Dental records

Dental records are an essential clinical tool for the dental professional.

A patient’s records may include:
• clinical notes
• radiographs
• consent forms
• photographs
• study casts
• audio or visual recordings of consultations
• laboratory prescriptions
• statements of conformity
• referral correspondence
• investigation reports
• NHS forms.

The purpose of records is to provide:
• an accurate picture of patient treatment and care which can be used at every consultation
• a means of professional communication e.g. between the various members of the dental team, and between members of the dental team and other healthcare professionals.
Records are an essential part of patient care and can provide evidence if your standard of care is called into question.

**Key points**

1. Good patient records follow the **four Cs**.
   a. **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.
   b. **Clear** - records should be written carefully, so that they can be understood by anyone who may need to read and interpret them.
   c. **Concise** - records should be just long enough to convey the essential information.
   d. **Complete** - all aspects of a patient’s visit should be recorded. This includes:
      - presenting complaints
      - histories (medical, dental and social)
      - dental charting
      - findings on examination, including negative findings (e.g. no teeth tender to percussion)
      - diagnosis
      - discussions about treatment options and risks
      - agreed treatment plan
      - consent to treatment
      - treatment given
      - mishaps and complications.

2. **Request forms**, such as those for pathology reports or radiographs, should be completed clearly with adequate detail, dated and signed legibly.

3. All **reports** should be seen, evaluated and initialled before being filed, with any abnormal results noted in the clinical record and any action recorded.

**Our advice**

Try to avoid the use of abbreviations as far as possible as they may be misinterpreted or misunderstood.

Use one system of dental charting (Palmer notation, FDI notation or another) consistently throughout the records.

Check dictated and typed notes, or notes made by somebody else on your behalf e.g. notes by a dental nurse on behalf of a dentist. Any errors on paper records should be crossed out with a single line and the correction handwritten alongside the error. The notes should be dated and signed legibly by the dental professional who dictated them.

**Checklist**

- Is your handwriting, including your signature, legible?
- Are all notes, including all amendments to the notes and contributions from others, signed and dated?
- Have all contributions from third parties, including reports, been evaluated and initialled before being filed?
The same dento-legal requirements apply to digital records as to manual records.

The ‘four Cs’ – that notes are contemporaneous, clear, concise and complete – remain essential requirements of a computer-held record. (See section 4.1 Keeping good records).

For dento-legal purposes, your computer software should be capable of producing a hard copy of records and radiographs. It also needs to be capable of producing a full audit trail of record creation and modification.

Key points

1. 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.

2. Every time a record is created or an existing record is modified the date must be recorded on the system.

3. Computer-held records must be robustly protected against unauthorised or unlawful access. They 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.

4. 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.’

5. Familiarise yourself with your workplace information security policy, including the name of the person in charge of data security and follow practice or trust procedures, for example, on the use of laptops and portable data storage.

6. 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.

Our advice

Check that the specification of a computer system or software allows you to fulfil your data protection obligations before using or purchasing it.

Checklist

- Is your IT system adequately protected from unauthorised access e.g. is it protected with the use of strong passwords and is the data encrypted?
- Is your software dento-legally compliant e.g. does it allow you to produce hard copies of records?
- Does your system provide a full audit trail?
- Do you regularly back up your electronic records and check that your back-up is working correctly and you are able to retrieve/restore records if necessary?
- Do you hold a back-up of your electronic files in secure off-site premises?
The Data Protection Act 1998 (DPA) applies to dental records and dental professionals must abide by its principles.

The DPA states that it is important that records are:
- accurately created
- carefully and securely maintained
- disposed of appropriately.

The DPA also gives patients a right to access their records, both paper and computer, including stored radiographs. Dental professionals can only limit or deny access if, in their view, disclosure would:
- be ‘likely to cause serious harm to the physical or mental health or condition of the data subject or any other person’
- give information about a third party, other than healthcare professionals involved in the treatment, unless that other person consents.

If a patient asks to see their records, under Section 7 of the DPA 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.

Disclosure must take place as quickly as possible or in any event within 40 days of receipt of the request. If the patient (or an authorised representative) wishes to have copies, a fee can be charged – currently up to £50 for hard copy records (or a combination of hard copy and electronic) or £10 for electronic records to cover reasonable copying charges.

Key points
1. Patients must be told of, and consent to, information being recorded about them, including visual and audio recordings.
2. If a patient observes you making a note and co-operates with you to provide information, that can be taken as implied consent but it is unlikely to be sufficient for wider information sharing.
3. Patients should be told what will happen to the data you hold about them, including when and how it is destroyed.
4. Patients and their authorised representatives have a right to access their records.
5. There is a statutory 40-day disclosure period.
6. Hurt feelings or simple anxiety are not sufficient reasons to deny patient access to the records.
7. You can charge for providing copies of patient records.

Our advice
Dental professionals should publish key points about the uses of patient information and give information about patients’ rights under the DPA in their practice information material.

Checklist
- Is a patient’s right of access to their records outlined in your practice literature?
- Are all members of the dental team trained in relation to their professional and legal obligations concerning clinical records?
- When disclosing records to a patient, have all named third parties, other than healthcare professionals involved in the patient’s treatment, consented to the disclosure?
Complaints and claims for clinical negligence can arise many years after treatment and, in the absence of records, it may be difficult or impossible to defend an allegation successfully.

The NHS General Dental Services contract (Schedule 3, part 5 paragraph 32) requires the contractor to keep patient records for up to two years after a course of treatment has finished.

Holding on to patient records for longer than two years may prove a vital part of your defence should you receive a claim under the Consumer Protection Act 1998. This Act allows claims in respect of defective products for up to 10 years and claims in contract for up to six years.

Key points
1. As an absolute minimum, NHS and private clinical records\(^1\) should be retained for:
   a. 11 years after the last entry for adults
   b. 11 years after the last entry for children or until they reach age 25 years, whichever is the longer.
2. The way in which you store your records should comply with your professional obligation to respect confidentiality. The GDC’s guidance Standards for the Dental Team (2013) paragraph 4.5.1 states: “You must not leave records where they can be seen by other patients, unauthorised staff or members of the public.” (See section 2.1 Your obligations).
3. Record disposal should only be carried out in a way that protects patient confidentiality e.g. shredding paper records.

Our advice
We recommend that you retain patient records longer than two years and ideally, indefinitely. This includes radiographs, photographs, study casts, referral correspondence, investigation reports and NHS forms.

If you do need to destroy records, be sure that they are no longer needed for dento-legal purposes. We recommend that you indefinitely retain records where there has been any adverse incident or complaint, even if it was satisfactorily resolved at the time. Electronic records can be especially difficult to destroy and we recommend that you seek specialist IT advice.

Checklist
- Have you a safe and secure method of storing your clinical records for lengthy periods of time?
- Have you reviewed all records you intend to destroy and kept those involving any adverse incident, complication or complaint?

Reference
\(^1\) Records Management, NHS Code of Practice, Part 2 - DoH (January 2009)
**Patients have a right to access their records under the Data Protection Act 1998 (DPA).**

### Ownership

NHS hospital and community dental service records are the property of the appropriate trust or health board.

NHS General Dental Services (GDS) records are arguably the property of the individual contractor and/or primary care organisation. NHS authorities have certain rights of access to these records under NHS regulations.

Dental records for private patients are the property of the individual dental professional or practice. The legal position of the ownership of private patients’ radiographs is, however, uncertain. It can be argued the patient has paid for the report or opinion from the radiograph, and not for the film itself. But patients may claim that as they have been charged, the film is their property, even though the dental professional may retain it with all the other elements of that patient’s records.

### Access and accuracy

Patients have a right to access their records under the DPA. They are also entitled to challenge the validity of records and to have factual errors corrected. (See section 4.3 Data protection legislation).

### Key points

1. Patient records, both private and NHS, are not the patient’s property. Patients are not entitled to take possession of the originals.

2. Patients have a right under the DPA to view their original records and to have copies of them.

3. A patient cannot stipulate the content of their records.

4. Dental professionals do not have to agree to requests for amendments or deletions, except to correct a factual error.

5. An entry in the patient’s records should not be amended simply because the patient does not like it.

### Our advice

If a patient insists on removing a radiograph from the records, they should be advised that they are then responsible for the radiograph’s safekeeping. They should be informed that if they lose it, any dentist treating them in the future will not have the clinical benefits of access to it. The fact that the patient has taken the radiograph should be recorded in the notes.

Any disagreement over factual matters in the records should be noted, signed and dated in the records.

### Checklist

- Is patients’ right of access to their records outlined in your practice literature?
Seeking patient consent to disclose any information about them is part of a dental professional’s legal and professional duty of confidentiality, and important to the relationship of trust with the patient.

Consent
If a patient’s identifiable personal data is to be disclosed, you must obtain their express consent, preferably in writing, unless disclosure falls within one of the legal exemptions where disclosure can be made without consent.

Public interest
If a patient withholds consent to disclosure, is not competent to give or withhold consent, or it is difficult to obtain, information may only be disclosed if it can be justified as being in the public interest or the best interest of the patient e.g. where the patient is at risk of significant harm. Dental professionals should document their efforts to obtain consent and their reasons for disclosing information, which should be the minimum needed for the purpose.

Children
Children aged 16 and over enjoy the same rights of confidentiality as adults. The confidentiality of Gillick-competent children, who are capable of understanding the significance of disclosure of their records, should also be respected, though they should be encouraged to involve parents or guardians. (See section 3.10 Consent and children under 16).

Deceased patients
The duty to respect patient confidentiality extends beyond a patient's death. Information, such as dental chartings and radiographs, can normally be disclosed to help identify a deceased patient as this would be justified as in the public interest. Otherwise, authority will need to be obtained from an executor of the patient's will, personal representative or next-of-kin. Anyone with a claim arising out of a patient's death may be entitled to see the patient's dental records under the Access to Health Records Act 1990. (See section 2.1 Your obligations).

Third parties
Dental professionals may be asked to disclose a patient’s dental records, and/or submit a formal written report (see section 5.4 Professional witness dental reports) to certain individuals and authorities. These include relatives and carers, other healthcare workers, NHS bodies, social services, the police, solicitors, the courts and other tribunals. The principles of patient confidentiality apply and generally the patient will need to give consent. (See section 2.2 Releasing confidential information).

Key points
1. Full, and preferably written, consent is required for all disclosures of identifiable personal data unless disclosure is in the public interest or the best interest of the patient.
2. For consent to disclosure of records to be valid, the patient must understand:
   a. to whom the information will be disclosed
   b. precisely what information will be disclosed
   c. the purpose of the disclosure
   d. the significant foreseeable consequences
   e. that relevant information cannot be concealed or withheld, except in exceptional circumstances.
   f. children aged 16 and over, and Gillick-competent children, enjoy the same rights of confidentiality as adults
   g. the duty to respect patient confidentiality extends to deceased patients.

Our advice
If information about a patient is to be disclosed against their wishes, the patient should be informed of this before disclosure, unless this increases the risk of serious harm or death to the patient or others. Before releasing information, call our dento-legal advice line.

If a school asks for confirmation that a pupil has booked or attended dental appointments, you should not disclose this information without the appropriate consent of the patient or parental authority in the case of children who are not Gillick-competent.

If disclosure is considered necessary to protect the patient or members of the public from a risk of serious harm or death, you should consider the possible harm to the patient, and patient-dentist relationship, against the benefit of releasing the information.

Checklist
• Before disclosing any confidential information, do you have the patient’s consent to disclosure, preferably in writing?

Reference
1 Gillick v West Norfolk and Wisbech AHA (1985) 3 All ER 402-437
Can I alter the records?

I have taken over the patient list of a retired dentist at my practice. One of my new patients has asked me to delete an entry in his dental record. The entry says the patient has not been following the dentist’s instructions but the patient says this is not true. What should I do?

Our response

A patient is entitled to challenge the accuracy of records and to have any factual errors corrected under the Data Protection Act 1998 (DPA). However, you are not obliged to amend an entry simply because a patient does not like it.

In this case, you are not in a position to know the circumstances that led your predecessor to make this entry in the records or to assess the nature of the dentist-patient relationship. It would be a good idea to discuss with the patient why he feels the entry requires amendment but you should exercise extreme caution before agreeing to make any alteration to a record.

In general, it would be inappropriate to alter an entry made by a colleague. You can however offer to include the patient’s comments alongside the entry. Make it clear to the patient what you can and cannot do and ensure you keep a note of the discussion for the record.

When factual errors do need to be corrected in paper dental records, strike through the entry with a single line and insert the correct information alongside. This should then be dated and signed legibly. Due to the variability of computerised record systems, we would recommend making an entirely new entry, correcting the previous one.