CPD4dentalhygienists

YOUR FUTURE IN YOUR HANDS

Record Keeping in Dentistry
Legal and Ethical

Aims: This article provides information about record keeping and the legal aspects relating to record keeping; details about CQC requirements for record keeping; what should be included in records; storage of records; computerised records and sharing records.

Objectives: On completion of this verifiable CPD article, the participant will be able to demonstrate, through completion of a questionnaire, the ability to:

- Recognise the key reasons of keeping accurate dental records.
- Recognise some of the GDC and CQC requirements for dental records.
- Identify the items that may be included in dental records.
- Identify some of the legislation that relates to dental records.
- Know the four Cs of record keeping.
- Know the limitations of using templates for records.
- Identify key points related to maintaining computerised records.
- Complete a questionnaire, scoring more than 70%.

Introduction

Record keeping in dentistry is a crucial aspect of patient care, legal compliance, and professional responsibility. Good record keeping is a requisite of competent professional practice. Dentists and dental care professionals must maintain accurate and up-to-date records for each patient. Guidelines for record keeping are provided by the General Dental Council (GDC).[1]

In general, the function of good record keeping is to support:

- Patient care and self-empowerment
- Interdisciplinary and patient/clinician communication
- Effective clinical judgements and evidence of the decision-making process
- Continuity of care
- Clinical and medico-legal risk analyses and mitigation if complications arise
- Clinical audit and research

The quality of record keeping reflects the standard of professional practice. From a professional and regulatory point of view, good record keeping serves a dual purpose to ensure that the performance of practitioners and dental care professionals ensures patient care and safety by maintaining accurate records which include all the appropriate information in relation to the care and treatment provided to each patient in line with best practice.[2]

GDC Guidance

Dental records should be written accurately, contemporaneously and they should be clear, concise, and easy to understand. Consent should be recorded and should the treatment plan change you should again record consent to the changes.

The GDC guidance states:

- "**4.1.1** You must make and keep complete and accurate patient records, including an up-to-date medical history, each time that you treat patients."
- "**4.1.2** You should record as much detail as possible about the discussions you have with your patients, including evidence that valid consent has been obtained. You should also include details of any patient's treatment needs where appropriate."[6]

And to recap:

- "**3.1.2** You should document the discussions you have with patients in the process of gaining consent. Although a signature on a form is important in verifying that a patient has given consent, it is the discussions that take place with the patient that determine whether the consent is valid."[4]

Key Aspects of Record Keeping

Patient Information:

Personal details	Full name, date of birth, address, and contact information.
Medical history	Details of the patient's general health, medications, and any relevant medical conditions.
Dental history	Information on previous dental treatments, surgeries, and any ongoing dental issues.
Social history	Information on patients smoking history, diet, alcohol intake factors that overall can affect their oral health.

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Clinical Records:

Comprehensive examination findings	Including intraoral and extraoral assessments, radiographs, and diagnostic results.
Prevention	Details of current oral hygiene techniques and advice demonstrations given. Periodontal examination. Caries risk assessment.
Treatment plans	A detailed plan outlining proposed treatments, alternatives, risks, and benefits.
Consent forms	Signed consent forms for treatments, including explanations of procedures and potential risks.
Progress notes	Detailed records of each appointment, including the procedures performed, materials used, and any complications or changes in the patient's condition.

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Radiographs and Images:

X-rays and other diagnostic images	Properly labelled and stored in a secure manner.
Radiographic interpretations	Detailed notes on the analysis of radiographic images and their implications for treatment.

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Communication:

Correspondence with the patient	Clear and concise communication regarding treatment plans, follow-up appointments, and any necessary instructions.
Referrals and consultations	Documentation of referrals to specialists, along with any correspondence or reports received.

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Data Protection and Confidentiality

Adherence to data protection laws	General Data Protection Regulation (GDPR).
Storage	Safeguarding patient confidentiality and ensuring that records are stored securely, and access is restricted to authorised personnel.

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Audit and Review:

Review	Regularly reviewing and updating patient records to reflect changes in health status or treatments.
Audits	Participating in clinical audit activities to assess and improve the quality of care provided and the quality of records Maintained.

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The Four Cs of Record keeping

The "Four Cs" of record-keeping are often referred to as a strategy to emphasise key principles in maintaining accurate and organised records. [12,13]

Contemporaneous – Records should be made at, or very close to, the time of the examination, treatment, observation, or discussion, and they should be dated and signed legibly. [12,13]

Clear – Information should be presented in a clear and understandable manner. This helps users of the records to easily interpret and make sense of the information. Clear records contribute to effective communication and decision-making. [12,13]

Concise – Records should be just long enough to convey the essential information. [12,13]

Complete – All aspects of a patient's visit should be recorded. Complete records provide a comprehensive and detailed account reducing the risk of missing important information. Consistency in recording information ensures that records are standardised and can be easily compared or combined. Consistency is vital for creating reliable and cohesive records over time.[12,13]

Team Working

Dental nurses are vital in maintaining and protecting patients' healthcare data. Working together and allowing nurses to extend their scope of duties to include notetaking helps the record be contemporaneous, as they can often record information while the patient is telling their story.

For the practitioner, it also offers reassurance that vital information is unlikely to be missed allowing clinical findings of the hard and soft tissues to be dictated in real-time. A registered dental nurse is trained and qualified to prompt the practitioner should they require it, which, enhances team working and ensures patient safety.
The practitioner should always check the notes and add their own additional observations if required. The overall responsibility for the notes remains with them.

Templates

While templates for dental records can be valuable tools for organising patient information, treatment plans, and clinical data, they also come with certain limitations and potential drawbacks including:

- Lack of flexibility: each patient may have specific dental issues or require individualised treatment plans that may not fit neatly into a standardised template.

- Inability to capture individual aspects: dental conditions can vary widely, and a template might not be able to capture all the details or specific aspects of a treatment case through a pre-designed template.

- Over reliance on templates: relying too heavily on templates may lead to a superficial or standardised approach to patient care. Dentists and healthcare professionals need to consider each patient's unique circumstances, and an overreliance on templates might compromise the quality of care.

- Not fully completing a template: when recording information, the practitioner only updates the sections of the template which are relevant to the current examination leaving the rest of the template unchanged. This can lead to questions as to how reliable, contemporaneous, and accurate the record is and can raise doubts as to whether a complete clinical record was taken.

- Updating templates: templates may become outdated or may not easily accommodate changes in treatment and protocols.

- Training: Dental professionals may need training to effectively use and navigate templates. If templates are not user-friendly or if staff members are not adequately trained, there may be inefficiencies or errors in recording and retrieving patient information.

- Patient-centred limitations: templates might not capture important patient-centred information, preferences, or concerns. A patient's experience and satisfaction with dental care may not be adequately reflected in a template designed primarily for clinical and administrative purposes.

To overcome some of these limitations, dental professionals should use templates as a starting point and supplement them with thorough clinical assessments, detailed notes, and a patient-centred approach to care. Regular updates to templates and ongoing professional development can also help address some of the challenges associated with their use.[13,14]

Computerised Records

Computerised dental records are more commonly used in dental practice. They offer several advantages and some challenges. Here are the pros and cons:

Pros:

- ✓ Efficiency: computerised records enable quick and easy access to patient information, reducing the time spent searching for paper records.

- ✓ Accessibility: authorised members of the dental team can access digital records remotely, facilitating collaboration among the team and making it easier to share information when needed.

- ✓ Space and Cost Savings: storing records digitally eliminates the need for physical storage space, reducing costs associated with paper, printing, and physical storage facilities.

- ✓ Accuracy and Legibility: digital records can help prevent errors associated with handwritten notes and improve overall legibility. This can contribute to better communication among dental professionals and enhance patient safety.

- ✓ Data Security: with proper security measures in place, digital records can be more secure than paper records. Access controls, encryption, and regular backups can help protect patient information from unauthorised access or loss.

Cons:

- ❖ Initial Cost: implementing a computerised dental system requires an initial investment in software, hardware, and staff training.

- ❖ Learning Curve: transitioning from paper records to a digital system may require a learning curve for dental professional.

- ❖ Updating: extra care needs to be taken when completing or modifying digital records to make sure the author is clearly identified and every time a new record is created or an existing record is modified, the date must be recorded on the system.

- ❖ Technical Issues: computerised systems may experience technical glitches, software bugs, or hardware failures. These issues can disrupt the workflow and potentially compromise the availability of patient information.

- ❖ Data Security Concerns: despite the potential for enhanced security, digital records can be vulnerable to cyber threats. It is crucial to implement robust security measures, such as encryption and regular system updates, to protect patient confidentiality.

- ❖ Dependence on Technology: a reliance on technology means that practices may face challenges if there are power outages, hardware malfunctions, or other technical issues that prevent access to patient records.[13,15,16]

Legislation and Regulations

The legislation affecting record-keeping in dental practices in the UK primarily revolves around data protection and healthcare regulations. The key legislation includes:

- General Data Protection Regulation (GDPR): The GDPR is a comprehensive data protection regulation that came into effect in May 2018. It applies to the processing of personal data, including health-related data, and imposes specific requirements on how dental practices handle patient information.[4]

- Data Protection Act 2018: This Act supplements the GDPR and provides additional details and exemptions specific to the UK. It outlines the conditions for processing personal data and includes provisions regarding the processing of health-related data.[5]

- Health and Social Care Act 2008 (Regulated Activities) Regulations 2022: This legislation outlines the fundamental standards that health and adult social care providers in England must meet. Dental practices fall under these regulations, and they include requirements related to record-keeping and the management of patient information.[6]

- The Caldicott Principles: These principles provide a framework for the appropriate use and sharing of patient information. While not legislation, adherence to the Caldicott Principles is expected in healthcare settings, including dental practices.[7]

- The NHS Records Management Code of Practice: While primarily applicable to NHS organisations, dental practices that provide NHS services should also be aware of and follow this code of practice. It sets out the standards for managing records, including patient records.[8]

- Access to Health Records Act 1990: Patients, or the patient's representative if the patient has died, have a right to see their healthcare records under the Data Protection Act[9]

Dental professionals must ensure compliance with these regulations and standards to protect patient confidentiality, maintain data security, and meet legal requirements related to record-keeping.

The Care Quality Commission (CQC) has powers under the Health and Social Care Act 2008 to access dental records for the purpose of checking that registered

providers are meeting the fundamental standards of good record keeping. They expect professionals to follow GDC guidelines, College of General Dentistry guidelines and IR(ME)R 2017 Regulations when completing dental records.[10]

Storage and Retention of Dental Records

Dental records are considered sensitive personal data and are subject to data protection laws. The General Data Protection Regulation (GDPR) and the Data Protection Act 2018 set out the rules and regulations for the processing and storage of personal data, including dental records.[4]

Dental professionals, including dentists and dental practices, are considered data controllers under the GDPR. As such, they are responsible for ensuring that dental records are processed and stored in compliance with data protection laws.[4]

Security Measures: Dental records must be kept securely to prevent unauthorised access, loss, or damage. Access to patient records should be restricted to authorised personnel only. [4]

Data Retention: The retention period for dental records is not explicitly defined in the GDPR or the Data Protection Act 2018. However, dental professionals are generally advised to retain records for a certain period after the last treatment. The retention period may vary depending on the type of record and individual circumstances.[11]

The NHS advice on retention in England and Wales recommends that records should be retained for 15 years and children's records should be retained until the 25th birthday or 26th birthday if the patient was 17 years when treatment was completed.[11]

The Scottish government provides guidance advising the recommended retention period for general dental records as 10 years for adults and 10 years or up to the 25th/26th birthday rule, whichever is longer for children.[11]

In Northern Ireland there is guidance on record retention from the Department of Health and contained within the Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspections) (Amendment) Regulations (Northern Ireland) 2011.[11]

Dental practices should have clear policies and procedures in place to address data protection requirements. Additionally, staff should receive training on data protection to ensure compliance. It's important to stay updated on any changes in data protection laws and regulations that may impact the storage and processing of dental records in the UK.[11]

Points to Remember

- Never alter or falsify dental records. Any changes made should be clearly documented, dated, and explained. Falsification can lead to serious legal consequences.
- Avoid omitting relevant information. Provide a complete picture of the patient's dental health to ensure proper care and treatment planning.
- Ensure that consent forms are complete and properly signed. Incomplete or improperly obtained consent can lead to legal complications.
- Treatment costs and any changes need to be recorded and provided to the patient.
- Avoid abbreviations as far as possible. They could be misunderstood or misinterpreted.
- Use one recognised system of dental charting consistently throughout the records.
- Make sure your handwriting and signature are legible if using paper records.
- Any errors on paper records should be crossed out with a single line and the correction hand-written alongside the error.
- It is highly unprofessional and unethical to use derogatory comments or language in any medical records, including dental records. Derogatory comments can compromise the trust between the patient and the healthcare provider, and they may also have legal implications.[1,13,14]

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Personal Development Plan and Reflective Learning

This CPD is linked to the following GDC Enhanced CPD Development Outcome:

A. Effective communication with patients, the dental team, and others across dentistry, including when obtaining consent, dealing with complaints, and raising concerns when patients are at risk.

B. Effective management of self and effective management of others or effective work with others in the dental team, in the interests of patients; providing constructive leadership where appropriate.

C. Maintenance and development of knowledge and skill within your field of practice.

D. Maintenance of skills, behaviours and attitudes which maintain patient confidence in you and the dental profession and put patients' interests first.

Reflective learning is now a requirement of the GDC Enhanced Professional Development Scheme. As such, you will now be offered the opportunity to answer some reflective learning questions for the CPD you complete. These will be:

1) What did you learn (or confirm) from the activity that was helpful or relevant to your daily work and patients?
2) Comment on any changes/updates needed in your daily work
3) How has completion of this CPD article benefitted your work as a DCP?

Further Reading

Dental Record Keeping Standards: a consensus approach – Useful document providing information on collecting and recording patient information in a consistent way.

NHS Records Management Code of Practice – A guide to the management of health and social care records.

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