alberta dental association & college

Guide for Patient Records and Informed Consent

Contents

Introduction

This Guide for Patient Records and Informed Consent is designed to ensure Alberta dentists are provided with the requirements of creating and maintaining appropriate clinical and financial records as part of the care they provide to their patients. It is the responsibility of all dentists to create and maintain accurate patient records as indicated in the Alberta Dental Association and College Standard of Practice for Informed Consent, Standard of Practice for Patient Records and this document.

Much of the information in this document has previously been provided to Alberta dentists by the Alberta Dental Association and College in either hardcopy or electronically on the website at www.abdentists.com.

Professional, ethical and legal responsibilities dictate that a complete patient chart and record containing all aspects of each patient's dental care must be created and maintained. Good records have many purposes, including:

a) facilitate the provision of effective clinical care;
b) ensure the continuity and comprehensiveness of oral/dental health services; and
c) satisfy a dentist's professional and legal obligations

Patient records must be accurate, well-organized, legible, readily accessible and understandable. If the dentist becomes unable to practise, another dentist should be able to easily review the chart, understand the past dental/medical history, rationale for treatment and carry on with the care of the patient. This Guide is designed to provide assistance to dentists and comfort to the public that dental patient information is both accurate and confidential.

Risk Management

In recent years, the requirements for dental records retention and management have been redefined, especially as they relate to documentation, release of information and storage. Dentists are expected to be familiar with current expectations and to ensure that their staff members understand and adhere to the updated protocols.

Use of this Document

This Guide is designed to assist dentists in meeting the legal requirements for patient records and as such should be viewed as minimal requirements. They apply to several areas of responsibility of the Alberta Dental Association and College: standards of practice, quality assurance and continuing competence.

It is important therefore, that dentists and their staff carefully read this document and take the necessary action to ensure that their dental recordkeeping practices comply. Once a dentist has determined that the dental record form being used allows for the collection and retention of the required patient information all that is required is that the records be kept and updated each time there is contact with a patient. For the purposes of clarification, the terms "records" and "charts" are used interchangeably and have the same meaning.

The document is organized in three sections. The first section outlines the **Recordkeeping Requirements** that apply to all dentists in Alberta. The second section deals with **Electronic Recordkeeping** and is designed to provide a basic understanding of its application. The third section addresses **Questions or Issues** that dentists often confront as they comply with legislation that is either federal or provincial. Additional resources are found in Appendix 1: Quick Points

and Check List for Patient Records and Informed Consent, Appendix 2: CDSPI Consent to Treatment including a CDSPI sample informed consent form and Appendix 3: Reference Documents.

Acknowledgement

This guide is based on similar resources in British Columbia, Ontario and Quebec. The Alberta Dental Association and College wishes to acknowledge the support and use of materials from the College of Dental Surgeons of British Columbia, Royal College of Dental Surgeons of Ontario and the Order of Dentists of Quebec.

Section One: Recordkeeping

A. Purposes of Records

A dental record must record an accurate picture of the patient's general health, oral/dental status and any patient concerns and requests. It must include the clinical findings, diagnosis, proposed treatment plan and treatment performed, as well as all supporting documentation including the informed consent process . Outcomes of treatment must be documented and any deviations from expected outcomes recorded on the patient chart at time of service. Patients should be advised of compromised results as soon as the dentist is aware of the situation. All relevant information presented to the patient should be documented. Patient records have many purposes, including:

a) facilitate the provision of effective clinical care;
b) ensure the continuity and comprehensiveness of oral/dental health services; and
c) satisfy a dentist's professional and legal obligations

B. What are Records?

In dentistry, a record is any item of information, regardless of form or medium that is created or received by a dentist, dental office or professional corporation that is created and maintained to provide care to patients and to conduct business. Records are maintained as a valuable resource in the safe and efficient delivery of dental services, to provide evidence of the dentist's clinical and financial interactions with patients, to ensure practice continuity in the event of a disaster, and to satisfy legal and regulatory requirements. The purpose of a record and the obligation to maintain it does not change with the manner in which it was created.

The Health Information Act of Alberta defines "record" to mean health information in any form and includes notes, images, audiovisual recordings, x-rays, books, documents, maps, drawings, photographs, letters, vouchers, papers, and other information about an individual that is collected when a health service is provided to the individual, that is written, photographed, recorded or stored in any manner.

1) Basic Assumptions:
   - Patients have a right to expect that their dental and overall health information will be kept confidential.
   - Patients have a right (with a few exceptions) to review and obtain a copy of their dental records including consultation reports of other dentists.
   - It is appropriate to share patient records with other individuals as permitted by the Health Information Act as necessary to ensure continuity and quality of care.
   - Every dental team member involved in a patient's care must maintain the confidentiality and security of a patient's dental records, only sharing them with other health care professionals for the purpose of assisting in providing optimal care.

- Dental records must only be disposed of in a manner that ensures that the confidentiality of the information is maintained.

2) In this document, the following additional assumptions have been made:
   - A dentist's responsibility to create and maintain patient records applies to any type of record, whether it is a traditional paper record or an electronic one.
   - Electronic records comply with all recordkeeping principles and requirements.
   - The electronic records management system is based on a private computer and network infrastructure (e.g. privately managed local area or wide area networks), where the ultimate control and responsibilities remain with the dentist, and does not involve any hosting or management of patient records with an external service provider (such as cloud computing).
   - All electronic copies of patient records in all locations are appropriately stored and secured.
   - The electronic records management system has no wireless access points, unless they are appropriately secured.
   - The term "user" encompasses any entity that may access the electronic records management system, including a person, a computer services account, a software application or a computer system.
   - The Alberta Dental Association and College Standard of Practice: Privacy and Management of Health Information provides further direction that is an integral component of recordkeeping requirements.

3) Essentials of Recordkeeping:
   - accurate general patient information that is periodically updated;
   - a medical history that is periodically updated and at a minimum verbally reviewed prior to each appointment and noted within the chart;
   - a dental history;
   - an accurate description of the conditions that are present on initial examination, including an entry such as "within normal limits (WNL)" or "no abnormalities detected (NAD)" where appropriate;
   - an accurate description of ongoing dental status at subsequent appointments;
   - a record of the significant findings of all supporting diagnostic aids, tests or referrals such as radiographs, diagnostic casts/models, reports from specialists;
   - all clinical diagnoses and treatment options;
   - a record identifying all reasonable treatment planning options including no treatment and that they were discussed with the patient;
   - the proposed and accepted treatment plan;
   - a notation and documentation that informed consent was obtained;
   - assurance that patient consent was obtained for the release of any and all patient information to a third party;
   - a description of all treatment that was performed, materials and drugs used, and where appropriate, the prognosis and outcome of the treatment;
   - details about referrals;
   - an accurate financial record;

- the patients, caregiver or guardians signature in most cases on the medical history, privacy policy and informed consent documentation; and
- a copy of all patient communications.

4) General Recordkeeping Principles

In keeping and maintaining acceptable patient records, a dentist must adhere to the following principles:

- All entries should be dated and recorded by hand in permanent ink or typewritten, or be in an acceptable electronic format and be complete, clear and legible.
- All entries, including electronic entries, should be signed, initialled or otherwise attributable to the writer and if different, the treating clinician.
- Radiographs and other diagnostic aids, such as diagnostic casts/models, should be properly labelled, dated and the interpretation of the findings documented by the dentist.
- An explanation of the overall treatment plan, treatment alternatives, any risks or limitations of treatment and the estimated costs of the treatment should be provided to each patient, parent, legal guardian, caregiver or government-appointed advocate as appropriate. This fact should be noted in the patient record. In surgical and/or elective, risky, extensive, cosmetic, expensive, invasive, complex or difficult cases, ensure that informed consent is signed.

C. General Patient Information

It is important that patient records contain the following general information for every patient and that this information be updated at regular intervals. Information should include the patient's name, contact information, date of birth, gender, primary care physician, emergency contact name and number and insurance and/or Alberta Personal Health Number (PHN) information, if applicable.

D. Medical History

A general medical history should be reviewed and signed by the treating dentist and dated at the initial examination. The information should be formally updated regularly based on the patient's age and history and the update noted in the patient record. The medical history should be signed by the patient, caregiver or guardian.

In taking a medical history, dentists must ensure that all necessary and relevant medical information is obtained in order to allow for the provision of safe dental care at the time of treatment and in the future.

It is important that the collection of necessary medical history information be done in a systematic manner. In determining, for example, if a patient has had any serious illnesses, conditions or adverse reactions that might impact on the provision of safe dental care, please refer to the following checklist:

- details of past hospitalizations and/or serious illnesses, conditions or adverse reactions;
- significant respiratory diseases, e.g. asthma, emphysema, tuberculosis;

- any known allergies;
- peculiar or adverse reactions to any medicines or injections, e.g. penicillin, Aspirin or local anaesthetics;
- heart disease, heart attack, blood pressure problems or stroke;
- history of infective endocarditis and/or prosthetic cardiac valve
- epilepsy or seizures;
- blood disorders, bleeding or bruising tendency;
- endocrine disorders, e.g. diabetes;
- cancer/radiation treatment/chemotherapy;
- hepatitis A/B/C, jaundice, liver disease or gastrointestinal disorders;
- kidney disease;
- immuno-compromising diseases, e.g. HIV positive status, AIDS, leukemia's;
- nutritional status/eating disorders, e.g. anorexia nervosa, bulimia;
- any prosthetic joints;
- medications and supplements taken regularly;
- pregnancy;
- psychiatric disorders/treatment;
- drug or alcohol dependency;
- details of recent travels and symptoms such as a cough or illness since the travel;
- height and weight; details of height and weight changes within last 12 months;
- details of difficulties walking or going up stairs such as pain or shortness of breath;
- when they last saw a physician and why; and
- any other conditions or problems of which the clinician should be made aware.

In addition there is a need related to the Alberta Dental Association and College 2010 Infection Prevention and Control Standards and Risk Management for Dentistry where additional questions are necessary when initial medical history and updates are obtained that may not be adequately identified in the above noted list. They are related to the identification and/or prevention of transmission of communicable diseases in community, institutional and professional settings. Medical history questionnaire forms and verbal questioning should be developed such that the information required within both lists is obtained. The following are questions that directly relate to the Infection Prevention and Control Standards and Risk Management for Dentistry standards:

- Do you have a new cough or shortness of breath?
- Have you developed a fever or chills in the last 24 hours?
- Have you had a recent and sudden onset of diarrhoea?
- Have you a new undiagnosed rash, lesion, or break in skin?
- Have you had a recent exposure to communicable infectious disease, (e.g., measles, chicken pox or tuberculosis)?
- Have you recently received antimicrobial therapy? If so, for what reason?
- Do you have a family history of prion disease, or symptoms that may be indicative of Creutzfeldt-Jakob disease (CJD), such as sudden onset of dementia?
- Have you recently travelled to areas where endemic diseases are present?
- Are your immunizations up to date?
- Are you taking any medications for immunosuppression?

In addition, any drug allergies, medical alerts or conditions pertinent to the patient's care should be conspicuously noted in the patient record.

The dentist should sign and date the medical history.

These requirements are minimal. Dentists may provide services covered under a specific standard of practice that will require a more detailed medical history. In the case of sedation or provision of general anaesthesia the dentist must consult the appropriate standards for additional requirements. These are notably the *Alberta Dental Association and College Dental Facilities Accreditation Standards 2011* or *Standards for Use of Sedation in Non-Hospital Dental Practice 2011*.

E. Updating the Medical History

Based on age and history, appropriate questions for updating a patient's medical information include:

- Have there been any changes in your health, such as any serious illnesses, hospitalization or new allergies? If yes, please specify.
- Are you taking any new medications or has there been any change in your medications? If yes, please specify.
- Have you had a significant weight change in last 12 months?
- Have you had a new heart problem diagnosed or had any change in an existing heart problem?
- Have you a history of infective endocarditis and/or placement of a prosthetic cardiac valve?
- Have you had an artificial joint replacement?
- Have you travelled outside of the country recently? If yes, have you had any illness since or other symptoms such as a cough?
- When was your last medical checkup?
- Were any problems identified? If yes, please explain.
- For women only: Are you breastfeeding or pregnant? If pregnant, when is the expected delivery date?
- Is there any other conditions or problems of which the clinician should be made aware?

In addition, as previously discussed, there is a need related to the Alberta Dental Association and College 2010 Infection Prevention and Control Standards and Risk Management for Dentistry where additional questions are necessary when initial medical history and updates are obtained that may not be adequately identified in the above noted list. They are largely related to the identification and/or prevention of transmission of communicable diseases in community, institutional and professional settings. Medical history questionnaire forms and verbal questioning should be developed such that the information required within both lists is obtained. The following are questions that directly relate to the Infection Prevention and Control Standards and Risk Management for Dentistry standards:

- Do you have a new cough or shortness of breath?
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- Have you had a recent and sudden onset of diarrhoea?
- Have you a new undiagnosed rash, lesion, or break in skin?
- Have you had a recent exposure to communicable infectious disease, (e.g., measles, chicken pox or tuberculosis)?
- Have you recently received antimicrobial therapy? If so, for what reason?
- Do you have a family history of prion disease, or symptoms that may be indicative of Creutzfeldt-Jakob disease (CJD), such as sudden onset of dementia?
- Have you recently travelled to areas where endemic diseases are present?
- Are your immunizations up to date?
- Are you taking any medications for immunosuppression?

F. Dental History

The past dental history is obtained from the patient at the first visit to a dental office. The information may be subjective but serves as a baseline to supplement the clinical findings. The dental history questions can be extensive depending on the care being sought. Questions tailored to the age of the patient are often necessary (e.g. bottle feeding). In addition to clinical findings, the patient record must contain a notation of any significant dental history including an assessment of caries risk and periodontal health. Information obtained regarding a patient's dental history can supplement the clinical examination, and assist in the planning and sequencing of dental care that is necessary and appropriate to improve the patient's dental health status.

G. Dental Examination

The patient record should include chart recordings, and written and/or electronic descriptions of the conditions that are present on examination of the patient.

This information can be categorized as follows:

- Extra-Oral Evaluation;
- Soft Tissue Evaluation;
- Dentition Evaluation;
- Vital Signs – The necessity of this information depends on the complexity of the dental treatment required, the medical history and present state of health of the patient, and whether sedation or general anaesthesia will be used;
- Periodontal Evaluation – This may be carried out in two stages, namely a recognized periodontal screening examination for adolescent and adult patients [i.e. Periodontal Screening Record (PSR), Community Periodontal Index of Treatment Needs (CPITN)] and a complete periodontal examination for those whose screening results warrant in-depth follow-up;
- Arch Relationship and Growth/Development; and
- Risk Assessment and Further Evaluation – This includes such items as caries, periodontal and cancer risk.

As part of a complete oral examination, it is important to break down each component area and show in the patient record that each of these areas has been addressed during the examination. For those patients with little or no history of dental disease and a relatively healthy mouth, this can be accomplished with a notation such as "within normal limits (WNL)" or "no abnormalities detected (NAD)" for most of the areas.

As part of a limited, specific or emergency examination it is important that the patient record shows that the appropriate clinical examination was undertaken to deal with the patient's chief complaint or past history so that the diagnosis can support the treatment recommendations.

While the choice of patient record or chart form is left to the individual dentist, it is important that there is sufficient space to record all relevant information unique to a particular patient and to update it whenever necessary.

These records must reflect initial conditions and differentiate these from subsequent findings. Any part of the record used on an ongoing basis, such as an odontogram, must allow sufficient space to record all relevant information and dated updates as necessary. Changes in clinical findings noted at subsequent recall examinations or emergency appointments should be recorded in writing in the patient record or noted on a separate odontogram.

H. Radiographs, Dental Models and Diagnostic Tests

Radiographs are an important part of the patient record. They should be clearly labelled with the patient's and the dentist's name, date and be of diagnostic and archival quality. All radiographs taken in a dental office should be noted in the chart, including any retakes or problems encountered, regardless of their diagnostic quality or whether a fee was charged.

The following factors may influence the diagnostic quality of radiographs:

- film fog
- stain, discolouration or foreign marks
- inadequate image density
- elongated or foreshortened images
- overlapping of interproximal surfaces
- inadequate view of the apex or apices

The number and type of radiographs prescribed for new patients should be appropriate to the age, oral health status, dental history and consent of the patient.

The decision to take recall radiographs should be based on the patient's age, general or systemic condition, dental history, current status and any existing radiographs. Recall and/or post-operative radiographs should only be taken when judged necessary, not on a routine basis.

Whenever a patient, patient's guardian or authorized representative refuses recommended radiographs, such refusal should be noted in the patient record.

The Alberta Dental Association and College has developed a comprehensive standard that is referenced as the Guide for the *Radiation Health and Safety Program* and is available on the members' website.

Photography is often used to access treatment options and outcomes. As with radiographs, they become part of the patient record and need to be maintained.

Diagnostic casts/models are valuable diagnostic aids that allow for initial assessment, follow the progression of treatment or study growth. They should be clearly labelled with the patient's and the dentist's name, date and be of diagnostic quality.

There is the increasing use of diagnostic tests in dentistry. There use, findings and implication is part of the patient record.

Interpretation of findings related to radiographs, dental models and diagnostic tests need to be documented in the patient record.

I. Diagnosis and Treatment Planning

The patient record should contain statements that identify any immediate needs or chief complaints as presented by the patient. Other than for emergency or single appointment situations, the overall condition of the teeth and supporting structures should be reviewed and documented regularly.

A statement regarding caries risk and the periodontal status of the patient based on the history and examination must be included in the record. Any discussions regarding general recommendations about future treatment options, a maintenance schedule, and the cost of treatment should be recorded in the patient record.

The **diagnosis** made from a review of the data that was collected and recorded during the clinical examination, supplemented by necessary radiographs and/or diagnostic casts/models and/or the results of any tests or consultations should be noted in the patient record. All diagnoses should be stated specifically. It should also be recorded that this information was communicated to the patient.

Where the possibility of there being another possible cause for a condition it is important to document this as a **differential diagnosis** and clearly indicate in the chart what was conveyed to the patient. How this might affect the treatment approach, outcomes or complications must be documented.

The treatment plan must list the recommended services to be performed for the patient and be based on the medical and dental history, clinical examination and diagnoses.

The treatment plan should be supported by a complete and accurate clinical record and take into account the relative urgency and severity of the patient's condition. This record should reflect:

- the urgency and order of treatment;
- the options presented to the patient for materials and methods;
- treatment options and alternatives, including no treatment;
- all recommendations, instructions and advice given, together with pertinent patient comments;

- discussions about financial implications and arrangements for payment options discussed;
- discussions about referrals to other dentists or dental specialists and why;
- an indication of the decision of the patient with respect to choice of treatment and that informed consent has been obtained; and
- a planned schedule of reassessment and/or outcome assessments on evasive, extended or complex treatment plans.

For elective, risky, extensive, cosmetic, expensive, invasive, extended, complex or difficult cases, the treatment plan should also include a schedule of visits, estimated timeline and, where appropriate, provide a brief description of the services to be performed at each appointment. Any conditions that are being monitored should be noted, as well as the fact that the patient was informed accordingly. The extent to which the patient has accepted or rejected the recommended treatment should also be recorded, where applicable.

As an aid to ensuring records are sufficiently detailed, particularly in emergency cases, the use of acronyms such as S.O.A.P (subjective, objective, assessment and plan), PARTS (problem, assessment, recommendations, treatment and subsequent advice) or RATPP (reason, anesthetic used, treatment, post-operative care, plan for next visit) can provide guidance and uniformity in recordkeeping protocols.

J. Informed Consent

Informed consent is based on the right of each person to determine what will be done to his or her own body. Informed consent guarantees each person the right to refuse treatment, to consent to treatment, and to withdraw consent to treatment. Informed consent also ensures that the person understands the risks and benefits of each treatment option presented as well as the costs involved.

Consent may be either implied or expressed. Implied consent is usually ascertained by the actions of the patient, as with the patient who opens his or her mouth for an examination. Express consent may be oral or written.

Informed consent is not an event or specific form but rather an ongoing dialogue with patients that begins at the first visit to the office and continues as treatment progresses.

Implied consent may be sufficient if: the patient voluntarily comes to the dentist's office and the dentist is performing a simple examination or non-invasive procedure that poses no risk of harm to the patient.

Express consent should be obtained when: any treatment required poses a potential risk to the patient, even if the likelihood for potential complications is low. This includes any procedure from something such as a simple filling to more complex procedures such as oral surgery, extraction or prosthetic rehabilitation

1) Obtaining Consent

The standard for obtaining informed consent used to be what a reasonable prudent dentist would disclose. In the early 1980s, the standard changed to a more patient-centered view. Now, the standard is what a reasonable person, in the patient's position, would need to know to make a decision. This makes it imperative that dentists know their patients and tailor the information that is provided to the needs of each patient and in a manner that the patient will understand.

In order for consent to be informed, the dentist must provide the patient with certain information:

- the diagnosis or problem noted;
- the differential diagnosis if there is some doubt;
- the treatment alternatives available including no treatment (not just the ones that the dentist provides);
- the risks and benefits of each treatment;
- the estimated cost of each option;
- the nature and purpose of the proposed treatment;
- future costs of care and life expectancy of treatment; and
- the likely consequences of not having treatment.

The dentist should be certain that the patient understands what has been explained and has consented to the procedure(s).

Although both oral and written consent are legally acceptable, oral consent should be confirmed in writing where risks are significant. There must also be a notation in the chart regarding the nature of the consent. For surgical and/or elective, risky, extensive, cosmetic, expensive, invasive, extended, complex or difficult cases the dentist must ensure written consent is obtained. Often the consent process extends over a considerable period of time and may not solely take place in the office setting. A variety of communication methods may be used by the dentist including verbal, letters, forms or electronic communication during this period. Regardless of whether the patient consents in writing or orally, the dentist must keep a record of the nature of the conversation, the information provided and the patient's decision.

The use of blanket consents where the patient signed a form that was used in futurity and for all procedures is not sufficient to obtain informed consent. Outlining office policy with general statements on appointments, payment of fees, general releases, privacy policy and transmission of claims to third parties may be useful at a first visit but must not be confused with having obtained informed consent which is an ongoing process. Such outlines should be viewed in the context of a general consent to define or inform patients regarding a variety of circumstances ranging from business to privacy concerns.

2) Other Significant Consent Information

In Alberta there is no specific age of consent and a minor can give consent if they have the capacity to understand and make decisions about health care. In Alberta the issues

of capacity and consent are covered by the *Adult Guardianship and Trusteeship Act* and *Personal Directives Act*. Consent for payment of the treatment may be a separate issue. Under the age of 18, a person may consent to treatment but cannot be held to a contract. Notwithstanding the above, the following are general rules to follow:

- A legal guardian or other substitute caregiver must consent to dental procedures for incompetent patients or children who are not capable of understanding information that is relevant to making a decision about the treatment and not able to appreciate the reasonable foreseeable consequences of a decision or lack of a decision;
- Age is a factor: 16 to 17 year olds require that you get their consent. For 12 to 15 year olds, age, maturity, ability to understand, type of treatment play a role. It is advisable to get the consent of both the parent and child. Under the age of 12 the consent of parents or guardian needs to be obtained;
- No consent is required in an emergency where a patient is experiencing severe pain or suffering or is at risk of sustaining serious bodily harm if treatment is not administered promptly;
- No consent is required if the patient is apparently impaired by drugs or alcohol or is unconscious or semi-conscious for any reason or in the health care provider's opinion, otherwise incapable of giving or refusing consent;
- The patient does not have a substitute decision maker, guardian or representative who is authorized to consent to the health care, is incapable of doing so and is available; and
- Where practicable, a second health care provider confirms the first health care provider's opinion about the need for the health care and the incapability.

3) Summary of Informed Consent

A signed piece of paper may not be an indication of informed consent. Informed consent is not a single event, just a signed document or sitting in a dental chair with an open mouth. It is a permission obtained as a result of the process of information sharing in ongoing dialogue between the dentist and the patient.

a) Patient must know the diagnosis or differential diagnosis;
b) Discuss the nature and purpose of the treatment and expected prognosis;
c) Patient should be told of the benefits;
d) Possible risks must be discussed:
    - Very low risks do not have to be covered;
    - Material risks are things the patient should know:
        - E.g. Breaking of an endodontic file;
e) Alternatives to what you are suggesting must be discussed with risks and benefits;
f) The option of no treatment with risk and benefits is always an option that needs discussion;
g) What is the cost of the treatment;
h) Always give the patient time and encourage them to ask questions before any decision is made;

i) The reasonable expectations respecting the duration and durability of appliances, products, procedures or treatment proposal; and

j) Always document in the patient record.

Appendix 1 provides a "Quick Points and Check List" to assist Alberta dentists with the review of practice protocols to meet the Standards of Practice in relation to *Patient Records* and *Informed Consent*. See Appendix 2 for the CDSPI Consent to Treatment document and a CDSPI sample Consent to Treatment Form.

K. Treatment Records

1) Clinical Progress Notes

Progress notes describe the treatment rendered for the patient at each appointment. They should be well-organized, legible (handwritten, typewritten or an acceptable electronic format), dated and provide a complete and comprehensive description of the patient's ongoing care by a particular dentist. They should also indicate the reason for the particular treatment, if it is not apparent from the record (i.e. loose or fractured restoration) and the tooth/teeth or area of the mouth being treated. It is also advisable to note on the patient record whenever a discussion of possible limitations of treatment was held with the patient.

The progress notes for each visit should provide a concise and complete description of all services rendered (including any consultation provided by telephone) and include:

- the date of treatment;
- the treating clinician's identity;
- the area or tooth number being treated and the identity of the writer;
- diagnostic tests and their results;
- the type and quantity of local anaesthetic used;
- the materials used;
- any other drugs that are prescribed, dispensed or administered and the quantity and dose of each; and
- all recommendations, instructions, explanations and advice given to the patient and any discussion with the patient regarding possible complications, success, outcomes, prognoses and follow-up requirements.

Dentists may rely on office staff to document their chart entries, but the dentist is expected to sign or initial each entry after reviewing it for accuracy and completeness to ensure that it captures the necessary information. Entries made by dictation must be initialled by both the dentist and the writer. The dentist is responsible for the accuracy of all chart entries.

Any complication and/or adverse outcome should be well documented. The chart entry should specifically note the patient was advised about the incident and the available options to address it.

As care is provided to the patient, circumstances may change and require alterations to the initial and/or recommended treatment plan. Such alterations should be clearly documented, along with a notation that they were discussed with and agreed to or declined by the patient. Any changes to a chart cannot be deleted, erased or whited-out. The change may be crossed out as long as the original intention remains legible.

Helpful Tips for Chart Entries

- When composing chart entries, adopt a methodical style. For example, the individual steps for each service may be documented in the order they were performed;
- Acronyms such as SOAP, PARTS or RATPP can aid in ensuring needed detail is included;
- Abbreviations and short forms are commonly employed for brevity. This is an acceptable practice, but they should be easily decipherable and used in a consistent fashion;
- If your writing is illegible have someone else write for you and have them and you initial the entry;
- Cross out mistakes with a single line – never erase, white out or delete;
- The original entry must remain legible;
- Always write in ink; and
- Do not worry about spelling errors – a spelling error is better than having something left out because it could not be spelled correctly

2) Referral Documentation

Notations of referral to a specialist or recommendations of referrals, as well as copies of any reports/correspondence to and from specialists must be kept on file. A written or electronic summary of any verbal conversations about a patient with another dentist, specialist or other health care professional should also be noted in the chart.

The use of procedures or work outsourced to a dental laboratory must be noted, detailing the date of service, make-up of materials used (e.g. gold content) and the name of the lab used, if appropriate.

A patient's consent must be obtained before his or her dental conditions and/or treatment needs are discussed with any third party.

It is also important to record patient refusal of a referral recommendation.

3) Patient Follow-up and Recall Examinations

It is advisable to have a systematic notification procedure for the ongoing care of patients, especially as it relates to the completion of treatment, postoperative checks, treatment follow-up and outcomes. The recommended return date, if applicable, should be noted on the chart. It is also advisable to keep a record of missed appointments or cancellations. Entering into the chart the nature of any communication with the patient that takes place outside of an appointment, whether it is verbal or electronic in regards to ongoing care and treatment must be standard practice.

When patients are seen for follow-up or reassessment, the chart entries should include:

- the type of examination conducted (recall, emergency, specific area);
- a notation that the medical history was reviewed and/or updated;
- the findings of the examination; and
- the details of any further treatment recommended and rendered.

L. Financial Records

Another important facet of the patient record relates to financial matters. It is prudent to include in the patient record a note or notes about the financial arrangements and agreements made with the patient and/or guardian concerning the settlement of accounts. The Uniform System of Coding & List of Services (USC&LS) Procedure Code applied must be supported by the treatment provided.

The financial record for each patient must include:

- a copy of any written agreement with a patient;
- the date and amount of all fees charged
- the date and amount of all payments made;
- an itemized listing of all commercial laboratory fees that were incurred in respect to prosthetic, restorative or orthodontic services; and
- copies of all dental claim forms.

If dental treatment is provided for a patient on a basis other than fee-for-service, or where the responsibility for payment is with a person other than the patient or patient's guardian, dentists should be aware of the following recordkeeping requirements.

Any such agreement with a patient must:

- be in writing;
- be maintained as part of the patient record;
- identify the person or persons entitled to dental services under it;
- outline the dental services to which they are entitled;
- state the period of time it will be in force; and
- specify the obligations of the parties in the event the dentist is unable to provide covered services, including the obligations to make further payments and the application of payments that were previously made.

M. Business Records

If payments for dental services are made on behalf of a patient by a third party, the financial record must include the patient's authorization if applicable, and the identity and authorization of the person or agency making such payment (XYZ Insurance Company, Health Canada Non Insured Health Benefits [NIHB], Alberta Social Service, etc.).

The signature of the patient or guardian authorizing release to one's insuring company plan administrator, the information contained in claims submitted or preauthorizations, either manually or electronically needs to be kept on file.

Dentists must also keep business records for the practice, including fees charged and received, scheduling (including day sheets), laboratory services and clinical equipment maintenance. Business records chronicle the day-to-day activities in a practice and although the significance of some of this information may seem to diminish after the fact, it can become very important in the event of a complaint or a lawsuit. Dentists should be aware of provincial and federal legislation governing business records such as the Income Tax Act.

N. Drug Records

The following information needs to be in the patient record and it is best practice to include a copy of the prescription:

- date of the prescription;
- name, strength, quantity and form of drug;
- dose of the medication, administration route and frequency of administration;
- duration of the period for which the patient is to take the medication;
- whether or not refills have been issued; and
- condition being treated and/or dental treatment provided.

Dentists must take adequate steps to protect narcotics and controlled drugs in their possession from loss or theft. Narcotics and controlled drugs must be kept in a locked cupboard out of sight and reach of patients or prospective patients.

Dentists must store benzodiazepines and targeted substances in a locked and secure location within their professional practice and in an area where only authorized employees have access. A drug register must record and account for all narcotics, controlled drugs, benzodiazepines and targeted substances that are kept on site. It is good practice to document in this register Over the Counter (OTC) medications that are given to the patient usually in the form of samples as well. The register should also be kept in a secure area in the office, preferably with the drugs. It goes without saying that all drugs given or prescribed and the dosage will be entered in the patients chart regardless of whether they are OTC or controlled.

- Whenever drugs in the above-mentioned classes are used or dispensed, a record containing the name of the drug, number or dosage dispensed, name of the patient and date should be entered in the register. Each entry should be initialled or attributable to the person who made the entry. In addition, this same information should be recorded in the patient record along with any instructions given;
- Prescription pads should never be pre-signed. They should be kept out of reach of patients, prospective patients or visitors to the office; and
- Triplicate prescription pads should be kept in a secure place that is accessible only by the dentist.

Drugs may only be provided or dispensed to dental patients of record, for dental conditions being treated, and according to accepted dispensing protocols.

It is not acceptable for dentists or their staff to access in-office supplies of narcotics, controlled drugs or other drugs that normally require a prescription, for their own personal use or use by their family members. Dentists must not prescribe drugs for themselves and can only prescribe drugs for family members when indicated specifically to dental issues.

Section Two: Electronic Recordkeeping

The use of electronic recordkeeping by dentists, including digital radiography, has grown substantially in Alberta and the sophistication of hardware and software continues to evolve. In addition, the public has a heightened sense of awareness and increased expectations around the issues of confidentiality and accuracy. Moreover, the nature of electronic records raises additional issues for both dentists and patients, particularly with respect to accuracy, authenticity and access.

It is important to note that electronic records must comply with all requirements of traditional paper records as outlined in other areas of this Guide. It is not acceptable to use templates to describe procedures and make notes without addressing the unique circumstances based on the conditions and situation encountered with each patient.

Electronic Recordkeeping System Requirements Overview

Dentists may make and keep electronic records provided certain guidelines are adhered to. Dentists must also take steps to ensure the reliability of data input and the subsequent accessibility and security of information.

When it comes to accuracy, the most important feature of electronic recordkeeping is an audit trail so the authenticity of the records can be verified by any party who has an interest or requirement to do so. The audit trail should follow any changes that have ever been made to the records to ensure that those changes have not compromised the integrity of the record.

It is important that any electronic recordkeeping system employed in a dental practice:

- has a login and password to access the data, or otherwise provide reasonable protection against unauthorized access, and can authenticate all entries;
- provides an accurate visual display of the recorded information and is capable of retrieving and printing this information within a reasonable time period;
- has an audit trail that:
  - records the author, time, date, workstation (for networked systems) of each entry for each patient with respect to the clinical or financial data entry, and is capable of being printed separately from the recorded information for each patient;
  - preserves the original content of the recorded information (text, image or chart) in a read- only format that when changed or updated tracks the author, time, date, and workstation (for networked systems) of the modification;
- provides a means of visually displaying the clinical and financial records of each patient by patient name and is easily printed or transferred with the inclusion of all of the original and modified entries, and the dates, order of entry and authors;
- has the capability to provide good quality printed copies of the records and digitized images;
- stores the original data in a read-only format from within the dental program itself, but protects the data files from entry and alteration from the database;

- backs up files on a removable medium that allows data recovery, or provides by other means, reasonable protection against loss, damage, and/or inaccessibility of patient information; and
- ensures the privacy of the patient's personal information is properly safeguarded in both the electronic recordkeeping and in the transfer of the patient's records.

The dentist and/or staff members need to be properly trained and have technical competence with the computer program.

There is increasing pressure on all health care professionals to convert from paper records to electronic records. The province of Alberta has committed to implementing a comprehensive electronic health record for all Albertans, and similar efforts are being made in other provinces and nations.

When converting analog patient records to a digital format for inclusion in an electronic health record system or for retention/archival purpose, a written policy and protocol must exist that ensures that the integrity and authenticity is maintained. The digital copy needs to be verified to assure its original quality, content and function is intact to fulfil its ethical, legal and professional roles. The Alberta Dental Association and College has developed a "Guide for the Conversion of Analog Health Records to Digital" to assist members.

Electronic records offer many benefits to dentists and patients. They require less space and fewer administrative resources to maintain, while supporting improved clinical decision-making, leading to more effective diagnosis and treatment, greater patient safety and increased efficiency. On the other hand, electronic records present unique security and privacy risks, such as the potential for exposing the personal health information of patients to hackers and others with malicious intent. The design and implementation of an electronic records management system requires careful consideration in order to address these risks, including the use of access controls, audit trails, encryption and other safeguards.

The risk of exposing personal health information may be greatest during the transition from paper records to electronic records. Many factors converge to increase this risk:

- Staff may not be fully trained on using the new electronic records management system, increasing the likelihood of human errors;
- During the initial implementation phase, the new electronic records management system may not be fully functional, and the security and privacy features of the system may be either turned off or set to a default minimal standard of protection;
- The conversion of existing paper records to electronic format may require more frequent access to records of personal health information by a broader range of persons than would normally be the case;
- Records may be duplicated in both paper and electronic formats, potentially doubling the volume of records that need to be protected;
- The archiving, retention and disposal of paper records, if not carried out in a secure manner, may also pose a threat to security and privacy;
- Dentists may require assistance from third-party service providers to make the transition; and

- Creating an additional layer of complexity to the security and privacy risks that must be managed.

According to Health Canada, patient management software fits the definition of a medical device and must be classified in accordance with the rules under the Medical Devices Regulation.

Any patient management software that is used only for visualizing, acquiring, transferring or storing data or images is considered a class I medical device

Any patient management software with capabilities beyond basic data visualization, acquisition, transfer and storage is considered a class II medical device, which requires a valid ISO 13485:2003 quality system certification, as well as a valid license for sale, importation and distribution in Canada. This includes any patient management software involved in data manipulation, data analysis, data editing, image generation, determination of measurements, graphing, flagging of results, identifying a region of interest or performing calculations.

The purpose of this document is to describe the essential principles in managing and protecting electronic records from the moment of their creation or capture, as well as the minimum requirements of related electronic records management systems.

A. Electronic Records

An electronic or digital record is any item of information that is created, recorded or stored on any medium in or by a computer system or other similar device. Electronic records include, but are not limited to, computer files (e.g. documents and spreadsheets), digital images (e.g. JPG, BMP, TIFF), digital video (e.g. MPG, AVI), e-mails in their original format and any attachments, databases (e.g. SQL, Microsoft Access, FileMaker), and all back-up copies.

Electronic records are produced and used for the same purposes as traditional dental records. Therefore, it is essential that they are securely created, stored, accessed and managed so as to ensure and preserve their documentary and evidentiary value, as well as the privacy of personal health information.

Electronic records management is a framework of policies, procedures and processes that leads to the creation and maintenance of authoritative electronic records, which have the following characteristics.

Authenticity

An authentic electronic record can be proven to be what it purports to be. This includes being able to prove who created it and when. To provide for authenticity, adequate controls are necessary to ensure that the creator of an electronic record is identified and authorized, and that the record is protected against unauthorized use, alteration or concealment.

Reliability

A reliable electronic record can be trusted as a full and accurate representation of the facts. The record should be created at the time of or soon after the event to which it relates by a person who has direct knowledge of the facts.

Usability

A useable electronic record can be located, retrieved, presented and interpreted. As well, the links between records that document a sequence of activities should be maintained.

Integrity

The integrity of an electronic record refers to its being complete and unaltered. To provide for integrity, a record must be protected against unauthorized alteration. Any authorized annotation, addition or alteration to a record should be explicitly indicated and traceable.

B. Requirements of Electronic Records Management Systems

An Electronic Records Management System (ERMS) captures and organizes electronic records, manages and protects them from unauthorized use or alteration, and provides access to all relevant records and related information over time. An Electronic Records Management System should be designed and implemented to assist health information custodians in meeting their privacy requirements under Alberta's *Personal Information Protection Act* (PIPA). Documentation should be kept about servicing and maintenance of computer equipment and other elements of the system. The *Health Information Act* requires a health information custodian to enter into a written agreement with a person or body that processes, stores, retrieves or disposes of health information, transforms health information to create non-identifying health information or provides information management or information technology services. This written agreement is necessary so that the information manager can access health information without the consent of an individual who is the subject of the information.

An Electronic Records Management System is comprised of software applications and supporting hardware that automates and integrates the records management principles. The Electronic Records Management System should:

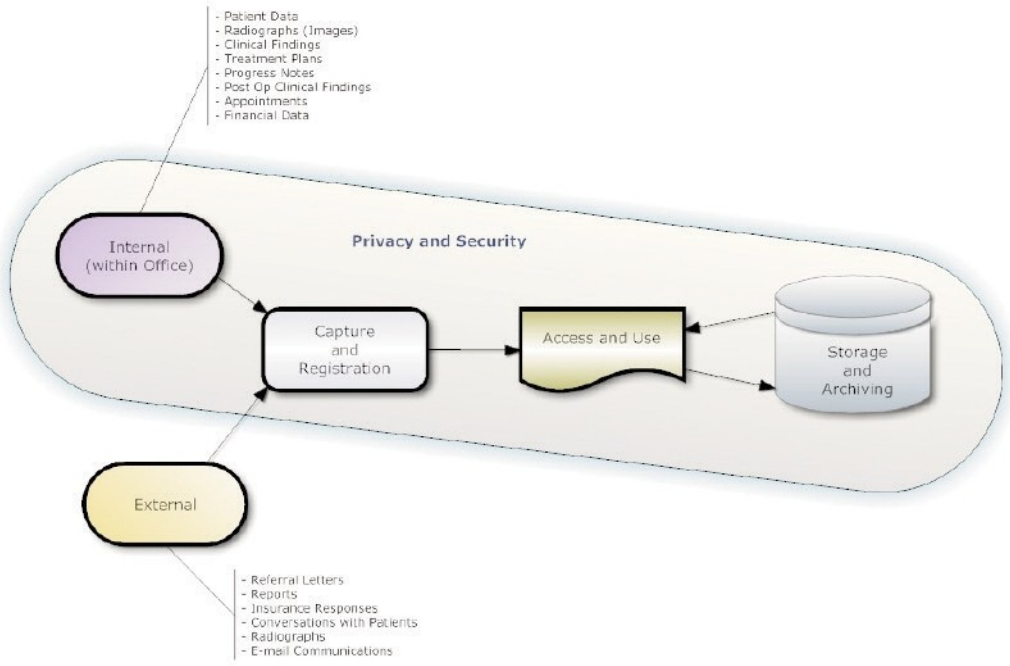
- be robust and capable of regular use, and the reliability of its operation should be documented;
- have adequate processing power and storage to meet the capacity demands of the dental office; and
- be capable of periodic upgrades to reflect the changing requirements of the dental office.

An electronic record may be created within the dental office or received from an external source in a variety of media. The record must be captured by the Electronic Records Management System through a formal registration process that assigns it a unique identifier and persistently associates it with relevant information, also known as metadata, which should be validated.

Metadata provide a brief description about the electronic record that facilitates organization and retrieval, and link it to other records for the patient. As a minimum, metadata should include the following:

- the unique identity of the creating user;
- the unique identity of the patient;
- an accurate date and time stamp;

- the nature of the record (e.g. document or image); and
- the access status assigned to it.



Each patient must be assigned an identifier or patient ID that can uniquely identify the patient within the Electronic Records Management System. The patient's health or social insurance number must not be used for this purpose.

Following their capture, electronic records must be stored and preserved by the Electronic Records Management System for as long as they are needed, and under conditions that will protect them from unauthorized access, loss or corruption.

The retrieval and use of electronic records is managed through the application of access controls for authorized users of the Electronic Records Management System, as described in the following sections on physical and logical access controls.

The Electronic Records Management System must be capable of the following:

- providing a secure means of access to all recorded clinical and financial information for each patient by the patient's name; and
- visually displaying, printing and exporting by secure means all recorded information for each patient promptly and in chronological order.

Authorized alterations to an electronic patient record are permitted through the application of auditable controls, in which the original record is maintained in a read-only format and cannot be modified or deleted, and is merely demoted by a more recent or current version. The Electronic Records Management System should be capable of providing an accurate visual

display of all previous versions of any record, as well as the associated metadata, at any point in the past.

Electronic financial records must provide an accurate statement of each patient's account and minimally provide the date and amount of all:

- USC&LS Procedure Code;
- fees charged;
- commercial laboratory fees that were incurred;
- payments received, including the method of all payments; and
- adjustments to the account.

As well, electronic financial records should provide an accurate reflection of the current status or running balance of each patient's account, in keeping with standard accounting practices.

Electronic images (e.g. digital radiographs, digital photographs) must be captured and maintained to the same standard as all other electronic records for the patient, including registration of metadata, and should be exportable in a format compatible with the International Standards Organization (ISO) referenced Digital Imaging and Communications in Medicine (DICOM) Standard.

For conveniences, a paper record, dental radiograph, photograph or diagnostic cast/model for a patient may be converted to electronic format. The protocols are outlined in the Alberta Dental Association and College *Guide for the Conversion of Analog Health Records to Digital*. A tamperproof digital image should be captured by the Electronic Records Management System, which serves as a copy of the analog original. The paper record, dental radiograph, photograph or diagnostic cast/model may then be placed into storage, archived or disposed. Records that are disposed must be in a manner that protects patient confidentiality and maintains physical security of the information. The decision to dispose of patient records rest with the custodian as defined under the Health Information Act and the Alberta Dental Association and College Standard of Practice: Privacy and Management of Patient Health Information.

In order to ensure that authoritative electronic records are captured and maintained, an Electronic Records Management System must employ a variety of safeguards or controls that regulate who may gain access to the system and what they may do.

If access is the ability to do something with a system resource, access control is the function of enabling or restricting this ability, which may be accomplished through both physical and technical safeguards.

C. Physical Access Controls

Physical access controls are physical safeguards that are taken to limit persons from entering or observing designated areas of the dental office that contain computer equipment and other elements of the system (e.g. servers, workstations, telephone and data lines, back-up media, etc.). Examples of physical access controls include:

- locked doors and security systems to restrict after-hours entry to the dental office;
- positioning servers and workstations in areas of the dental office that are secure during normal business hours;
- positioning or shielding monitors so that their displays are not observable by persons in other areas, such as waiting rooms; and
- using logout and/or automatic timeout at unattended or idle workstations.

D. Logical Access Controls

Logical access controls are technical safeguards that are taken to limit the information persons and other users can access, the modifications they can make and the software applications they can run. These safeguards may be designed into computer and network operating systems, incorporated into software applications and system utilities or carried out by add-on security programs.

Logical access controls are the means by which policy decisions are implemented and enforced. They enable staff to have access to the information they need to carry out their duties, while controlling the kind of access they are allowed and restricting their access to information that is not job-related.

Most access controls are based on who is attempting to use the system (i.e. identification and authentication) and what privileges they have to use a system resource (i.e. authorization).

E. Identification and Authentication Identification

This is the means by which a user provides the system with a claimed identity or user ID. Authentication is the means by which the user establishes the validity of this claim. There are three primary methods of authenticating a user's identity, which should be used in combination. The user may provide:

- a secret, such as a password or personal identification number (PIN);
- a token, such as a swipe or security card; and
- a biometric, such as a fingerprint or retina scan.

<u>The use of minimum two-factor authentication (I.E. a combination of two methods) is strongly recommended.</u>

Identification and authentication are essential to computer security, as they are the basis for most access controls, which must recognize authorized users of the system and differentiate between them. In addition, they provide for accountability by linking specific users to their activities on the system, whether they are accessing the system from within the dental office or remotely.

Ideally, the identity of a potential user is established once and registered with the system, before access control decisions are made and privileges assigned to a unique user ID.

F. Authorization

Authorization is the means by which a user is granted permission to access a system resource. Most systems use role-based access controls that rely on staff job titles to define privileges. In this way, staff are provided access to information on a need-to-know basis. In addition, staff are limited in their ability to perform certain functions, based on the kind of access they require to carry out their duties.

There are three basic types of functions:

1. **Read** – The user can read information in a system resource, such as a patient record, but cannot alter it;
2. **Write** – The user can add information in a system resource; and
3. **Execute** – The user can run a program.

These privileges may be used alone or in combination. For example, an individual staff member may be given read and write access to patient records, but not execute privileges to run programs.

In appropriate circumstances, an individual staff member may be registered with more than one non-overlapping role in the dental office, each with a unique user ID, in order to carry out specific tasks. In all circumstances, the Electronic Records Management System should ensure that a user may access applications and services in only a single role at a time.

Although privileges are assigned to authorized users at initial registration, they should be reviewed at least annually and changed as required. Further, the system must support the revocation of access privileges; that is, a user must be immediately prevented from accessing the system once his/her privileges have been revoked.

Full access to the system must be strictly limited and never granted to anyone without absolute need. The dentist must retain ultimate control over the system and assumes final responsibility for ensuring that its resources are appropriately used.

G. Audit and Accountability Controls

An audit trail is a record of events or actions concerning the activity of the operating system, a software application or a person using the system.

A system may have several audit trails, each devoted to maintaining a record of a specific type of activity.

Audit trails are the means by which several security-related objectives are accomplished, including individual accountability, the reconstruction of events and intrusion detection.

Audit trails should contain the necessary information to answer the following questions:

- For a given user, what patient record did the user access, create or alter, what did the user do and when?

- For a given patient record, what users have accessed, created or altered the patient record, what did the users do and when?

At minimum, an audit trail must contain the following information:

1. The unique identity of the accessing user;
2. The role the user is exercising;
3. The practice location and specific computer identification of the accessing user;
4. The identity of the patient;
5. The activities performed by the accessing user; and
6. An accurate date and time stamp.

H. Individual Accountability

Audit trails ensure that users are accountable for their actions by recording their activities on the system. They work in concert with logical access controls, which limit the ability of users to access system resources. While users cannot be prevented from accessing resources to which they have legitimate authorization, audit trail analysis can be used to examine their activities.

For example, an audit trail should be capable of displaying the content of a patient record at any point in the past, as well as the associated metadata of who accessed the record, what alterations were made and when this was done.

I. Reconstruction of Events

Audit trails may be used to reconstruct events after a technical problem occurs in order to identify how, when and why normal performance or functionality of the system ceased. Audit trail analysis of the activity of the system can often distinguish between user-induced errors (during which the system may have performed exactly as instructed) or system-created errors.

For example, if the system fails or the integrity of a patient record is questioned, an analysis of the audit trail can reconstruct the series of steps that were carried out by the system, a software application or any user.

In addition, audit trails may aid in the recovery process. For example, if a patient record is corrupted, an audit trail analysis can be done to ascertain the alterations made and reconstruct it.

J. Intrusion Detection

Audit trails may be used to detect users attempting to gain unauthorized access to the system. They may also be used to detect changes in the system's performance or functionality, which might indicate a virus or worm attack. Attention can then be focused on damage assessment or reviewing controls that were attacked. Reporting an intrusion to the Information and Privacy Commissioner of Alberta should be considered as part of the review.

It is important to note that the use of audit trails is fundamental in establishing the authenticity and integrity of stored records. Therefore, access to audit trails must be strictly limited to protect them from tampering. In addition audit trails:

- Must be operational at all times;
- Must not be modifiable;
- Must be retained for the entire retention period of the records audited;
- Must be exportable by secure means and able to provide evidence when necessary; and
- Must be printable

Laptop Computers and Other Portable Storage Devices

Once a patient record is available in electronic format, it can be easily transferred to a laptop computer or other portable storage device (e.g. USB flash drive, PDA, Smartphone) and transported outside of the workplace. Despite the convenience they offer, only the minimum necessary data should be stored on such devices. Moreover, due to their potential for loss or theft, dentists must ensure that all patient records stored on these devices are either strongly encrypted or de-identified.

The term "strong encryption" does not refer to a particular technical or design specification or a distinct encryption feature. Rather, a variety of circumstances and factors need to be considered in order to ensure that personal health information is adequately protected.

The Information and Privacy Commissioner of Ontario has provided a working definition for strong encryption, as well as guidance on the minimum technical and functional requirements for a health care environment. For more detailed information, refer to fact sheet 16: Health-care requirement for strong encryption, which is available on the website of the Information and Privacy Commissioner at www.ipc.on.ca Similarly the Office of the Information and Privacy Commissioner of Alberta has addressed the need for security in detail in the Health Information Act Practice Note #5 (www.oipc.ab.ca) and Health Information Act publication – Guidelines and Practice Manual, March 2011 (www.health.alberta.ca).

K. Wireless Devices

Wireless devices broadcast information via radio waves, which radiate in all directions from the point of transmission. As a result, the signal may be intercepted by any receiver within range that is tuned to the same frequency. For this reason, dentists must ensure that the personal health information of patients transmitted using wireless devices is either strongly encrypted or de-identified.

L. Teleworking

The use of teleworking (i.e. working remotely, such as from a home computer or wireless device, via external internet connection to the Electronic Records Management System) in dentistry is increasing and offers many advantages. However, it also raises significant security and privacy concerns for dentists, due to the nature of the external connection to the Electronic Records Management System.

The use of teleworking should be prohibited, unless a clear security policy is in place and the user agrees to abide by it. Even so, it should be strictly limited to authorized users, and restrictions may be imposed on the connection duration and window (e.g. time-of-day, day-of-week). In addition,

the use of teleworking must require minimum two-factor authentication and employ strong encryption.

M. Back-Up and Contingency Planning

All existing electronic patient records and critical data must be backed-up on a routine (i.e. daily) basis and stored in a physically secure environment off-site. Further, recovery procedures should be periodically tested to ensure that all patient records and critical data can be retrieved and reliably restored from the backup copy.

Appropriate measures should be taken to ensure the confidentiality, integrity and availability of all patient records and critical data during storage, such as by employing strong encryption.

Appropriate detection and prevention controls should be implemented to protect the Electronic Records Management System against malicious software (e.g. viruses, worms, etc.). In addition, it is important to regularly check for and install updates for operational systems and software programs that protect the Electronic Records Management System from known security risks.

In the event of a security incident, all staff should know the dental office's security management protocol to ensure that the necessary steps are taken to ensure a rapid, effective and orderly response to minimize any loss of confidentiality or data and system integrity.

The physical setup and environment of the Electronic Records Management System should be evaluated to protect it from environmental threats and hazards, such as fires and floods, as well as power failures or surges and other electromagnetic disruptions.

In the event of a disaster or catastrophic failure of the Electronic Records Management System, business continuity may be at significant risk. It is important to have a contingency plan in place to provide for business continuity, both from the perspective of the safe treatment of patients and the maintenance of required dental recordkeeping.

Copies of all Electronic Records Management System software programs should be kept to facilitate recovery and consideration should be given to equipping a standby system. In addition, traditional paper records and dental radiographs should be available, in case they are needed for a period of time until the Electronic Records Management System can be reliably restored.

N. Data Migration

As noted above, the Electronic Records Management System must be capable of periodic upgrades to reflect the changing requirements of the dental office. There will come a time, however, when a decision is made to switch to a new Electronic Records Management System, at which point the dentist must consider how to maintain the integrity of existing electronic patient records and critical data.

Options include migrating the patient records from the old Electronic Records Management System to the new Electronic Records Management System or archiving the patient records on the old Electronic Records Management System.

Regardless of how the switch to a new Electronic Records Management System is accomplished, the dentist must ensure that a secure means of access to all recorded information for each patient is maintained, and that the recorded information and related metadata is not compromised or otherwise changed in the process.

O. Retention and Disposal

The regulations governing the retention of patient records are the same, regardless of the form or medium in which they are kept. The dentist must take reasonable steps to ensure that patient records are accessible for continuity of care for patients. The dentist must determine appropriate retention periods for patient records, considering that patient records for adults must remain accessible for a minimum period of ten (10) years following the date of last service, and patient records for minors must be accessible for a minimum period of ten (10) years past the patient's age of majority. In the event of a patient becoming deceased the retention period is not changed. The age of majority in Alberta is eighteen (18) years of age.

Once the retention period has been satisfied, the records for a patient may be disposed of in a manner that maintains confidentiality. The disposal of patient records of any type or form including electronic must be authorized by the dentist (custodian).

Effective disposal of electronic patient records requires that they be permanently deleted or irreversibly erased, including any back-up or other copies (e.g. copies created by the Electronic Records Management System for system purposes). An audit trail should maintain a record of the name of the patient whose personal health information was disposed, the time period to which the information relates, and the person responsible for authorizing the disposal of the information.

In the event that electronic media (e.g. hard drives and other storage devices found in computers, servers, photocopiers, fax machines, scanners, printers, etc.) are to be disposed, dentists must ensure that all patient records are permanently deleted or irreversibly erased from them. Alternatively, the device may be physically destroyed. Dentists must not sell or give away electronic media devices that have stored patient records.

P. Security Policy for the Dental Office

The dentist must assume responsibility for setting and enforcing a security policy for the dental office, dealing with the roles and responsibilities of staff and third-party contractors who are authorized to access the Electronic Records Management System.

In order to ensure that the security policy for the dental office adequately addresses all necessary criteria, a logical and deliberate process should be followed. The first step is to conduct a comprehensive threat and risk assessment of the Electronic Records Management System, and create an inventory of all assets. This should be repeated on an annual basis. The next step is to develop and maintain a written security policy for the dental office. It should address the following:

- the responsibility of all staff for the security and privacy of the personal health information of patients;
- education and training of all staff in security and privacy policies and procedures;
- the security roles and responsibilities of all users by job definition;
- compliance with section 66 of the *Health Information Act*; and
- the access control policies for the dental office, including the precautions to be taken when:
  - working in the dental office on the local network;
  - producing copies of electronic patient records (e.g. all electronic copies must be authorized and appropriately secured by employing;
  - strong encryption, and all printed copies must be labelled to disclose the confidential nature of their content);
  - removing copies of electronic patient records, equipment or software from the dental office;
  - using portable storage and wireless devices; and
  - teleworking is permitted.

If services are provided by a third-party contractor, there must be a formal written agreement in place, which addresses the following:

- the responsibility for the security and privacy of the personal health information of patients;
- all repairs, changes and upgrades to the Electronic Records Management System
- must be authorized and documented;
- all planned new information systems, upgrades and new versions must meet acceptance criteria;
- functional and security tests of the Electronic Records Management System must be carried out prior to acceptance;
- compliance with section 66 of the *Health Information Act*; and
- all existing electronic patient records and critical data must be continually safeguarded during upgrades.

Q. Additional Issues

As the use of electronic records and digital technology in health care is increasing, issues are emerging that raise new medico-legal questions, which are still to be addressed.

For example, software programs and devices have been developed that allow a person to electronically sign a document, such as a medical history questionnaire. The term "electronic signature" refers to electronic information that a person creates or adopts in order to sign a document, and that is attached to or associated with the document. One method involves the use of a special pen with a computer screen or touchpad, which captures a digital image of a handwritten signature. Other methods involve the use of letters, numbers or symbols that are attached to or associated with the document.

In order to be accepted as valid, dentists must be able to demonstrate that the person's electronic signature was unique, and that it was properly associated with the document in question via auditable means.

Another example is cloud computing, which allows a user internet-based access to a shared pool of computing resources, which are rented from a third-party provider for a fee. In this model, the user does not own or manage the underlying physical infrastructure, and has varying degrees of control over the operating systems, software applications and storage of data.

Cloud computing raises significant security and privacy questions for dentists, who are responsible for the custody and control of personal health information. Dentists considering a cloud service provider should perform due diligence, assess the risks involved, minimize the amount of personal health information exposed and provide for appropriate remedies. A thorough review of the Alberta Dental Association and College Standard of Practice: Privacy and Management of Patient Health information needs to be undertaken as such technology application would require a Privacy Impact Assessment.

A further example relates to internet-based products for patients that allow them to create their own health records. Patients may collect health information about themselves, maintain it online and grant access to their healthcare providers. Dentists should be cautious about relying on information contained in a patient-created health record, and take appropriate steps to verify that it is accurate and complete.

Section Three: Related Issues and Questions

A. Ownership of Records

Under common law and in the absence of an agreement to the contrary, the dentist owner of a dental practice owns all patient charts. A dentist leaving or selling a practice should ideally give patients advance written notice about the change. If the outgoing dentist is unable to do so, it becomes the responsibility of the incoming dentist to notify patients that he or she is in possession of their records. The *Health Information Act* (Alberta) and the Alberta Dental Association and College *Standard of Practice: Privacy and Management of Patient Health Information* further defines the custodianship of patient records.

B. Retention of Records

Dentists must consider a variety of factors when determining the appropriate retention periods for patient records. Legislated requirements are only a minimum. There are many reasons where it is prudent to keep records for longer periods such as in the case of a lost or missing person, health research, litigation, or a member of a family of record who might return home for care from their dentist after a prolonged period of time.

There are a number of acts and regulations pertaining to the retention of patient records. The Health Information Act establishes defined retention periods of a minimum of 10 years for adults. The Alberta Limitations Act includes further requirements particularly in relation to minors.

The Alberta Dental Association and College Standard of Practice for Patient Records reflects the minimum legislated requirements.

> The dentist must take reasonable steps to ensure that patient records are accessible for continuity of care for patients. The dentist must determine appropriate retention periods for patient records, considering that patient records for adults must remain accessible for a minimum period of ten (10) years following the date of last service, and patient records for minors must be accessible for a minimum period of ten (10) years past the patient's age of majority. In the event of a patient becoming deceased the retention period is not changed.
>
> The age of majority in Alberta is eighteen (18) years of age.

Communication with patients, whether written or in electronic format regarding informed consent, treatment and outcomes is part of the permanent patient record. This does not include such items as the routine scheduling of appointments.

Diagnostic casts/models are also considered part of the permanent patient record and must be kept for the prescribed period. Other records that must be retained include lab prescriptions and invoices.

Working casts/models do not have to be retained for any specific period of time. A decision to keep working casts/models should be based on the complexity of the case and is left to the judgment of the individual dentist.

A dentist must keep a record of appointments showing for each day the names of patients who received professional services for a period of at least two (2) years.

Dental Claim forms (e.g. Dent 29) should be kept for 2 years. Other business records such as coordination of benefits, claims acknowledgement or payment notification can be discarded after their intended purpose is fulfilled.

When converting analog patient records to a digital format for inclusion in an electronic health record system or for retention/archival purpose, a written policy and protocol must exist that ensures that the integrity and authenticity is maintained. The digital copy needs to be verified to assure its original quality, content and function is intact to fulfil its ethical, legal and professional roles. The Alberta Dental Association and College has developed a "Guide for the Conversion of Analog Health Records to Digital" to assist members.

C. Release and Transfer of Records

Patients have the right by law to access a copy of their complete dental record and dentists are obligated by law to provide copies of what the patient has requested, including radiographs, diagnostic casts/models, photographs and other items. If the patient moves to a different dental practice, records should be transferred within one to two weeks to the new dentist. If the new dentist requests records electronically, they may be provided in that format. Sending electronic records with email or other digital communication means can only be done through a secure portal or service. The electronic records can be provided to the patient to take to the new dentist or sent through the mail.

In most cases, the originating dentist should maintain all original records on file. The dentist may charge reasonable fees for expenses associated with copying records, as long as the patient is advised of these charges in advance.

Fee disputes or other disagreements between the patient and dentist are not grounds to withhold access to, or transfer of, patient records.

D. Disposition of Records

At the end of the retention period, records must be disposed of in a manner that protects patient confidentiality and maintains physical security of the information. Once patient records have been converted to a digital format as referenced under **B. Retention of Records,** the analog originals may be disposed in most cases. The decision to dispose of patient records rest with the custodian as defined under the Health Information Act and the Alberta Dental Association and College Standard of Practice: Privacy and Management of Patient Health Information.

Methods include:

- confidential return to the individual or dealing with the records in accordance with the patient's instructions;
- controlled physical destruction such as shredding or incineration; and
- confidential transfer to another agency that will provide appropriate services to destroy the information.

The process used to destroy electronic records must render them unreadable and eliminate the possible reconstruction of the records in whole or in part.

E. Confidentiality

Patient information and dental records contain sensitive personal information and must be kept in confidence. A patient's personal information and dental records must be protected from any unauthorized use or disclosure, except as required by law or where the patient has given their express consent, ideally in writing. Information must only be disclosed as authorized by law or where the patient has given their express consent in writing.

Dentists are also responsible for ensuring that their staff is aware of the requirement of maintaining confidentiality with respect to patient information and dental records. Dentists and their staff must also be aware of the requirement under the Health Information Act as to whether disclosure can occur with or without patient consent.

The Health Information Act contains provisions that would authorize disclosure to a third party or family member without the consent of the individual in certain circumstances. For example under section 35 of the HIA authorize the disclosure of health information to third parties without consent including:

35(1)(b) to a person who is responsible for providing continuing treatment and care

35(1)(c) to family members of the individual or to another person with whom the individual is believed to have a close personal relationship, if the information is given in general terms and concerns the presence, location, condition, diagnosis, progress and prognosis of the individual on the day on which the information is disclosed and the disclosure is not contrary to the express request of the individual.

Confidentiality requirements apply to paper, electronic, and other forms of patient information and dental records.

Records should be stored securely, not left unattended or in public areas of the office, and destroyed appropriately and securely at the end of the required retention period.

Regardless of the type of records that are used, whether in written or electronic format, dentists have a duty to ensure that the personal health information of patients is protected at all times.

Electronic format records bring with them additional issues to ensure compliance which is discussed in greater detail in the Electronic Recordkeeping section.

F. Privacy Compliance

The requirements for how registered members of the Alberta Dental Association and College (dentists) collect, use, manage, disclose and protect health information are governed by applicable privacy legislation, including Alberta's *Health Information Act (HIA)*. The *Health Information Act* was amended to apply to dentists as of March 1, 2011. Currently, the amended *Health Information Act*, applies to all health information collected, used and disclosed by "custodians" in relation to the provision of a health service, regardless of the source of payment. "Health information" and "health services" have specific, defined meanings under the *Health Information Act*.

All regulated members of the Alberta Dental Association and College will be custodians for the purposes of the *Health Information Act* unless they are an affiliate of another custodian. Individuals who are affiliates of another custodian are deemed not to be a custodian while acting in the capacity of an affiliate. Dentists who are practice owners will typically be custodians. Dentists who are associates or employees of a custodian will typically be affiliates of the custodian, as will be other non-dentist employees or contractors of the custodian.

Dentists may also be employed by other organizations such as corporations and educational institutions that are not custodians under the *Health Information Act*. Although the employer is not a custodian under the *Health Information Act*, the regulated members (dentists) are custodians subject to the *Health Information Act* for the health information that they collect for the purpose of providing a health service.

Dentists must continue to be aware of and follow all relevant privacy legislation. Members will still be governed by a variety of privacy legislation that applies to the personal information that they collect, use and disclose. Where the *Health Information Act* does not apply, Alberta's *Personal Information Protection Act* (PIPA) or the federal *Personal Information Protection and Electronic Documents Act* (PIPEDA) may apply.

The ethical obligations of dentists with respect to maintaining privacy and confidentiality are embodied in the Alberta Dental Association and College Code of Ethics. Dentists need to refer to the Alberta Dental Association and College Standard of Practice: Privacy and Management of Patient Health Information with its associated guides to fully implement this legislated requirement.

G. Special Consideration When Dealing with Medical Examiner Office

As dentists and consumers of the media, we are all aware of human remains being identified by dental records. This process involves the comparison of post-mortem records, obtained by a qualified forensic dentist at the time of the post-mortem examination, to ante-mortem records of a person the investigating agency has reason to believe is the person in question.

At times, a body will have been found; while in other cases, the person is presumed dead and the Chief Medical Examiner wishes to commence an investigation.

The responsibility of the dentist to provide all original ante-mortem records to the Chief Medical Examiner is law in Alberta. Without the ante-mortem records, no comparison can be made and the body remains unidentified.

The role of the dentist is important in these cases, and it is the moral and legal responsibility of the community dentist to release the records to the Chief Medical Examiner. The *Fatality Inquires Act* and *Fatality Inquires Regulation* provide the appropriate context to deal with this issue notably under Section 21. These include but are not limited to the ability to inspect and extract information from any records or writings relating to the deceased or his or her circumstances and reproduce such copies there from as the Chief Medical Examiner believes necessary. In addition seize anything that the Chief Medical Examiner has reasonable grounds to believe is material to the purposes of the investigation.

This being said, it is unlikely that the Chief Medical Examiner or medical examiners will personally arrive at your office to request dental records. For this reason the *Fatality Inquiries Act* allows for the appointment of an Investigator to act on behalf of the office. In most cases this will be a police officer or qualified medical/dental practitioner to exercise all or any of the medical examiner's power. The *Fatality Inquires Regulations* under Section 7.1 identifies the dental profession as required to comply with any requests. Document who you are transferring the records to and provide all original records and radiographs pertaining to the subject in question. There should be no undue delay in doing this. The information you obtained from the medical examiner or their representative should be kept in the chart.

No doubt at this time, you are wondering what is happening to your records. They will be looked at by a forensic dentist, and used for the sole purpose of identifying or excluding the unknown body as the person whose records you provided.

At times, as part of the medical examiner's investigation, the forensic dentist may make and retain copies of some or all the material. This material will be kept secure and confidential and all the original material will be returned to you. Forensic dentists in this province have undertaken the human remains identification for many years, and with the co-operation of the community dentist, have undertaken hundreds of identifications. Even in this age of DNA analysis, dental identification has the advantages of being faster and cheaper.

H. Patient Records and Data In Motion

The use of **e-mail** in our society is commonplace. It is a convenient, inexpensive and quick means of communication. However, as a general rule, e-mail is not a secure means of communication, and may be vulnerable to interception and hacking by unauthorized third parties. Accordingly, dentists should avoid using e-mail to communicate the personal health information of patients, unless they are employing a secure e-mail service with strong encryption.

The Office of the Information and Privacy Commissioner of Alberta released two documents in August of 2012 in regards to email and other forms of electronic communication including text. Dentists should review directives to ensure they are compliant with the direction.

The first directive is *Health Information Act* Practice Note #5 in which a section denoted as ENCRYPT says the following:

"if you need to send or receive detailed diagnostic, treatment and care information, encryption is the best technical safeguard"

The second document is titled Email Communication FAQs says the following:

"Custodians can add email to their existing EMRs after completing the privacy impact assessment required by section 64 of the HIA.":

There are products and services that are available to permit dentists to communicate with each other via secure e-mail. The Canadian Dental Association through Continovation Services Inc. which provides services such as CDAnet and ITRANS also provides a secure record sharing service via its "eReferral Service" is operational and by calling 1-866-788-1212 or visit www.ereferralservice.com to enroll.

Appendix 1- Quick Points and Checklist for Patient Records and Informed Consent

Introduction

This document is provided as a member service to assist Alberta dentists with the review of practice protocols to meet the Standards of Practice in relation to *Patient Records* and *Informed Consent*. Standards of Practice are requirements that professional bodies must have in place for their members as conditions of the *Health Profession Act*. *These standards have roles and application under the Health Information Act for dentists as custodian's of patient health information*. Dentists have different practice profiles and some dentists may provide services that will require additional documentation and records. For this reason, dentists need to regularly review all the Standards of Practice and Guides that are found on the members' website. Regardless of whether patient records are maintained in analog or electronic format, the same standards apply. Patient records play an integral role in the delivery of health care to ensure it is effective, comprehensive and continuity is maintained. The *"Quick Points and Check List"* is not intended to be definitive or include all the circumstances that a dentist will encounter in ensuring they meet the expected standards of practice for Alberta Dentists.

Patient Information

Privacy legislation in Alberta stipulates that dentist can collect, use and disclose only the amount of personal and health information that is essential for the intended purpose and with the highest degree of anonymity. Regularly updating of the information should be a routine part of practice protocols. Formal consents authorizing communication with third party carriers or practice contacts (e.g. practice newsletter, email) are often included as part of this initial information gathering.

Patient Information Checklist	
Patients name	☐
Contact Information	☐
Date of Birth	☐
Gender	☐
Primary Care Physician	☐
Emergency contact name and number	☐
Insurance Information or Alberta Personal Health Care Number (PHN) if applicable	☐
Date obtained/updated/reviewed	☐

Medical History

The Standards of Practice and associated guides for *Patient Records and Infection Prevention and Control provide* details on the pertinent medical information that all dentists need to obtain from their patients before providing care. In addition dentists providing services that are covered by other standards (e.g. Standard for the Use of Sedation in Non-Hospital Dental Practice) need to be reviewed to ensure that the medical history requirements that are specific for such treatment are obtained. It is essential for dentists to develop medical history forms and protocols that are consistent with the standards and their practice profile. Review of the medical history is required at each appointment.

Medical History Checklist	
Initial Exam	
Complete medical history	☐
Signed by patient/caregiver/guardian	☐
Reviewed and signed by dentist	☐
Medical history updated	
Reviewed/initialled each appointment by:	
Staff	☐
Dentist	☐
Drug allergies, medical alerts or conditions pertinent to patient care conspicuously noted on chart	☐

Dental history

The past dental history is obtained from the patient at the first visit to a dental office. The information may be subjective but serves as a baseline to supplement the clinical findings. The dental history questions can be extensive depending on the care being sought. Questions tailored to the age of the patient are often necessary (e.g. bottle feeding). For patients of record the need to update is based on ongoing care. Patients that are seeing multiple practitioners for comprehensive care will require notes regarding such care to be recorded. Patients that are seen on emergency basis only or irregularly will require this information to be updated at each appointment. The following are some key points that should be part of information gathering.

Dental History Checklist	
Reason for appointment or chief complaint	☐
Frequency of visits to dental office	☐
Date of Last dental appointment and reason	☐
Oral hygiene home care	☐
Periodontal disease	☐
Caries experience	☐
Significant past dental history recorded (e.g. orthodontics, trauma, surgery, myo-facial pain and dysfunction, dental prosthetics)	☐
Diet	☐

Dental Examination

Documentation of the clinical findings of a dental examination must contain detail that would allow another dentist to come to a similar diagnosis. It must include descriptions of the conditions that are present on examination of the patient regardless of whether they are normal or abnormal. Except for emergency or single appointment situations, the overall condition of the teeth and supporting structures should be reviewed and documented regularly.

Dental Examination Checklist	
Extra-oral evaluation broken down by system/area	☐
Soft Tissue evaluation broken down by system/area	☐
Dentition evaluation broken down by area/disease	☐
Periodontal evaluation with PSR	☐
Periodontal evaluation with complete probing	☐
Arch Relationship and Growth/Development	☐
Odontogram documenting existing restorations, caries or breakdown of dentition, periodontal status, missing teeth and other findings	☐
Evaluation including caries and periodontal risk	☐

Radiographs, Dental Models and Diagnostic Tests

Radiographs, dental models and diagnostic tests are important tools to aid in diagnosis. There use is based on the individual presenting circumstances, not routine protocols. In the case of radiography, all exposures must be documented even if they are not of diagnostic quality. The

Guide for the *Radiation Health and Safety Program* outlines the standards expected of Alberta dentists. Interpretations and recording of findings needs to be included in the clinical records for radiographs, dental models and diagnostic tests.

Radiographs and Dental Records Checklist	
Type and number of radiographic exposures	☐
Interpretation	☐
Dental models/casts	☐
Interpretation	☐
Diagnostic test	☐
Results	☐
Interpretation	☐

Diagnosis and Treatment Planning

The diagnosis must be supported by the documented clinical findings. The nature of the diagnosis, whether it is tentative, differential or established must be recorded. Treatment planning is based on the medical and dental history, clinical examination and diagnosis. Treatment plans need to be supported by a complete and accurate clinical record and take into account the relative urgency and severity of the patient's condition. Patients must be presented with treatment options including no treatment as part of the informed consent process.

Diagnosis and Treatment Planning Checklist	
Diagnosis:	
Tentative	☐
Differential	☐
Established	☐
Treatment plans documented	☐

Informed Consent

Informed consent is not a one-time event. Consent needs to be reaffirmed at each appointment and documented. Consent can be withdrawn at any time or point during treatment. Consent can be implied or expressed. Implied consent is limited to situations that pose no or limited risk to a patient such as a dental exam. Express consent is required when treatment poses a potential risk, even if the likelihood for complications is low. Express consent can be either oral or written. Oral consent should be confirmed in writing where risks are significant. Regardless of how consent is

obtained, the clinical record must include documentation of the consent process. Informed consent is not having the patient sign a blanket consent that is used in futurity. CDSPI as the malpractice carrier for Alberta dentists has developed a document outlining the legal issues associated with informed consent including a sample consent form that is appended with this guide. The Alberta Dental Association and College Standard of Practice: Informed Consent sets out the overall requirements. The following is a checklist of what a dentist must discuss with their patients.

Informed Consent Checklist	
The diagnosis and supporting clinical findings	☐
The exact nature, anticipated benefits and cost of the proposed examination or treatment	☐
The reasonable and accepted alternative examinations or treatments that are generally available, including no treatment and their estimated cost	☐
The consequences of not undertaking the examination or treatment	☐
The common and significant risks of the examination or treatment	☐
The serious risks, even if unlikely	☐
The future costs of care and life expectancy of treatment	☐
The special risks, that although uncommon, may have particular relevance to the patient	☐
Responding to any questions the patient may have about their medical history and dental treatment	☐

Documentation requirements supporting the above include the following:

Informed Consent Documentation Requirements Checklist	
The consent was obtained verbally and the key points noted in the chart	☐
Initialed by patient	☐
Initialed by dentist	☐
The consent was obtained in writing and the signed forms maintained in the patient record	☐
Copies or notes of all materials provided to the patient as part of the informed consent process maintained in the patient record	☐
For ongoing treatment, consent was affirmed at each appointment and documented	☐
Change of the treatment plan results in a new informed consent process	☐

Treatment Records

The progress notes for each visit should provide a concise and complete description of all services rendered (including any consultation provided by telephone). Dentists may rely on office staff to document their chart entries, but the dentist is expected to sign or initial each entry after reviewing it for accuracy and completeness to ensure that it captures the necessary information. Entries made by dictation must be initialled by both the dentist and the writer. The dentist is responsible for the accuracy of all chart entries. Digital templates require customization based on the presenting clinical circumstances. In addition, dentists providing services that are covered by other standards (e.g. *Standard for the Use of Sedation in Non-Hospital Dental Practice*) need review to ensure that the appropriate treatment records are maintained. The following is a checklist for the information that is expected:

Treatment Records Checklist	
Date of treatment	☐
Informed consent reaffirmed	☐
Treating clinician's identity	☐
Area or tooth number being treated and the identity of the writer	☐
Diagnostic tests and their results	☐
Type and quantity of local anaesthetic used	☐
Materials used	☐
Description of technique	☐
Other drugs that are prescribed, dispensed or administered and the quantity and dose of each	☐
All recommendations, instructions, explanations and advice given to the patient and any discussion with the patient regarding possible complications, success, outcomes, prognoses and follow-up requirements	☐
Signature or initials of dentist	☐

Drug Records

Dentists must maintain a record of both prescription or over the counter (OTC) medications dispensed or administered in house, given as professional samples, recommended or prescribed to a patient. It is best practice to maintain a copy of the prescription. The following information needs to be in the patient record:

Drug Records Checklist	
Date of the prescription	☐
Name, strength, quantity and form of drug	☐
Dose of the medication	☐
Administration route and frequency of administration	☐
Duration of the period for which the patient is to take the medication	☐
Whether or not refills have been issued	☐
Condition being treated and/or dental treatment provided	☐

Financial Records

Financial records are classified as health information. As such they form part of the patient record. The Uniform System of Coding & List of Services (USC&LS) procedure code applied must be supported by the treatment provided. The financial record at a minimum includes:

Financial Records Checklist	
Copy of any written agreement with a patient	☐
Date and amount of all fees charged	☐
Date and amount of all payments made	☐
Itemized listing of all commercial laboratory fees that were incurred in respect to prosthetic, restorative or orthodontic services	☐
Copies of all dental claim forms	☐

Business Records

Dentists must also keep business records for the practice, including fees charged and received, scheduling (including day sheets), laboratory services and clinical equipment maintenance. The process of facilitating payment of dental services made on behalf of a patient by a third party involves disclosure of health information. This is specifically authorized without consent under the Health Information Act Section 36(b). However, the signature of the patient or guardian should be obtained and maintained on file, as it may be a condition required by an insuring company plan administrator. The information contained in claims submitted or preauthorization's, either manually or electronically needs to be kept on file.

Communication between a dental office and patients is an important part of managing a dental practice. The move to electronic communication has brought with it legislations to protect ones privacy. It is important that dentists discuss with their patients the preferred route of communication and obtain the appropriate consents where necessary. The Alberta Dental Association and College has developed the *Guide for Canada's Anti-Spam Legislation* to assist members.

Business Records Checklist	
Signature of patient or guardian on file	☐
Consent to receive correspondence via electronic communication on file – this is for items covered by Canada's Anti-Spam Legislation only such as News Letters. (This is not for sending identifiable health information, as this must be done through a secure portal or service.)	☐

Appendix 2 – CDSPI Consent to Treatment and Sample Form

In order for a valid consent to treatment to be given, several requirements must be met, both as to the ability of the patient to consent and the nature of the information provided. In some provinces and territories, these requirements have been codified in legislation.[1] However, the law applicable to informed consent is governed by the same general principles in all Canadian jurisdictions.

Ability of Patient to Consent

Legal Capacity

The patient must have the capacity to consent to treatment. Most dental patients will have this capacity. The exceptions are:

- people who have been declared mentally incapable, in which case their guardian, or substitute decision maker, must provide the consent; and
- minors who are incapable of providing consent due to their age, in which case their parent or guardian must provide the consent.

Whether or not there is a specific age of consent for medical treatment, and if so, what the age is, varies from province to province. In New Brunswick, a person over the age of 16 is presumptively capable of giving or refusing consent to medical treatment on his or her own behalf. A person younger than 16 may consent if the attending physician or dentist believes he/she is capable of understanding the nature and consequences of treatment, and if the treatment and the procedure to be used are in the minor's best interests for continued health and well-being. In Quebec, a person over the age of 14 is presumptively capable of giving or refusing consent to medical treatment on his or her own behalf, if the treatment is not one that is required by the patient's state of health; however, if the treatment entails a serious risk for his/her health or it may cause grave or permanent effects, consent from the minor's parent or guardian is required.

In most other provinces the common law applies. This means that a minor can give or refuse consent on his or her own behalf if he/she is capable of understanding the information about a treatment and appreciating the risks and likely consequences of proceeding with or without the treatment. If you are not sure what the age of consent is in your jurisdiction, you should contact your licensing body.

Mental Capacity

The patient must have the mental capacity to provide consent. This means that he/she must have the ability to understand the information about the treatment and understand the likely consequences of having treatment or not having treatment. If a patient does not understand English, an interpreter should be used. In Ontario, the *Health Care Consent Act, 1996* provides that a person is presumed to be capable with respect to treatment decisions unless there are reasonable grounds to believe otherwise.
If a patient lacks either the required legal or mental capacity, a substitute decision-maker legally authorized to provide consent on behalf of the patient may consent on his/her behalf.

Voluntary

The consent to treatment must be given voluntarily by a capable individual and cannot be coerced or obtained through fraud or misrepresentation.

Consent to Treatment

Information Provided

The patient must give an informed consent to the treatment. This means that you must provide them with the information about:

- the treatment and its benefits
- the material risks and side effects of the treatment
- reasonable alternatives to the treatment (if any) that are available, and
- the consequences of not having the treatment that any reasonable person in the same circumstances would want to be aware of prior to treatment.

In Hopp v. Lepp (1980), which remains a leading Supreme Court of Canada case on informed consent, the Court held that the patient should be advised of all probable risks that might cause serious injury or death and also advised of material risks, which are defined as those risks associated with treatment that a reasonable person would attach significance to in deciding whether or not to undergo the proposed therapy. A third category of risks, special or unusual risks, which may go beyond those that are probable and could relate to serious consequences, should also be disclosed, even if they are less likely to occur. The Court added, however, that the scope of the duty of disclosure depends on the circumstances of each particular case. Remote risks do not have to be disclosed to a patient, unless the patient specifically asks about such risks.

In determining whether the patient has been provided with appropriate information, Courts will consider what the general practice is among other dentists.

In Carter v. Higashi (1993), the patient suffered a fractured jaw while having her wisdom teeth extracted. She had not been warned prior to the surgery of the risk of a fractured jaw. Experts at trial testified that the risk of jaw fracture during wisdom tooth extraction was remote and therefore, most dentists do not warn patients of this risk. The Court agreed that it was the standard practice among dentists at the material place and time (Calgary in 1990), not to warn of the remote possibility of jaw fracture and accordingly, found that the dentist had not been negligent in failing to warn the patient of this.

Similarly, in Schinz v. Dickinson (1984), the patient sustained paraesthesia and permanent damage to her lingual nerve likely caused by the needle used to administer a local anesthetic, as part of an operation to extract the patient's third right molar. The Court held that she had not been warned of any possible risk of damage resulting from the operation. The Court ruled that it "was not the practice of the dental community to warn patients of the risk of possible nerve damage resulting from local anesthesia injections because such damage rarely occurs". Accordingly, the Court held that no warning was required by the dentist. In its decision, the Court noted that no special or unusual circumstances existed, such as an impingement of the roots on the alveolar canal or the mandibular canal. If special circumstances do exist making certain risks more likely with respect to a specific patient, the dentist may have a duty to warn of those risks, even if he or she does not ordinarily do so.

In DeFerrari v. Neville (1998), an Ontario case involving lingual nerve paraesthesia

which persisted after a mandibular nerve block, the patient claimed that had she known of the risk of permanent numbness, she would not have consented to the treatment (and the injection). The Court relied on expert testimony in finding that the risk of paraesthesia after an injection is a remote risk which most dentists do not warn their patients about and therefore, no duty to disclose such a risk was required.

Despite the Court's decision in DeFerrari v. Neville, there is a body of scientific knowledge suggesting that some local anesthetics may be more likely than others to be associated with paraesthesia, especially lingual paraesthesia. While this is not intended to suggest that dentists should or should not warn patients of the risk of paraesthesia when they use these local anesthetics, they should be up-to-date on the scientific studies for all the materials they use in their practice, in order to be in a position to disclose such material risks, if disclosure is warranted in the circumstances.

The failure to disclose required information is not necessarily determinative of the dentist having failed to meet the required standard of care. Even if a Court were to find that a dentist failed to disclose a probable, material, special or unusual risk, the dentist would not be found negligent in failing to advise the patient of the risk if the Court were to find that the average person in the patient's position would have consented to treatment even if they had been aware of the risk.

In order to determine if a failure to disclose a risk "caused" a patient's injury, the Courts evaluate what a reasonable person in the patient's circumstances would have decided about treatment if they had they received adequate information. The test used is whether a reasonable person in the patient's position would have refused the treatment if the risks had been disclosed to them.

In applying this legal test, one factor considered is how necessary the treatment was. A patient whose life is at stake or is in intense pain is more likely to accept a small risk of serious harm than a patient undergoing a treatment which is elective. It is therefore particularly important to provide full information about possible negative consequences to patients who are consenting to elective treatment.

In <u>Rawlings v. Lindsay (1982)</u>, a dental malpractice case against a British Columbia oral surgeon for his alleged failure to disclose the risk of possible nerve damage in the lower lip and chin during the extraction of a lower impacted wisdom tooth, the patient was warned of pain, swelling and soreness, but not about any possible long-term numbness. After hearing the evidence, the Court held that the oral surgeon's warning was insufficient on the basis that he himself acknowledged that the roots were in close proximity to the inferior alveolar nerve, but decided not to warn the patient about the risk of permanent paraesthesia. The case, however, turned on the patient's particular circumstances, in that she was not suffering any discomfort from her wisdom teeth prior to surgery, and they were not acutely infected. The Court held that a reasonable person in the patient's position, when faced with "optional" surgery and confronted with a choice between, on the one hand, surgery which may not have improved her condition, but which carried a chance of nerve damage and not having the surgery, even though there was the possibility that her wisdom teeth might cause her problems in the future, would most likely have elected to not have the surgery. Therefore, in the case, the failure

to disclose the risk was seen as "causing" the injury.

<u>Dickie v. Minett (2012)</u> is a dental malpractice case against an Ontario dentist alleging the dentist's failure to disclose the risk of a jaw fracture during the extraction of three wisdom teeth. Similar to the Court in Carter v. Higashi (discussed above), the Court concluded that the risk of jaw fracture was not one that dentists routinely discussed with patients in advance of this type of procedure, as the risk is quite remote. Furthermore, the Court determined that, given the health risks that would exist if the impacted wisdom teeth were not extracted, a reasonable person in this patient's situation would have consented to the procedure, even if all risks, including that of a fractured jaw, had been thoroughly disclosed.

You should also advise the patient of any risks arising to the patient following the completion of the procedure. If the treatment will affect the patient's ability to drive or to function safely, your responsibility extends to ensuring that the patient will have the assistance he/she needs after leaving your premises. You should ensure that any patient undergoing any such procedure whose ability to drive is affected is either accompanied by someone who can drive him/her home or is escorted to a taxi by your staff. You should also advise any such patient against driving for an appropriate period of time.

You must also answer any questions about the treatment the patient may have and provide the patient with any further information he/she may request.

Consent to Treatment Performed

The treatment performed must be the treatment to which the patient has consented.

You can obtain consent for a "treatment plan". However, any treatment you perform must be covered by this treatment plan. You should therefore ensure that the treatment plan is broad enough to cover all of the specific treatments you provide. If any individual treatment is not clearly a part of the treatment plan, you should obtain a further consent for that treatment.

Quick v. Reitzik (2007) is a B.C. decision that is helpful in outlining the level of specificity that needs to be provided to a patient, to allow them to give true informed consent. The patient in this case saw a maxillofacial surgeon to have her lower right second premolar tooth ("Tooth 4.5") extracted. Upon examination, the surgeon told the patient that she actually needed two "roots" extracted, not one. The patient interpreted this to mean that Tooth 4.5 had two roots, not one. In fact, the surgeon meant to indicate that he needed to extract not only Tooth 4.5 but also the one beside it, Tooth 4.4. The Court held that the surgeon had not obtained proper informed consent for this procedure, as he had used vague and imprecise language that left an unacceptable degree of ambiguity for the patient. The Court found that a reasonable person, in the shoes of the patient, would have wanted to discuss the procedure more fully, including the nature and scope of the steps the surgeon was about to undertake.

Withdrawal of Consent

There may be occasions during dental treatment where a patient initially consents to treatment, but later changes their mind. What should a dentist do if part way through a procedure a patient tells them to stop?

In <u>Ciarlariello v. Schacter</u>, a Supreme Court of Canada decision, while having a cerebral angiogram performed which the patient consented to, the patient

experienced discomfort, hyperventilated and told the doctor to stop the test. The patient then calmed down and five minutes later, told the doctor to proceed and complete the test. The doctor then administered another injection of dye, following which the patient suffered an immediate reaction to the dye and was rendered a quadriplegic. In the case, the Court held that an individual has the right to stop a procedure, even while it is underway. If consent is effectively withdrawn during the course of the treatment, the treatment must be terminated, except in those circumstances where to terminate the process would be either life-threatening or pose immediate and serious problems to the health of the patient.

Once a patient withdraws consent for a procedure, the issue then becomes what is required for valid consent for the continuation of the procedure. The Court in Ciarlariello v. Schacter held that in order to proceed with a procedure after consent has been initially withdrawn, before re-starting the procedure, a patient should be told whether there are any significant changes in the risks involved and/or if there has been a material change in circumstances which could alter the patient's assessment of the costs / benefits of continuing with the procedure. Once this has been accomplished, the treatment can be restarted.

Persons Providing Treatment

You should ensure that the consent obtained is broad enough to include any person who may be assisting or replacing you in the procedure.

Who Should Obtain Consent

You should obtain the consent from your patients and should not delegate this task to your assistants. Your staff should be instructed that if the patient asks any questions when you are not present that cause them to question whether the patient fully understands the procedure, you should be advised immediately. You should then have a further discussion with the patient before any treatment is commenced. Similarly, your staff should be instructed to advise you immediately if a patient indicates to them that they want to amend their consent in any way or if they ask any further questions about the procedure. While the dentist is ultimately responsible for ensuring that informed consent is obtained prior to treatment, their staff is considered part of the "health care team" and their actions are considered as part of the overall informed consent process.

In <u>Keane v. Craig (2000)</u>, the patient had a Bartholin's cyst and gland removed from her vulva by a surgeon. She then underwent a further surgical procedure which was intended to be a reconstruction of the vagina. Before that surgery, a nurse gave the patient a consent form on which the procedure was described as a "vaginal reconstruction". The patient added the words "reattach labia" to the form. The nurse did not advise the doctor of the patient's amendment and the doctor cut off the patient's right labium. The Court found that the nurse had a duty of care to advise the doctor of the amended consent form and that her actions constituted negligence. The Court found that "the addition to the consent form should have raised a red flag" that the nurse should have immediately acted upon.

Emergency Treatment

The requirements for informed consent outlined above do not necessarily apply in an emergency situation where the patient is unable to give consent. This could be due to a language barrier or a disability which prevents communication from taking place. However, in such circumstances, steps should be taken to try and find a practical way of communicating, provided that any delay does not prolong the suffering that the person is apparently experiencing, nor put the person at risk of sustaining serious bodily harm. However, if and when a dentist proceeds to provide treatment without a patient's consent in an emergency situation, the dentist should only do so if they have no reason to believe that the person does not want the treatment.

Form of Consent

Consent may be written or oral, as the law does not specifically state how consent should be obtained. Further, the form of the consent does not determine whether the consent is valid; the issue is whether the legal tests set out above have been met. While an executed written consent form provides evidence that the necessary information was given and the patient consented, it is not, in and of itself, determinative of informed consent. An executed consent form will not prove that informed consent was obtained if, in fact, the person consenting was not given the required information with respect to the treatment.

Written Consent

Where the appropriate information has been given by the dentist proposing the treatment, an executed written consent form will provide supporting evidence of a patient's consent. A sample consent form is set out at the end of this article. When using this or any consent form, you should also make detailed notes in the patient's chart, of the fulsome consent to treatment discussion you had with the patient. This will aid in establishing that the criteria for a valid consent have been met, if questioned in future. You should ensure that your records describe the information that was provided to the patient and any questions or concerns the patient raised. Accompanying the sample form is a list of issues you should review and discuss with the patient.

In Dickson v. Pinder (2010), an Alberta case involving chiropractor negligence, the Court noted that "informed consent is a process, not a form", and that medical practitioners should not rely only on a signed informed consent form. The medical practitioner should take reasonable steps to ensure that the patient understands and appreciates the nature of the procedure, as well as the contents of the form that the patient has signed. Furthermore, just because a patient has not asked questions about the contents of the form, this does not necessarily mean the medical practitioner can assume that the patient understands the various risks. This will be especially true in the case of an unsophisticated patient.

Notes in the patient's chart detailing the contents and context of an informed consent discussion can be helpful in providing evidence of informed consent; conversely, a paucity of notes can severely weaken a medical practitioner's defence and can result in the drawing of an adverse inference from the lack of such notes. Under such circumstances, a medical practitioner could be hampered in re-constructing events and he/she runs the risk of being met with a different account of what happened. In essence, their

credibility can be called into question and the evidence of the patient preferred.

Despite the above, even if a medical practitioner has incomplete or inaccurate notes, this will not automatically result in a finding of negligence if the notes, or lack of them, were not a cause of the patient's injuries. A lack of appropriate charting alone will not necessarily result in an inference, in a civil malpractice claim, that the doctor failed in other duties to his patient. This distinguishes between a civil lawsuit and a regulatory College complaint or investigation where a lack of appropriate charting on its own may be sufficient to warrant a finding of professional misconduct.

Oral Consent

In most cases of routine dental care, a written consent form may not be obtained. You should ensure that the patient has verbally given an informed consent to the treatment to be provided and that you have kept a detailed written record of your discussion with the patient and his/her verbal consent. In some cases, the patient's consent will not be specifically stated but will be implied from the patient's actions. For example, a patient who sits in your chair and opens his/her mouth is implicitly consenting to an examination. The difficulty with implied consent is that it can be difficult to prove exactly what was and was not agreed to. For example, did your patient consent to you cleaning their teeth as well as examining them or did the implied consent only include the examination? For anything more than very routine procedures, specific consent (oral or written) to the procedure or treatment you are recommending should be obtained and recorded in the chart.

An important aspect of obtaining informed consent is not how you convey the information to the patient, but that you can establish by your documentation that you covered all of the required elements of consent.

Consent to Treatment Form

A sample consent to treatment form developed by CDSPI is set out below. As part of CDSPI's loss prevention program, this form has been prepared by its counsel with input from a number of provincial dental associations.

The purpose of the form is to provide you with evidence of what information you have given your patient with respect to the proposed treatment. This evidence may be valuable if the patient subsequently alleges that you did not provide him/her with sufficient information on which to base a decision as to whether or not to undergo the treatment.

In order for a consent to treatment form to be valid, you must provide the patient with necessary information, as described in the form. As discussed above, a consent form will not necessarily prove that informed consent was obtained if the patient is subsequently able to convince a Court that the nature and/or potential risks of the procedure were not adequately described to him/her in advance of treatment. The form should be used in conjunction with the notes you normally record in the patient's chart or records. If you use a written consent form, your chart notes should describe the circumstances under which the signed written consent form was obtained from the patient.

The sample Consent to Treatment Form set out below provides a checklist for the information which should be included in your records as evidence that the patient was fully informed before he/she signed the

form. **You should ensure that you maintain records which set out the advice you have given to the patient.**

When a consent form is used, it should be signed by:

- the patient
- if the patient is a minor and incapable of consenting to treatment or the law requires parental/guardian consent (see p.1 above), the patient's parent or legal guardian, or
- if the patient is mentally incapable of consenting to the treatment proposed, the patient's legal guardian or substitute decision-maker.

In paragraph 1, you should insert a basic description of the proposed treatment or procedure, details of any anesthetic to be used and your name and the name of anyone who may assist you or replace you in performing the treatment or procedure.

Paragraph 5 is intended for use if you treat patients who live outside Canada, either on a continuing or an emergency basis. You should consider consulting your legal counsel to ensure that the form includes everything necessary in your jurisdiction for your type of practice. You may wish to customize the sample form to reflect your practice and various procedures you perform.

The form should be signed by the patient, parent or guardian, and/or substitute decision-maker (as required), witnessed by someone other than you and kept with the patient's records for future reference.

CDSPI SAMPLE CONSENT TO TREATMENT FORM

Name of Patient_____

Date _____Expected Duration of Treatment_____

1. I authorize Dr._____, or whomever he/she may designate

to perform on_____
(Name of patient - or myself)

the following procedure(s) and treatment:

1.

2.

3.

4.

5.

_____
(State nature of procedure(s) and treatment and, if anesthetic is to administered, the type of anesthetic to be used)

If during the course of such treatment as described above, in Dr._____
_____'s opinion and judgment or whomever he/she may designate, any treatment or procedure different from that now contemplated should be indicated for which there is no reasonable opportunity for additional explanation and authorization, I further request and authorize Dr. _____, or whomever he/she may designate, to do whatever they consider advisable.

2. The nature and purposes of the treatment, possible alternative methods of treatment, the risks involved and the possible complications have been fully explained to me by

_____
(Name(s) of dentist(s) explaining)

including the following information on alternative methods of treatment, including no treatment, risks and possible complications (insert information below):

_____

_____

CDSPI SAMPLE CONSENT TO TREATMENT FORM

3. I acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained. The average life expectancy of the treatment(s) described in paragraph 1 has been provided.

4. I consent to the administration of the anesthetics named above (if any) or any such other anesthetics as may be considered necessary or advisable by the dentist(s) referred to in this consent.

5. I understand that this Consent to Treatment form and the treatment provided as described in paragraph 1 above will be governed by the laws of the Province of_____ and I consent to the Courts of the Province of _____ having exclusive jurisdiction to entertain any action, suit or proceeding in respect of, or in any way relating to, such treatment, whether based on alleged breach of contract or alleged negligence in providing such treatment or on any other grounds whatsoever, and whether against the dentist(s) named in paragraph 1 or against any of his/her partners, associates, employees or staff.

I undertake and agree to not commence any action relating to such treatment, whether based on alleged breach of contract or alleged negligence in providing such treatment, or on any other grounds whatsoever, in any other legal jurisdiction outside of the Province of whether or not I may have a right to do so.

I acknowledge and understand that Dr._____ has agreed to provide professional services for me conditional on this undertaking being given and honoured by me with regard to my declaring that the Province of_____ has exclusive jurisdiction over any action, suit or proceeding and Dr._____ has made it clear that without my making this undertaking, he would not have agreed to provide treatment for me.

6. I confirm that I have discussed the estimated cost, future costs and method and terms of payment for the treatment described in paragraph 1 with Dr._____ and that I have agreed to make such payment on the terms we discussed.

BY INITIALING HERE "_____", I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO TREATMENT AND THAT THE EXPLANATIONS REFERRED TO WERE IN FACT MADE TO ME AND THAT THE FORM WAS FILLED IN PRIOR TO TREATMENT. I ALSO CERTIFY THAT I WAS GIVEN AN OPPORTUNITY TO ASK QUESTIONS AND ALL OF MY QUESTIONS HAVE BEEN SATISFACTORILY ANSWERED.

BY SIGNING BELOW, I ACKNOWLEDGE MY UNDERSTANDING OF THE INFORMATION ABOVE AND THAT I AGREE TO PROCEED WITH TREATMENT AS PROPOSED.

Signature of Patient_____

or

Signature of Parent of Guardian_____
(or other person authorized to consent for patient)

Relationship of Person Signing to Patient_____

CDSPI SAMPLE CONSENT TO TREATMENT FORM

Note: When a patient is a minor and/or is otherwise incapable of consenting to the treatment, the consent of a parent, guardian or substitute decision-maker must be obtained.

Date:_____

Witness: In my opinion, the patient/parent/guardian appears able to understand the treatment proposed and the information provided concerning the treatment.

Signature of Witness_____

Date:_____

Appendix 3 - Reference Documents*

- STAYING SAFE Tips From Your College, Royal College of Dental Surgeons of Ontario
- GUIDELINES Electronic Records Management, Royal College of Dental Surgeons of Ontario, March 2012
- GUIDELINES Dental Recordkeeping, Royal College of Dental Surgeons of Ontario, February 2008
- Dental Recordkeeping Guidelines, College of Dental Surgeons of British Columbia, Spring 2010
- Age Relevant Dentistry, Records, Legal Issues, Informed Consent, Insurance, Fred Quarnstrom, DDS, May 2012
- Alberta Electronic Health Record Regulation Section 5 Framework, College of Physicians and Surgeons of Alberta, September 2011 Version 1.1
- Alberta Legislation, The Health Information Act – Netcare and the Alberta Electronic Health Record, Pages 2-7, April 2012, Alberta Dental Association and College Updater
- Alberta Dental Association and College MEDICAL HISTORY RECORDKEEPING, Compliments of: Royal College of Dental Surgeons of Ontario, Revised November 2007
- Province of Alberta, HEALTH PROFESSIONS ACT, Revised Statutes of Albert 2000,
- Chapter H-7, Current as of July 2, 2012
- Province of Alberta, HEALTH PROFESSION REGULATION, Alberta Regulation 254/2001
- Alberta Dental Association and College, BY-LAWS, October 2010
- Alberta Dental Association and College, CODE of ETHICS, October 10, 2007
- Province of Alberta, HEALTH INFORMATION ACT, Guidelines and Practice Manual, March 2011
- Province of Alberta, HEALTH INFORMATION ACT, Revised Statutes of Alberta 2000 Chapter H-5, Amendments in force as of May 16, 2003
- Province of Alberta, HEALTH INFORMATION AMENDMENT ACT, 2006
- Province of Alberta, PERSONAL PROTECTION INFORMATION ACT, Statutes of Alberta, 2003, Current as of July 1, 2012
- Province of Alberta, PERSONAL INFORMATION PROTECTION ACT REGULATIONS, Alberta Regulation 366/2003, Amendments up to 51/2010
- Alberta Dental Association and College, PRIVACY GUIDE FOR ALBERTA DENTISTS, 2003
- Government of Canada, PERSONAL INFORMATION PROTECTION and ELECTRONIC DOCUMENT ACT, S.C 2000, C.5, Current to September 4, 2012
- Alberta Dental Association and College, Guide for the RADIATION, HEALTH AND SAFETY PROGRAM
- Alberta Dental Association and College, STANDARDS FOR THE USE OF SEDATION IN NON-HOSPITAL DENTAL PRACTICE 2011
- Alberta Dental Association and College, 2010 INFECTION PREVENTION and CONTROL STANDARDS
- American Dental Association, DENTAL RECORDS 2010
- Alberta Dental Association and College, Memo, Dr. Randall Croutze, President, January 10, 2007, Re: Staying Safe DVD and Workbook

- Government of Alberta, Fatality Inquires Act, Revised Statutes of Alberta 2000, Current as of May 4, 2012
- Government of Alberta, Fatality Inquires Regulation, Alberta Regulation 65/2000 with Amendments up to and Including Alberta Regulation 288/2009
- Government of Alberta, Personal Directives Act, Chapter P-6
- Government of Alberta, Alberta Guardianship and Trusteeship Act, Chapter A-42
- Government of Alberta, Limitations Act, Revised Statutes of Alberta 2000, Chapter L-12, current as of October 1, 2011
- Alberta Dental Association and College, Dental Facilities Accreditation Standards, 2011
- Office of the Information and Privacy Commissioner of Alberta, August 2012, Health Information Act Practice Note #5
- Office of the Information and Privacy Commissioner of Alberta, August 2012, EMAIL COMMUNICATION FAQs
- SOAP Note, Wikipedia
- Information and Privacy Commissioner of Ontario, Fact Sheet 16, HEALTH-CARE REQUIREMENTS FOR STRONG ENCRYPTION, July 2010

*Some of the above can be found on the members' website at www.abdentists.com