Record Keeping - Legal and Ethical Core CPD

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:

- Demonstrate an understanding of principle four of the GDC Standards for Dental Professionals to “Maintain and protect patients’ information”.
- Recognise the key reasons of keeping accurate dental records.
- Identify some of the legislation that relates to keeping dental records.
- Recognise some of the CQC requirements for dental records.
- Identify the items that may be included in dental records.
- Identify key points related to maintaining computerized records.
- Complete a questionnaire, scoring more than 70%.

Introduction

Dental professionals are required to make and keep accurate dental records of care provided to patients, whether NHS or private. Record keeping is an essential part of clinical dentistry, with a direct relationship to patient safety and care. The General Dental Council Standards for Dental Care Professionals specifically mentions keeping good and accurate clinical records in four of its nine key principles. Records should be legible, accurate, comprehensive and contemporaneous (recorded at the time) and each patient should have an individual dental record.

Key reasons for the necessity of keeping an accurate dental record for each patient include:

- As an official document/record of events
- To facilitate the process of dental audit
- To monitor the patient’s state of oral health
- To aid the process of forensic odontology.
In addition, good records can act as a defence in medico-legal cases against claims of professional misconduct or clinical negligence.²

**Legal Requirements and Keeping Records**

There are a number of pieces of legislation that require both NHS and private practitioners to keep records. These include: The Consumer Protection Act 1987 under which an action could arise for a defective product, the Medical Devices Directive (Directive 93/42/EEC), which relates to custom-made devices, the Medicines Act 1968 and the Misuse of Drugs Regulations 2001. In England, the Health and Social Care Act 2008 has led to the formation of the Care Quality Commission (CQC), which sets out detailed requirements for records.

The NHS General Dental Service contract requires that records are made of any treatment provided and that they are full, accurate and contemporaneous in respect of the care and treatment given to each patient.¹ It also specifies the length of time that records must be kept, in accordance with the contract. The NHS contract currently requires records to be kept for two years in England, Wales and Scotland and six years in Northern Ireland. It is also necessary to retain any radiographs and study models for two years after the course of treatment has been completed.

However, it is recommended by indemnity providers that records are retained for a lot longer. This is due to the time constraints of different limitation acts that allow legal action to be taken for some years. Examples of these are:

<table>
<thead>
<tr>
<th>Limitation Act</th>
<th>Relevant Time Limits</th>
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<tr>
<td>Personal Injury</td>
<td>3 years from incident to issue proceedings plus 4 months in which to serve proceedings</td>
</tr>
<tr>
<td>Breach of Contract</td>
<td>6 years from the date of commencement of the contract plus 4 months in which to serve proceedings</td>
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<tr>
<td>Inland Revenue</td>
<td>7 years</td>
</tr>
<tr>
<td>Consumer Protection Act 1987</td>
<td>Product liability 10 years</td>
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As there is no clear specific legislation for dental records it is suggested by the NHS code that dental records are retained for 11 years after the last course of treatment for adults and up to the age of 25 for children.

**CQC**

In England, the Health and Social Care Act 2008 has led to the formation of the Care Quality Commission (CQC), which sets out detailed requirements for records.

Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (No 2936) states that:

- The registered person must ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of:
  - An accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user; and such other records as are appropriate in relation to.

The registered person must ensure that the records (which may be in paper or electronic form) are:

- Kept securely and can be located promptly when required;
- Retained for an appropriate period of time; and,
- Securely destroyed when it is appropriate to do so.4

Patients should be able to be confident that their personal records including medical records are accurate, fit for purpose, held securely and remain confidential. Other records required to be kept to protect their safety and well-being are maintained and held securely where required. This is because providers who comply with the regulations will:

- Keep accurate personalised care, treatment and support records secure and confidential for each person who uses the service.
- Keep those records for the correct amount of time.
- Keep any other records the Care Quality Commission asks them to in relation to the management of the regulated activity.
- Store records in a secure, accessible way that allows them to be located quickly.
Securely destroy records taking into account any relevant retention schedules.

**What do Records Comprise of?**

Any of the following could be included in a patient’s records:

- Handwritten clinical notes which include detailed medical history information.
- Computerised records.
- Radiographic films and other imaging records.
- Investigations e.g. pathology reports, printouts from monitoring equipment.
- Models.
- Photographs or intraoral camera images.
- Correspondence between health professionals.
- Other information e.g. receipts, estimates, laboratory instructions, diagnostic wax ups and bite registrations.
- Videos.
- Practice documentation.
- Tape recordings of telephone conversations.

All entries should be dated, summarising the treatment provided for the patient, including anything the patient reports to you, and any results of investigations.

Excellent records are more than just simply listing a factual list of events. They provide evidence of the thought processes which lie behind the decisions that were made. They will also provide a lot more useful detail and because of this they can anticipate and answer all the key questions that might be asked in the future.

The dental nurse is ideally placed to provide an additional level of backup, ensuring that all key conversations between the dentist and patient, all discussion, warnings, explanations and advice are recorded in the notes. On a busy day when the team are under pressure, crucial details could easily be over looked, so sharing the business of recording information can go a long way to ensuring that the record is complete.
What should the Dental Record Contain?

The Patient's name and contact details: Their address, telephone number and email or any other contact details they provide. This information should be kept up to date as it could be needed in an emergency situation.

An up to date medical history: A full medical history including a note of any prescribed or self administered medication should be taken at the initial examination and checked and updated at each visit. Any allergies the patient may have. It is always useful to have details of the patient’s doctor. At each visit a written formal note is required to confirm that the medical history has been updated.

Treatment information: The date diagnosis and treatment notes should be recorded every time a patient is seen. It should include full details of any treatment carried out specifying the teeth treated, materials used and clinical findings. An accurate record of treatment findings, patient’s symptoms and what the patient tells you should all be recorded. Also include anything that you do not find, for example, tooth not tender to percussion, lymph nodes not enlarged, no swelling, not painful or no change in medical history. If a patient declines a referral or other treatment it should be recorded.

Missed appointments: The date and details of any appointment offered to a patient but declined or which a patient fails to attend or cancels or if the patient arrives too late and needs to be rebooked.

Phone contact: Dates and details of any phone conversations with the patient whether this involves the dentist or another team member should be retained in the records.

Investigations: A summary of any investigations including positive and negative findings should be included. Information such as BPE scores and full pocket charting and any other indices should be included.

Financial records: These are often kept separate to the clinical notes but a record should be kept of all fees quoted and payments made by the patient. If any unpaid fees are pursued a record of this should be meticulously recorded.

Correspondence: Any correspondence sent to the patient or third party should be copied to the records.

Consents obtained: Consent to treatment and any specific warnings to the patient should be recorded.

Advice: Any advice or diet advice or oral hygiene instruction or smoking cessation advice should be recorded.

Instructions given: Pre or post-operative instructions given to the patient should be recorded.
**Drugs given:** Including the route, dosage, frequency and quantity and any adverse reaction warnings given to the patient should be recorded.

**Anything else that could be relevant:** Here you may want to include details of the patient’s previous dental history, why the patient has come to see you, what the patient has requested and any conversations that took place should be recorded.

**An accurate detailed baseline charting:** This should be updated at each appointment.

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**Storage of Records**

The dentist has a responsibility to keep records safely and securely (Data Protection Act principle 7). Keeping them securely also requires that they are kept confidential (employed staff who have been instructed on security policy are exempt). Access to the records by others must only be given if necessary, and with necessary and appropriate safeguards. The dentist is expected to make, and be able to demonstrate, an assessment of risk in deciding on appropriate security measures.

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**Computerised Records**

Increasing numbers of dental practices are now using computer-based dental records for clinical record keeping and booking appointments. There are many advantages to this type of system. Manual records have the disadvantages of storage, difficulty in writing styles and they may get miss filed or lost.

If computer records are used there must be a robust software program and audit trail so that any deletions or alterations can be identified and if necessary retrievable from the hard drive. This is to ensure that notes are kept contemporaneously, and to maintain the integrity of the records as they existed at the time the treatment was provided. The computer software should be capable of producing a hard copy of records and radiographs.

Data protection and security is an important consideration and access to systems should be password protected and limited to only authorised members of staff. Every time a record is created or an existing record is modified the date must be recorded on the system. Extra care needs to be taken when completing, or making modifications to, electronic records to ensure the author, e.g. the dentist, locum or dental care professional, is clearly identified.

The system should also be protected against accidental loss, including corruption, damage or destruction through regular backups. If sending confidential information, a
secure method should be used. The storage of patient identifiable data on personal mobile devices should be avoided. The Department of Health has said that ‘the movement of unencrypted data held in electronic format should not be allowed in the NHS’ and ‘wherever possible, person identifiable data should always be stored on a secure server.’

Any member of staff authorised to use the system should be aware of the security policy, including the name of the person in charge of data security and follow practice procedures, for example, on the use of laptops and portable data storage.

Computer-held records may be difficult to delete completely from a hard drive and appropriate IT advice should be sought about data destruction before disposing of computer hardware.¹

**Clinical Audits of Clinical Records**

Regular clinical audits of clinical records should be undertaken to ensure the highest standard is maintained. The following areas could be considered for audit:

- Written medical history questionnaires.
- Examination of soft tissue.
- Charting.
- Periodontal screening and examination.
- Written diagnosis.
- Treatment planning.
- Radiographs.⁷

**Sharing Information**

If a patient asks to see their records, under Section 7 of the Data Protection Act they have a right to access personal data held about them. Dental professionals who control patient records are obliged to disclose a patient's dental record to that patient. Before doing so, they must have the patient's written request or have satisfied themselves of the authority of any person making a request, if that person is not the patient.¹

The General Dental Council state “You must explain to patients the circumstances in which you may need to share information with others involved in their healthcare.”
This includes making sure that they understand:

- What information you will be releasing;
- Why you will be releasing it; and,
- The likely consequences of you releasing the information.

You must give your patients the opportunity to withhold their permission to share information in this way unless exceptional circumstances apply. You must record in your patient’s notes whether or not they gave their permission. If a patient allows you to share information about them you should ensure that the person you are sharing it with knows it is confidential.

If other people ask you to provide information about patients (for example, for teaching or research), or if you want to use patient information such as photographs for any reason, you must:

- Explain to patients how the information or images will be used;
- Check that patients understand what they are agreeing to;
- Obtain and record the patients’ consent to their use;
- Only release or use the minimum information necessary for the purpose; and
- Explain to the patients that they can withdraw their permission at any time.

If it is not necessary for patients to be identified, you must make sure they remain anonymous in any information you release.\(^8\)

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<td>The following subjects can be accessed from the non verifiable CPD section of the website:</td>
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<tr>
<td>- GDC Standards (See principle 4 for record keeping – maintain and protect patients’ information)</td>
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<tr>
<td>- CQC Mythbuster – Dental Records</td>
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Don’t forget to log the hours you spend reading into your non-verifiable CPD log and ensure you keep up to date with any changes to the documents.

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References


