCSA)[2].

Patient health records should ideally be stored indefinitely, if this is not practical the following retention periods are suggested:

Patients – Stored for at least a minimum of six (6) years as from the date that a patient health record has become dormant (dormancy commences at the time when a patient was last treated by a healthcare practitioner).

Exceptions to the above rule

Minor patients – Until their 21st birthday as legally minors have up to three years after they reach the age of 18 years to bring a claim.
Mentally impaired patients – until the patient's death.
Occupational illness or accident – 20 years after treatment has ended.
Provincial hospitals and clinics – Records to be destroyed with authorisation of the Deputy Director-General.
Patients exposed to conditions that manifest in a slowly developing disease – At least 25 years.
Professional indemnity provider – Recommended retention period of a minimum of 11 years for adults.

A balance must be reached between the costs of (indefinite) retention of records and the occasional case where the practitioner's defense of a case of negligence is hampered by the absence of records.

Retention of electronic records

Storage of electronic clinical records must include the following protective measures:
- All electronic clinical records, including those stored on external hard drives, must be encrypted and protected by passwords in order to prevent unauthorised persons from gaining access to such information.
- Copies of backup hard drives must be kept and stored in a physically different site so that the two discs can be compared in case of any suspicion with tampering.
- Effective safeguards against unauthorised use or retransmission of confidential patient information is to be assured before such information is entered on the computer. The right to patient privacy, security, and confidentiality should be protected at all times. All staff should not have access to all electronic records, access must be granted on the basis of their responsibilities.

The cost and space implications of keeping records indefinitely must be balanced against the possibility that records will be found

useful in the defence of litigation or for academic or research purposes.

A person normally has three years to initiate a claim after the relevant incident took place in terms of the Prescription Act (Act 68 of 1969).

The prescription period is delayed in some cases like in the case of minors under the age of 18 years, dental records should be kept until the minor's 21st birthday. It is important to remember that prescription may even run from when the patient has knowledge of the facts giving rise to a claim.

Therefore, not only the treatment date is crucial but also the date on which the patient has knowledge (or should, by the exercise of reasonable care have had knowledge) that harm was caused by the treatment.

Practitioners would thus have to balance the costs of indefinite retention of records and the case where the practitioner's defence of a negligence case or complaint to the regulator is handicapped by the absence of such records.

Ownership and Access to Dental Records

Where records are created as part of the functioning of a private practice, including the original radiographs or ultrasound or scanned images, the dentist is the legal owner of such records and they remain solely the property of the dentist. Patients do not have the right to possess their original record, but they may request access to, or have a copy of, their dental records for various reasons.

Patients are entitled to have access and obtain information contained in the records. A copy of the records, radiographs, study models, and so on can be provided to the patient or transferred to a new practitioner on request.

The patient may be charged an appropriate fee for such copies, provided that the patient is made aware of the charges.

In the case of a deceased practitioner, the executor of his or her estate will administer dental records as well. Should the practice be taken over by another practitioner, the executor shall pass the records to the new practitioner. The new practitioner is obliged to inform all patients in writing regarding the change of ownership, and the patient can remain with the new practitioner or request that the patient's records be transferred to a practitioner of the patient's choice. Should the practice not be taken over, the executor should inform all the patients in writing and transfer those records to other practitioners designated by the individual patients. The remaining files shall be kept in safe-keeping by the executor for at least 12 months with full authority to further deal with the files as deemed appropriate, provided the provisions of the rules on professional confidentiality are observed.

Practitioners closing their practice for whatever reason (retirement, ill health, change in profession) shall within three months of closure inform all their patients in writing that date when it will close, records will be transferred to the practitioner of the patient's choice and others be kept in safekeeping for at least twelve (12) months. Although this period is mentioned in ethical guidelines, indemnity providers and insurers may require practitioners to keep it for longer in the event a complaint or claim is made.

In the event that a dentist in private practice decides to close or sell his or her practice for any reason, the practitioner shall inform in writing and in a timely manner all the dentist's patients as follows:

- That the practice is being closed from a specified date;
- That requests can be made for records to be transferred to other practitioners of the patient's choice;
- That after the date specified, the records shall be in safe-keeping for a specific period with an identified person or institution with full authority to deal with the files as deemed appropriate, provided the provisions of the rules on professional confidentiality are observed.
- That in the case of sale, the new practitioner owner will take custody of files unless they object to the transfer of their personal information. The incoming dentist should notify patients that he or she is the new owner of the practice and is now in possession of their dental records.
- Patients have the right given the right to alter or edit information if they consider it incorrect or inaccurate.

A dentist may make information available to a third party without the written authorisation of the patient or his or her legal representative in cases where, for example:

- It is demanded by the court in medico-legal cases, for example, when the dentist is a witness in a trial between a patient and another party, or where the patient has instigated action in court against the dentist, and the dentist is ordered to testify on the patient's dental condition or to produce his or her dental record.
- A professional body has instituted disciplinary hearings, and the dentist must answer the charge to defend him or herself.
- The dentist is under a statutory obligation to disclose certain facts (e.g., in the case of suspected or known child abuse).

The Promotion of Access to Information Act gives persons the right of access to any information required to exercise or protect their rights before the institution of court proceedings. These will have to be done in terms of the manual of the particular practice and should include:

1. sufficient particulars to enable the practitioner to identify the requester
2. sufficient particularity regarding the record being requested.
3. the form of access to the record required (copies or electronic format).
4. postal address or fax number of the requester.
5. how the requester would like to be informed of the decision on the request.
6. if the request is made on behalf of a person (if attorneys make the request, for example), proof of the capacity in which the person is making the request, e.g. a power of attorney or consent of the patient.

A reasonable fee may be requested in producing copies of records. The HPCSA has ruled that where the patient has paid for x-rays or images, they are entitled to request and obtain originals and the practitioner must keep copies in the patient file.

Disclosure of patient records to patients

The ethical rules of the HPCSA on disclosure of records provide:

Person 12 years or older – The practitioner can provide the patient with a copy or abstract or access to his/her dental records should they request it.

Under the age of 12 years – Information regarding the

patient may only be divulged with the written consent of the patient's parent or guardian

The parent making a request for records in respect of a patient under 16 years – Disclosure can only be made subject to the consent of the patient in terms of the Promotion of Access to Information Act

Deceased patient – May only be divulged with the written consent of the next of kin or the executor of the deceased's estate

Third-party – No dentist shall make information available to any third party without the written authorisation of the patient or his or her legal representative.

Disclosure without consent of patient/legal representatives

a) Court order records be handed over to the third party
b) The dentist is under a statutory obligation to disclose certain medical facts, for example, reporting a case of suspected child abuse in terms of the Children's Act (Act 38 of 2005).
c) A patient has instituted an action in Court against a healthcare practitioner and the practitioner needs access to the records to mount a defence
d) The third party is a healthcare practitioner who has had disciplinary proceedings instituted against him/her by the Health Professions Council and the practitioner requires access to the records to defend himself/herself.
e) Where the ailment of a patient becomes known to a dentist and the nature thereof is such that the dentist concerned thinks that the information ought to be divulged in the interest of the public at large. Before the information is divulged the relevant information should be given to the patient and voluntary authorisation should be sought from the patient

Divorced or separated parents

Disclosure of their child's records may be with the consent of the parent with full parental rights and responsibilities in respect of a child.

Where more than one parent holds the same parental rights and responsibilities in respect of a child, each of the co-holders may act without the consent of the other co-holder when exercising those rights and responsibilities, except where this Act, any other law, or a Court Order provides otherwise.

One way of dealing with the troublesome issue of consent with divorced, separated, or estranged parents is to have an office policy that requires the consent of both parents, even where there is joint legal custody of the minor. Retain a copy of the custody court order in the patient file.

Provincial hospitals

The records are kept under the care and control of the clinical manager and access to such records shall be subject to compliance with the requirements of the Access to Information Act and such conditions as may be approved by the superintendent.

Storage of dental records

Making a record is only the start of your professional responsibilities. Whether records are held on paper or electronically, you also have an ethical obligation to uphold patients' rights by making sure records are appropriately stored, shared, and disposed of. There are few if any legal obligations, however, the ethical rules provide that all records must be kept in a safe place.

The Protection of Personal Information Act, provides that you must ensure the integrity and confidentiality of the personal information under your control. This means that you must take appropriate, reasonable technical, and organisational steps to prevent the loss, damage, or unauthorised destruction of personal information or the unlawful access to or processing of information. It is no longer safe to keep patient records on an open shelf in an area of the practice where it is open to everyone in the practice.

Some of the measures to be implemented include:

- keep hard copies of records under lock and key
- implement IT security measures such as firewalls, virus protection, and encryption. Seek professional advice if necessary
- arrange regular data protection training for staff. In NHS practices, staff should know the identity of their local data protection officer
- require all staff to have individual log-in profiles and strong passwords to prevent unauthorised access to patient data. Passwords should be regularly changed and password sharing should be banned
- ensure staff only have access to the information they need to do their job
- back up electronic records regularly to protect against file corruption or accidental loss. Back-ups should be held securely off-site in case of accidental loss
- have a signed written contract with all third-party suppliers, including IT contractors, which sets out your confidentiality requirements
- keep personal and professional computers and mobile devices entirely separate, to avoid confidentiality breaches.

Paper Records

Paper records can be easily damaged by moisture, water, fire, and insects. As paper records are irreplaceable, it is a good idea to identify ways in which to safeguard them.

If you keep all your dental records in paper format, you must ensure there are systems in place to protect them in case of fire, flood, or other circumstances that could damage the records.
You must ensure you install smoke and fire alarms to allow you to act quickly in the event of a fire breaking out. Water sprinkler systems can damage electronic equipment so install chemical fire extinguishers to protect your paperwork.

Basements are not recommended for storing records as they are prone to flooding, instead, store records above floor level and ideally on a high shelf.

It is also important to conduct regular inspections of your premises and have control measures carried out by experts to keep damaging insects and rodents at bay.

Electronic Records

In the case of electronic records, they should be encrypted and safeguarded by passwords so that not all personnel have access thereto and no changes can be made.

If records are saved in the cloud or on a server, it is useful to have a backup copy that is stored off-site so records can be reconstituted if the need arises.

It is no defence to argue that records or in particular x-rays were lost due to hardware or software malfunction and that all or a portion of records were permanently lost or destroyed.

What are the legal requirements for the disposal of records?

There is no legislation prescribing how records should be destroyed. The ethical rules are also silent in this regard.

Common sense would have to prevail here and one must be mindful of the provisions of the Protection of Personal Information Act,

2013, which provides that personal information of patients must be protected at all costs when destroying records.

Records should not be disposed of in the ordinary waste or given to unregistered recyclers but rather contract a professional waste disposer. It can be incinerated by a service provider or shredded in a manner that these records or personal information cannot be reconstructed. All identifying information on casts and models must be removed prior to disposal.

An efficient records management system should include arrangements for archiving or destroying dormant records to make space available for new records, particularly in the case of paper records.

Records held electronically are covered by the Electronic Communications and Transactions Act, which specifies that personal information must be deleted or destroyed when it becomes obsolete.

The records should be examined first to ensure that they are suitable for disposal and an authority to dispose of them should be signed by a designated member of staff.

The records must be stored or destroyed in a safe, secure manner. If records are to be destroyed, paper records should be shredded or incinerated. CDs, DVDs, hard disks, and other forms of electronic storage should be overwritten with random data or physically destroyed.

Be wary of selling or donating second-hand computers – "deleted" information can often still be recovered from a computer's hard drive.

If you use an outside contractor to dispose of patient-identifiable information, it is crucial that you have a confidentiality agreement in place and that the contractor provides you with certification that the files have been destroyed.

You should keep a register of all healthcare records that have been destroyed or otherwise disposed of. The register should include the reference number (if any), the patient's name, address and date of birth, the start and end dates of the record's contents, the date of disposal, and the name and signature of the person carrying out or arranging for the disposal.

Standards of dental records

The guidelines state that:

1. No information or entry may be removed from a health record.
2. Be consistent.
3. Be complete and concise sometimes diagrams are useful.
4. Avoid self-serving, derogatory, insulting, or disapproving comments in patient records.
5. Contain notes about history, physical findings, investigation, diagnosis, treatment, and outcome.
6. An error or incorrect entry discovered in the record may be corrected by placing a line through it with ink and correcting it. The date of change must be entered and the correction must be signed in full. The original record must remain intact and fully legible.
7. Contain a line through the item that requires alteration so that the revision is visible under the line, dated, and signed. Under no circumstances should the note simply be deleted or torn out and thrown away.
8. Contain separate labels for diagrams, lab results, photographs, charts, and x-rays. Do not rely on sheets of paper bound or stapled together.
9. Be kept separate from financial or billing records.

For medico-legal purposes, the following are important to note:

1. Do not rewrite your notes as only notes written contemporaneously have any value in court. A practitioner may, however, make further notes at a later stage. These notes should be correctly dated and signed. The reason for recording the note should also be stated.
2. Where you are proposing treatment with inherent complications, a record that the patient proposed has been advised of the material risks and complications of the treatment in question. If possible, ask your patient to sign a confirmation that s/he has been warned of the material risks and complications of the treatment to which s/he has agreed. Such discussions regarding the material risks and complications of a procedure should take place well in advance of the date of the proposed treatment so that the patient has time to digest and consider the information conveyed
3. Practitioners should note any discussions with patients regarding fees or fee estimates.