College of Dental Hygienists of Nova Scotia

CDHNS

Record Keeping

Best Practices

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COLLEGE OF DENTAL HYGIENISTS OF NOVA SCOTIA
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1. INTRODUCTION

Record keeping is a key component in the delivery and continuity of dental hygiene care. It brings together the ethical and legal considerations that must be evident in all client care. The College of Dental Hygienists of Nova Scotia (CDHNS) Code of Ethics, Standards of Practice documents and relevant legislation guide members in providing competent and effective care.

Record keeping or documentation substantiates the services provided. It confirms the client's informed consent and participation in the decision making about treatment choices.

Record keeping supports claims for payment of services submitted to private insurance carriers and to government health insurance programs.

While completing documentation is often seen as being tedious and time consuming, it is a member's best legal defense should a complaint be filed with the CDHNS. It is also a member's legal defense should a client decide to sue in civil court. In preparation for a member's legal defense, one of the first things the CDHNS or a lawyer will want is access to the member's client records.

Remember, no records, no defense. It is generally interpreted that if it has not been recorded, then it has not been done.

These following best practices are designed to ensure the member understands and meets record keeping requirements. It will also outline strategies to facilitate and maintain accurate and complete documentation for each client.

Members who are self employed shall follow the guidelines for record keeping outlined in the CDHNS Best Practices for Record Keeping.

Members who are employed by a dentist, corporation or institution shall follow the protocols set by the employer. If no record keeping protocols are in place or in the instance where the employer's record keeping protocols are in conflict with these guidelines, the member shall follow the guidelines outlined in the CDHNS Best Practices for Record Keeping. Members should contact the CDHNS directly if questions arise regarding record keeping protocols.

2. COMPONENTS OF BEST PRACTICES FOR RECORD KEEPING

2.1 Record of Daily Appointments

Each member shall maintain a daily appointment record that contains the name of each client who the member assesses, treats or for whom the member renders any dental hygiene service. The daily appointment record can be either a hard copy or one that can be accessed through the computer records.

2.2 Record of Equipment Service

In the case where the member owns or leases dental equipment, each member shall maintain an equipment service record that contains servicing information of any equipment used by the member to examine, treat or render any dental hygiene service to a client. This record should include any equipment used to sterilize instruments.

2.3 Financial Records

Each member shall maintain a financial record for each client, unless a client is in a communal screening program or in any other instance where there is no payment from or on behalf of the client to the member.
Where the member is self-employed, the financial record shall contain the treatment or procedures rendered, the fee charged or received and where available, the record of any receipt issued by or on the behalf of the member.

2.4 Record Maintenance and Retention

The member shall maintain his or her client records in a manner that ensures a client or client's substitute decision –makers and an investigator, assessor or an authorized representative of the CDHNS, has access to the records, including a method to readily copy those records.

Every client records shall be retained for at least 10 years following:

- the clients' last visit or the date of the last entry in the client's health record, whichever is longer, or
- the day the client became, or would become, 18 years old if the client was younger than 18 years at the time of his or her last visit.

2.5 Release and Transfer of Client Records

Clients have the right of access to or a copy of their complete oral health record.
Members are required to provide copies of oral health records upon receipt of a written request from the client or authorized representative.
The member shall ensure the confidentiality of the client records during any transfer of records to another health professional.
Where the cost replication of records is significant, the member, at his/her discretion, may decide to charge the client a reasonable fee.

3. GENERAL RECORD KEEPING PRINCIPLES

3.1 Recording Entries

a. Record all dental hygiene care in permanent ink and in legible documentation.

b. Entries should be clear, concise and factual and recorded during or as soon as possible following the appointment.

c. Each oral health care professional should date and initial care they have provided.

d. Record the actual time spent with the client.

3.2 Correction of Entries

a. To correct errors draw a line through the incorrect information and initial.

b. Never erase the previous entry.

c. Never use white out.

3.3 Use of an Order

If an order to proceed with dental hygiene care is required, the member shall ask the dentist to sign the order. The Dental Hygiene Regulations Schedule A: Protocol for Authorizing Dental Hygienist to Perform Procedures provides an example of a protocol for an Order. The use of an Order authorizing a dental hygiene care procedure must also be recorded in the client's oral health record.

3.4 Verbal or Written Informed Consent / Refusal of Treatment

Informed verbal consent to treatment or verbal declining of treatment is often the standard.
If a client continually refuses treatment, the member shall ask the client to sign a form or directly in the client's oral health record, indicating she/he has been informed of her/his choices but does not wish to proceed with the recommendations provided.

3.5 Periodontal Charting

Evidence -based practice is essential. Every client must have a baseline periodontal charting completed, as it provides evidence for treatment recommendations.
A full periodontal probing should be done every 12-18 months or as the client's oral health status indicates.
As a minimum standard, periodontal screening record (PSR) can be used at debridement intervals.

3.6 Individualized Treatment Plans

Members must ensure client dental hygiene care plans are individualized and documented accordingly. Members must not fall into the pattern of prescribing the same types of treatment plans for each client, For example, every client may not require 2 units of scaling and a complete polish.

3.7 Continuity of care

Documentation must reflect clients' continuity of oral health care.

A comprehensive history of oral health care includes past and current interventions, recommendations and outcomes.

3.8 Time Constraints

Documentation can be time consuming and members are always aware of time constraints.
Despite the pressure of the clock, members must make sure their documentation is complete and accurate.
The development of a chart form specifically for recording dental hygiene care could expedite record keeping requirements.

3.9 Use of Acronyms and Short forms

CDHNS permits members to use short forms or acronyms to record dental hygiene services as long as a master copy is kept in the office so the short form can be referenced in the future.

3.10 Computer Files

A computer filing system must maintain documentation standards.
Develop a template to ensure all components of the dental hygiene process of care are recorded in the documentation.
It is critical that computers have safeguards to prevent the deletion or altering of files. There must be a tracking mechanism and backup system.

4. CLIENT HEALTH RECORD

The member shall ensure that every page of a client health record has a reference, either a number or name which identifies the client.

The member shall ensure that every entry in the client health record is dated and includes the identity of the person who made or dictated the entry.

Each member shall maintain a client health record that contains:

a. the client's name, date of birth, address and telephone number;

b. the date of each professional contact with the client, or the client's substitute decision-maker, and whether the contact was made in person, telephone or electronically;

c. for each intervention, the amount of time the member spent providing dental hygiene care;

d. the name and address of the client's primary care provider, if available;

e. the name and address of the client's primary care dentist, if available, unless the record is shared with that dentist;

f. the name and address of any referring health professional;

g. an appropriate medical and dental history of the client;

h. every written report received by the member respecting examinations, tests, consultations or treatments performed by any other person relating to the client;

i. a copy of every written communication sent by the member relating to the client;

j. each examination, clinical finding and assessment relating to the client;

k. any medication taken by the client as a precondition to treatment or examination by the member for each intervention, including the name of the medication, the time it was taken, and if the medication was not administered to the client by the client the name of the person who administered it to the client;

l. any dental hygiene treatment plan;

m. each treatment or procedure performed for each intervention, and the identity of the person applying the treatment if the person applying the dental hygiene treatment was not the member;

n. any advice given by the member including any pre - treatment or post-treatment instruction given by the member to the client or the client's substitute decision - maker;

o. every referral of the client by the member to any other person;

p. every procedure that was commenced but not completed, including reasons for non-completion;

q. evidence of every consent provided by the client, or the client's substitute decision-maker; and

r. evidence of every refusal of a treatment or procedure by the client, or the client's substitute decision-maker.

5. PERSONAL INFORMATION

Because of the fast paced world we live in and the ability of the electronic age to send information instantaneously, it has been necessary for legislation to be put in place to set out rules for how health information is collected, used, disclosed, retained and destroyed by all health care providers.

The purpose of this section is to acquaint you with the principles of the Federal Government's Personal Health Information Legislation, the Personal Information Protection and Electronic Data Act, commonly referred to as PIPEDA.

Please note that Nova Scotia is in the developmental stages of creating Personal Health Information Legislation specific to our province. Until such time that Nova Scotia's legislation is formally introduced, members are required to follow the Act set down by the Federal Government.

It is essential that members, as health care professionals, safeguard the personal information they acquire about their clients.

5.1 PIPEDA

Dental hygiene practices must follow and comply with PIPEDA by:

a. collecting only information that is necessary for providing dental hygiene care to the client;

b. sharing a client's information only with his/her consent;

c. ensuring storage, retention and destruction of a client's personal information complies with existing legislation and privacy protection protocols;

d. ensuring office privacy protocols comply with privacy legislation, standards of the regulatory colleges (College of Dental Hygienists of Nova Scotia, Provincial Dental Board of Nova Scotia, and respective regulatory colleges for denturists and dental technologists if working in the same office);

e. understanding that access to that information should be on a need-to-know basis only;

f. following protocols for transmittal of client information;

g. signing a confidentiality agreement among staff in the office in an effort to ensure clients' privacy. This would include other individuals who are not regular office staff, such as IT consultants, maintenance workers and cleaning staff who have access to personal information that is not in a secure or locked area. Requesting these individuals to sign a confidentiality agreement would assist in assuring that confidentiality be maintained;

h. using security measures for electronic data;

i. ensuring personal information on paper be shredded;

j. continually monitoring that safeguards are in place; and

k. identifying a Privacy Information Officer in the office. Is there any statement about informing individuals if there is a known or suspected security breech?

In the event of security breach of client records, the Privacy Information Officer shall report same to his/her Regulatory Authority.

CHART AUDITS

A chart audit is a systematic process for confirming that all the required elements of record keeping are included and appropriately documented. The member can use the following list of components to periodically check their record keeping procedures.

The following components must be included in your documentation.

5.2 Assessment

a. Initial health history and updates;

b. The clinical assessment;

c. Client interviews;

d. Dental and pharmacological history; and

e. Clinical and radiographic history.

5.3 Diagnosis

The assessment must support the dental hygiene diagnosis and should be client specific.

5.4 Planning

An individualized client treatment must include:

a. Goals/outcomes;

b. Sequence of interventions;

c. Informed consent; and

d. Client collaboration.

5.5 Implementation

a. The date of each dental hygiene service provided; and

b. The particulars of each professional contact with the client.

5.6 Evaluation

a. A clinical assessment to determine whether oral health outcomes have been met;

b. The care plan is reviewed and modified as required;

c. The client receives appropriate recommendations and instructions in oral self-care; and

d. The member consults and/or refers to other health professionals as required.

6. CLIENT BILLING

The member shall bill only for the dental hygiene services provided and only for the amount of time required to render the service regardless of employment status.

A member shall not bill for the time the client is in the chair and not receiving any services.

The member shall record the billing codes, and may wish to document in the following manner: debridement (2.5 units), selective polish (.5 units).

A member who is employee shall use the billing codes and fee guide specified by the employer.

A member who is an independent practitioner shall use the Canadian Dental Hygienists Association (CDHA) National List of Service Codes. Each member in an independent practice setting must acquire a Unique Identifier Number directly from the CDHA.