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Off the Record*

Abstract: Clinical dental records fulfil a variety of functions. Whilst there is no standard data set for dental records, it is essential that these are contemporaneous – that is, they are 'recorded at the time'. A good written record should contain details of the patient's identification data, medical and dental history, clinical examination, diagnosis, treatment plan, reference to consent, and progress notes. This paper covers these aspects in detail, and provides information on how long records should be stored, and who may access clinical records.

Clinical Relevance: The recording of contemporaneous patient/treatment information is central to treatment planning and good patient care.

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Clinical dental records are primarily designed to record treatment carried out on a patient and to act as a historical record. They are essential to the delivery of dental care, contributing to the processes of diagnosis, treatment planning and the provision of care in an ordered manner. Clinical records are a communication tool, allowing a patient's care to be accessed by the treating dentist, the patient themselves and other healthcare workers.

Records, however, assume a different significance when a patient either complains, makes a claim in negligence, or something goes wrong. In this respect, a dentist's legal position may be undermined by the lack of supportive information in the patient's clinical records, even when the treatment provided has been of a high standard. Poor record-keeping can make it difficult or impossible to defend claims of clinical negligence or professional misconduct. Record-keeping should therefore not be considered an afterthought, used merely to record treatment items, or to note financial or administrative functions. The rise of consumerism means that patients' expectations of their care is higher and patients are ever more ready to question the care that they have been given.

This threat of litigation has prompted many dentists to change their note-taking and improve the explanations given to patients.[1] Also, records may come under the scrutiny of patients, their legal advocates, statutory NHS bodies, third party payers and regulatory bodies, such as the General Dental Council.

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- Handwritten clinical notes (record cards/envelopes), including medical history
- Computerized records
- X-ray films and other imaging records (and tracings if relevant)
- Investigations (pathology reports, printouts from monitoring equipment)
- Models
- Photographs
- Correspondence between health professionals
- Other information eg laboratory instructions and receipts, estimates
- Videos
- Tape recordings of telephone conversations

Table 1. What do records comprise?

What are records?

A medical record is:

- Any record which contains information relating to the physical or mental health or condition of an individual; and
- Any record that has been made by, or on behalf of, a medical professional in connection with the care of that individual.[2]

It is therefore apparent that dental records may cover a wide range of material. Table 1 shows what records comprise.

Standards in record keeping

Whilst there is no standard data set for dental records, there are some key elements common to all good records. The first and most important of these is that the records are contemporaneous – that is, they are 'recorded at the time'. Entries should be dated, summarizing the treatment provided for the patient, including what the patient

Up-to-date medical history.
The date, diagnosis and treatment notes every time the patient is seen, with full details of any particular incidents, episodes or discussions, including options.
Monitoring information, such as BPE scores, periodontal probing depths and other indices, tracking oral pathology and other conditions.
All payments made by the patient.
All correspondence to and from the patient, or any third party (consultant, other dentists, doctor, etc).
Consents obtained and warnings and information given.
Findings/diagnosis on radiographs – particularly if discovered after the patient has left the surgery.
Drugs and dosages given.

Table 2. What should a written record contain?

reports to the clinician or chairside team, results of any investigations such as pulp testing, percussion and pain history.

The second requirement is the completion of a medical history completed in writing by the patient or parent, if a child. There are many proformas for this and each patient is expected to complete one at the initial visit. This should be subsequently updated, with any changes noted. If the medical history remains unchanged this should also be noted.

Excellent records will help the dentist and others to understand not only what was done, when and how but, more importantly, to appreciate why it was done – the thought processes and logic behind the actions. They will capture details that could be pivotal to the final outcome if a complaint or claim was ever raised. Table 2 shows what a written record should contain.

The ten essential requirements in clinical record-keeping are as follows.[3]

Identification data

These will include name, address, telephone numbers and e-mail addresses. Text messages (SMS-short message service) are being increasingly used by practices to remind patients of appointments; mobile phone numbers are therefore useful.

Medical history

This should be in the form of a written proforma which will cover all aspects of the patient's general health. This should be signed and dated by the patient and have a space for the treating dentist to date every time the medical history is checked at recalls. There should be an enquiry about smoking and alcohol consumption.

Dental history

This should cover previous dental experiences, why the patient has come to the particular practice, as well as an understanding of risk factors, such as diet and oral hygiene measures. Lifestyle questions about attitudes to dentistry and cosmetic treatment can be covered in a questionnaire.

Clinical examination

This clinical examination should cover both extra-oral as well as intra-oral structures, including an oral cancer screening. Both negative and positive findings should be recorded. A baseline charting to include the current status of the teeth and supporting periodontal structures should be undertaken with a record that this has been done. A Basic Periodontal Examination (BPE), or some other equivalent objective measurement, should be recorded.

Radiographic examination

Any radiographs taken should be justified and the report on any findings should be in the notes.

Diagnosis

This provides a rationale for treatment and should be present even for routine fillings, eg 'recurrent caries – broken filling' or 'irreversible pulpitis'.

Treatment plan

A list of treatment to be done, as well as any referral that needs to be made, should be recorded. This allows the proper sequencing of treatment according to appropriate principles of relief of pain first, followed by increasingly complex treatment, depending on the patient's response to prevention and other advice.

Reference to consent

The options available should be discussed and recorded as well as the relevant advantages and disadvantages. The patient's preference for a particular treatment should be recorded, and the reasons for doing so, especially if the dentist is not in complete agreement.

Progress notes

These will form the bulk of the records and should always be dated and a note made of the treating dentist. The nurse's initials are also useful. The treatments undertaken, details of local anaesthetics and any instructions given should be noted. Some warnings may be given as standard and therefore, to avoid continually recording them, an advice sheet can be given and a copy retained in the file for future reference. These may be on post-extraction instruction, advice about orthodontic appliances, or the care of dentures.

Exit notes

If a patient informs the practice that he/she is leaving, it is useful to record the reasons for the departure. This is particularly so if the patient is in the middle of a course of treatment. Many practices send questionnaires to patients who have not visited the practice for some time and these will assist in developing a customer-orientated approach to patient care. Some patients may request copies of their notes or radiographs when they leave and they are entitled to copies of them under the Data Protection Act.

Oral Health Scores

Healthcare provision is moving

towards outcome measures as a way of judging whether dental care has improved over a period of time. The Oral Health Index was developed by Burke and Wilson in the mid-1990s.[4] It covers aspects of the patient's satisfaction with his/her mouth, assessment of caries, the restorations, wear, periodontal condition, occlusion and dentures.

This is a reproducible score and it is an easy way to provide the practitioner with a means of measuring the effectiveness of treatment and improving communication with patients.

Baseline charting

It is important that all patients have a baseline charting done of all existing restorations. This establishes the basis upon which future treatment is carried out, but it is also useful in the event of the need to identify the patient forensically. In this respect, dental identification was in the forefront of identifying the victims of the 9/11 terrorist attacks in New York and Washington, as well as the tsunami earthquake disaster in Indonesia and the surrounding countries in December 2004.

Forensic dental identification uses ante-mortem records such as dental chartings, radiographs and photographs taken by general dental practitioners to compare with post-mortem records taken by forensic odontologists on-site at the scene. In an era where increasing numbers of patients have few or no restorations, other identifying features, such as a midline diastema, rotated teeth and tori can usefully be recorded in the notes for future reference.

One study concluded that the two major problems that have faced forensic odontologists for decades are the failure by dental practitioners throughout the world to maintain comprehensive records, particularly full mouth chartings, and the failure to add patient names to dentures.[5]

Allergies

Allergies in dentistry are becoming an increasing problem. The most common is a Type I latex allergy, which is more problematic to clinical staff than patients because of the likely sensitization to the latex proteins found in natural rubber latex (NRL) gloves over a period of time. Irritant contact dermatitis and Type IV reactions are the result of the residual chemical employed during the manufacture and processing of medical gloves. A medical history questionnaire must enquire about allergies and, if patients disclose an allergy of this nature, it is important to record this prominently in the notes for future reference. The use of latex gloves and rubber dam would therefore be contra-indicated in these patients, but there are non-latex alternatives.

Nickel sensitivity is also a problem and therefore it is important to know what metals the dental laboratories are using to construct the crowns and dental appliances used in patients. Suppliers, aware of this, provide metal content cards, which can be affixed to record cards, or kept in the notes.

General Dental Council

Standards for Dental Professionals (UK) is the General Dental Council guidance on what is to be expected of dentists.[6] Record-keeping is highlighted and the contemporaneous nature of records is also highlighted. Whilst failure to comply strictly with these guidelines with regards to record-keeping will not in itself render a dentist liable to a charge of serious professional misconduct, fraudulent record-keeping or alterations certainly would.

A number of cases that have come before the Professional Conduct Committee have highlighted poor record-keeping as either a contributory factor to the main problem complained of or an important and relevant issue, proven as fact, but not germane to the outcome of the case itself. They have admonished dentists for reconstituting dental records in an inappropriate attempt to overcome administrative problems, for fabrication of dental records, deliberately withholding dental records from patients and keeping poor records that were liable to prejudice future treatment of patients.

National Health Service

General dental practitioners holding contract numbers and providing National Health Service dental treatment are bound by statute regulations, the National Health Service Act 1977(as amended) which gives rise to secondary legislation; *National Health Service (General Dental Services Contracts) Regulations 2005*. These make provisions for the requirement of NHS dentists to keep full, accurate and contemporaneous records in respect of the care and treatment given to each patient. The Regulations also expect that copies of treatment plans (FP17DC), referral notices (FP17RN), orthodontic treatment plans (F17DCO), and any statements concerning any custom-made devices provided under the Medical Devices Regulations (ie laboratory sheets) should be retained as part of the records.

The transition to local commissioning of dental services in England has led to more local service level agreements between Primary Care Trusts and dentists, which has resulted in a variety of different contracts and obligations throughout the country.

How good is our record-keeping?

Audit and clinical governance

Clinical audit is an integral part of *clinical governance* processes in practice and is an essential tool in assuring and improving quality.

Clinical audit is defined as the systematic critical analysis of the quality of dental care, including the procedures and processes used for diagnosis, intervention and treatment, the use of resources and the resulting outcome and quality of life as assessed by both professionals and patients.[7]

The main components of clinical governance are:

- Clear lines of responsibility and accountability for the overall quality of clinical care.
- A comprehensive programme of quality improvement systems (including clinical audit, supporting and applying evidence-based practice, implementing clinical standards and guidelines, workforce planning and development).
- Clear policies aimed at managing risk.
- Procedures for all professional groups to identify and remedy poor performance.
- A partnership with patients in the designing and delivery of services.[8]

It is the only instrument that is capable of documenting all aspects of patient care that can readily be used to gain insight into not only the clinician's adequacy in diagnosis and treatment planning, but also into the sequencing of treatment procedures, their delivery and, in conjunction with radiographs, the technical quality of the procedures themselves.[9]

With handwritten records legibility is a significant problem, with one audit concluding that some dentists could not read their own notes: 'more accurate, understandable reporting could be produced by dictation to the dental assistant, provided that the record is signed by the dentist to ensure its accuracy.'[10]

Abbreviations

Individual dentists often have their own shorthand way of writing up their notes but this, along with poor handwriting, is one of the biggest areas of confusion in manual records. Computer records may also contain codes and abbreviations which may be totally alien to another practitioner or, indeed, the dentists themselves some time afterwards!

As part of clinical governance procedures, any practice abbreviations or note-taking short cuts should be recorded separately and periodically updated. This is also a useful training document for new staff.

Computerized records

Increasing numbers of practices are moving to computer-based records, both for clinical record-keeping, as well as appointment scheduling. There are many advantages to this from an efficiency perspective, but dento-legal issues are equally important.

Manual records that are currently stored within a card or envelope, such as laboratory sheets, signed medical history forms, credit card slips and correspondence and details of materials used in a case (eg implants and crown metal contents) may be lost in a paper-free practice, unless they are scanned and retained electronically. Any of these items may be crucial in the context of a specific investigation about an episode of treatment for a particular patient.

There must be a robust audit trail to any software program so that any deletions or alterations can easily be identified and retrievable from the hard disc by the supplier, if necessary. This has the benefit of demonstrating that any notes recorded were made contemporaneously, but equally should deter practitioners from embellishing, altering, deleting or otherwise interfering with the integrity of the records as they existed at the time the original treatment was provided.

Data protection and security is an important consideration since access to confidential information should be limited to only those authorized to see it. Entry should be password-protected and users should keep these secure. Many software packages have access to managerial and administration functions which also need to be password-protected so that access to sensitive financial information is restricted.

Carrying out audits of clinical records

Taking as a starting point what should be in a clinical record (Table 2), it is relatively straightforward to carry out an audit of clinical records in practice.

Having first identified the record component, it is important to describe the standard expected. Some of the standards may be legal requirements, whilst others may be 'peer' standards from guidelines which may not have an evidence base but are considered 'good practice'. Many of the guidelines in record-keeping are of this nature, since there is very little in the way of published evidence that the achievement of certain standards in record-keeping can deliver a specific quality outcome.

Taking the broad record components, the following should be considered:

- Written medical history questionnaire;
- Examination of soft tissue;
- Full tooth charting;
- Periodontal screening and examination;
- Written diagnosis;
- Treatment planning.

Published data on quality of records

A recent study by Morgan[11] found that the frequency of recording for patients whose treatment was funded under NHS regulations was significantly worse than for patients whose treatment was privately funded. The reason postulated by the audited dentist in this study were that the time constraints produced by the need to deliver care as quickly as possible under NHS regulations leaves little time for accurate record-keeping.

A similar level of poor record-keeping was found in Sweden.[12] In nearly 40% of the variables investigated, the documentation did not follow the rules and guidelines expected. Patient history, status, diagnosis, therapy plans and other important information was missing from the records of general dental practitioners. The specialist records, however, were, in general, very accurate. Interestingly, the dentist's age related to the quality of the records, with older practitioners not having as accurate records as younger dentists.

Record-keeping of students has also been found to be far from optimal. In a study of final year students, the scores for updated medical history and the patient's complaint had deteriorated.[13] A similar finding was found amongst dental students in the School of Dentistry in the University of Washington, Seattle.[14]

Referral letters

Referral letters also form part of the records and are important in establishing why a referral was made. Its purpose primarily is to assist the recipient to make administration decisions on accepting the referral, prioritizing the referral, contacting the patient and making a suitable appointment.

The Department of Health has issued guidance[15] about copying referral letters to patients, based on the Government commitment in the NHS Plan in 1997 that patients should be able to receive copies of clinicians' letters about them as of right.

It is considered good practice to copy patients into correspondence as it keeps them informed. There are some provisos relating to when this is not advisable. These include:

- Where the patient does not want a copy;
- Where the dentist feels that it may cause harm to the patient or for other reasons;
- Where the letter includes information about a third party who has not given

consent;
- Where special safeguards for confidentiality may be needed.

Radiographs

Radiographs are very much part of clinical records and should be retained for the same length of time as other clinical records. Storage of these records presents two problems:
- Wet, film-based radiographs, if not processed properly, will discolour.
- While an increasing number of practitioners are mounting intra-oral radiographs, many continue to be filed in envelopes from which radiographs are readily lost or misfiled. Digital radiographs, attached as a file to the patient's computer records, will obviate these problems.

Radiographs should only be taken when clinically necessary and a note of how many and the type should be recorded in the notes. It is prudent to take radiographs of any tooth that is planned for surgical extraction, root filling or extensive treatment, such as crowns. Radiographic reports should also be included in the patient's records. Pathology, such as caries, bone loss, lesions or other factors of significance, such as overhanging restorations, subgingival calculus or suboptimal dental treatment, should be noted. As part of audit and clinical governance procedures, a quality assessment of each radiograph may be made and recorded at the same time as the radiographic report. A three point scale is recommended.[16]

How long should we keep records?

Paper records can cause storage problems. Add to this radiographs, such as lateral cephalometric views and orthodontic study models, and it is not difficult to see why the limited space of a practice compounds the situation.

National Health Service (General Dental Services Contracts) Regulations 2005 Part 6 Sched 3 Part 5 Para 32 (4)

The patient record and the items referred to in sub-paragraph 3 [treatment plans and lab sheets] shall be retained for a period of two years beginning with the date on which:
- a course of treatment or orthodontic treatment is terminated, or
- a course of treatment or an orthodontic course is completed.

The two year retention period also starts from the date by which no more services can be provided by virtue of the fact that the course of treatment was not completed within a reasonable time.

Limitation Acts

Personal Injury

Three years (from incident or the date of knowledge that something had gone wrong) to issue proceedings plus four months in which to serve proceedings.

Breach of Contract

Six years from the date of commencement of the contract plus four months in which to serve proceedings.

Inland Revenue

Seven years. NB In the case of minors, the time limits do not commence until the age of 18.

The limitation in the Limitation Act is a legal construct which controls the time a claimant has to bring an action in court after the incident in which a complaint was lodged. The Limitation Act provides a primary limitation period in respect of personal injury of three years from the date on which the cause of action accrued, or the date of knowledge (if later) of the injured person.

The Data Protection Act 1998 lays down the following guidelines for the minimum retention of records:
- Records relating to children and young people (including paediatric, vaccination and community child health records): until the patient's 25th birthday; or 26th birthday if an entry was made when the young person was 17; or 10 years after the death of a patient if sooner.
- Records relating to those serving in HM Armed Forces; not to be destroyed.
- Records relating to those serving a prison sentence: not to be destroyed.
- All other personal health records: 10 years after the conclusion of treatment, the patient's death or after the patient has permanently left the country.
- Patient records used in connection with clinical trials should be kept for at least 15 years. (NHS Executive HSC 1998/217).

Disposal of records

When records are destroyed, it is important that confidentiality is maintained. Specialist security firms are available to do this, but they must be asked to sign a confidentiality agreement. Paper records should be incinerated or shredded. Disk, tapes and CD-ROMs should be overwritten with random data (software is available for this purpose) or destroyed. The hard disks of computers will not have data permanently destroyed by either deleting files or reformatting the drive, but software can be purchased that will overwrite the drive with random data. Alternatively, the disk can be destroyed. The practice should have a written policy on the destruction of records.

Who may have access to clinical records?

Patient access

The relevant law, as it relates to England and Wales controlling access to dental records, is to be found in The Access to Health Records Act 1990 and The Data Protection Act 1998.

The Access to Health Records Act 1990

This Act created, for the first time, the right for a patient to see his/her medical records. This has largely been superseded by the Data Protection Act, since now the only categories of applicant entitled to access records under this 1990 Act are the personal representatives of a patient who has died or any person who may have a claim arising out of the patient's death. The times, therefore, when this is relevant in general dental practice will be few.

The Data Protection Act 1998

The Data Protection Act, which became effective from 1st March 2000, is a complex piece of legislation intended to protect people's privacy by preventing unauthorized or inappropriate use of their personal details. For the purposes of the Act, a health record is any record that consists of information relating to the physical or mental health or condition of an individual, and has been made by, or on behalf of, a health professional in connection with the care of that individual.

In terms of access, a patient can have access to all dental records held concerning them, be they on a computer or on manual records. This will include any

correspondence, laboratory instructions sheets, photographs, intra-oral images and radiographs. They should be provided within 21 days of the request being made. If it appears that providing the records may take longer than 40 days, the applicant should be informed and an explanation of the delay provided.

Access can only be refused where providing access would disclose information about someone else who has not given consent, or where disclosure would be likely to cause serious harm to the mental or physical health of the applicant or any other person. In the case of dental records this is unlikely.

Children and young adults

As a general rule, a person with parental responsibility will have the right to apply for access to a child's health record. The law in England and Wales regards young people aged 16 or 17 to be adults for the purposes of consent to treatment and right to confidentiality. Therefore, if a 16-year-old wishes a dental practitioner to keep treatment confidential, then that wish should be respected and access to health records could be denied to parents.

Third party access to records

Other than patients or their representatives, there are a number of other agencies that may request, or have legal access to, patients' records. These include insurance companies, who may be paying for treatment, the police, the Inland Revenue, when investigating the tax affairs of a practitioner, or the Health Authority or Regulatory Body.

Cost of access

The Data Protection Act 1998 clarifies the costs to access records from the holder:

- A maximum fee of £10 for granting access to health records which are automatically processed or are recorded with the intention that they are so processed.
- A maximum fee of £50 for granting access to manual records, or a mixture of manual and automated records.

Radiographs and traces are included as part of the records and copying them may attract a maximum fee of £50, which will also include the charge for copying the manual records.

Refusal of access

Situations arising where refusing access to clinical records will be allowed will be rare in a general dental practice situation but they are:

- Where you believe that access to the record would disclose information likely to cause serious harm to the physical or mental health of the patients or of any other individual, which may include a health professional (eg terminal illness, AIDS, etc).
- When you believe that access to the record would disclose confidential information related to, or provided by, an individual other than the patient, who could be identified from that information.
- When the patient is a child (under 16) and you believe that he/she is capable of understanding the nature of an application made, eg by his/her parent.
- When the patient is dead and had previously requested that certain information was not to be disclosed (eg to the applicant).
- Where the data was obtained as a result of any examination or investigation to which the data subject consented on the basis that the information would not be disclosed.

Freedom of Information Act 2000

NHS dentists are included in the scope of 'public authorities' as defined in the Act and, as such, have to comply with the Act from November 2003. The Freedom of Information Act is intended to promote greater openness and accountability across the public sector, and every NHS practice has to adopt and maintain a 'publication scheme' which has been approved by the Information Commissioner.[17] In relation to clinical records, any official caught shredding or defacing e-mails or records they know to be requested by a member of the public wanting to view his/her private files will be committing a crime.

Who owns the clinical records?

In the case of NHS records, true ownership of the notes probably lies in the ownership of the paper upon which they are written. In the case of general dental practitioner notes, the FP25 records are the property of the NHS and the owner would be the relevant Primary Care Trust/Health Board. In the case of private record cards, the ownership would lie with the purchaser of those blank record cards, ie the practice owner, be it an individual or corporate.

Electronic dental records

The electronic dental record has been given impetus by the Government's desire to allow medical patients in the NHS to be treated seamlessly in either primary care or secondary care and geographically anywhere in the UK. The obvious benefit is that healthcare professionals, in a multidisciplinary environment, will have instant access to a patient's previous or current records and diagnostic information.

The intention is to create a 'Spine record' for every patient, holding essential information anyone making health decisions about that patient needs to know. It will also allow patients to know what information is being shared about them and who is seeing it. Eventually, patients will be able to view their records in their own homes via a well-protected internet link (The Public View on Electronic Health Records – Consumers Association/ NHS National Programme for Information Technology Oct 2003).

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BOOK REVIEW

Management of Medical Emergencies for the Dental Team. By Martin H Thornhill, Michael N Pemberton and Guy J Atherton. London: Stephen Hancocks Ltd, 2005 (72pp. p/b, £29.95). ISBN 0-9546145-4-2.

This is a reader-friendly clinician's handbook. At 72 pages in A4 paperback format, it initially appears to be lightweight; more like a collection of lecture notes.

Set in three sections of, basic requirements and training, life support and then specific conditions, this guide scores highly on practical advice and tips based on the authors' own experience. An example is the suggestion of using a carbonated drinks bottle as a spacer for emergency use of Salbutamol in asthma (the authors wisely steer clear of advising what to do with the contents first). There is also good advice on how to administer injectable medications.

The serious subject matter is dealt with in a matter of fact way and protocols for management of conditions are stated simply and understandably. This is very important for a guide intended to be adopted for the whole dental team. The layout includes summary tables, which provide ready reference. Colour illustrations are artist drawn and look like low resolution web page images, with distortions in the colour of many images in the appraisal copy I was given (for example, a green injection needle is shown as blue).

This is not a physiology text and the authors must be applauded for focusing it on the types of occurrences, which comprise everyday practice, not on specialized areas of sedation and general anaesthetic work. A comprehensive range of conditions is covered, matching areas in the *Dental Practitioner's Formulary* part of the BNF (though not in the same order). Indeed, the core of the advice for specific conditions can be obtained by logging onto 'Medical emergencies in dental practice' at the BNF website **http://www.bnf.org/bnf/bnf/current/noframes/128360.htm** and for some this may meet their needs.

Some of the advice needs to be viewed in terms of recent changes in drug regimes and Resuscitation Council Guidelines, where there are significant changes to management of Choking, Anaphylaxis, and Basic Life Support in both the BNF (number 50 onwards) and the 2005 Resuscitation Council Guidelines.

It is sensible to be fully prepared for Medical Emergencies and this is a General Dental Council requirement for all the dental team. This book goes a long way towards helping in this area and is useful for both the DwSI/FGDP Key Skill area of Medical Emergencies and also for DCPs, covering in particular DN 1.3 of the NVQ syllabus for Dental Nurses. The language is straightforward and helpful worked examples are given of clinical situations. A final thought, only in Britain can a pizza get to your house faster than an ambulance!

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