Recordkeeping Guidelines

Approved by Council

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COLLEGE OF
ALBERTA DENTURISTS

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CONTENTS

INTRODUCTION

All denturists are required to create and maintain clear and accurate patient records. Clear and accurate records not only help to facilitate the provision and continuity of safe, competent, and ethical patient[1] care and services, but also provide legal and financial records.

The Patient Recordkeeping Guidelines outline the minimum requirements for patient recordkeeping that denturists must employ in meeting the professional, ethical, and legal requirements related to recordkeeping and are mandated by the College's Standards of Practice.

It is essential that the denturists review and understand these guidelines and ensure that their practices meet or exceed the contained minimum requirements. A denturist's recordkeeping practices must comply with all applicable legislation, including the *Health Professions Act* (HPA), *Personal Information Protection Act*, and *Health Information Act* (HIA). Legislation is paramount in any discrepancies between this document and the current legislation.

Through legislation, a healthcare provider can only collect, use, or disclose the amount of health information essential to carrying out the purpose for which the information was provided in the first place. In other words, you must collect, use, and disclose the least amount of information necessary, and preserve the highest degree of patient anonymity possible, to carry out the intended purpose. [2]

Please refer to any College advisories pertaining to the HIA for further information. All denturists should seek independent legal counsel regarding issues related to recordkeeping protocols to ensure compliance with all applicable legislation. Denturists use the principles of evidence informed decision making in recordkeeping practices.

Adherence to the requirements for patient recordkeeping is an integral and paramount procedure in any denture clinic for both the denturist and their employees. It is essential that denturists recognize that they are responsible and accountable for their own recordkeeping practices and those of their employees. The denturist is responsible for all information recorded (or not recorded) in the patient record.

Failure to maintain and disclose patient records as outlined in this document and mandated by the Standards of Practice; falsifying a record or other document; collecting, using, and disclosing patient information without the consent of the patient, except where required by law; and failing to store, maintain, transfer or dispose of patient records may be considered unprofessional conduct and be subject to discipline proceedings adequately and appropriately.

[1] Note that reference to the patient in this document is inclusive of a denturist's client.
[2] Office of the Information and Privacy Commissioner of Alberta – *Health Information, A Personal Matter*

PRIVACY AND CONFIDENTIALITY

Privacy Legislation

The Federal Government's *Personal Information Protection and Electronic Disclosure Act* (PIPEDA), and the Alberta Government's *Personal Information Protection Act* (PIPA) and *Health Information Act* (HIA) govern the use of an individual's personal information. A patient or client attending a denturist clinic must be advised of these laws.

This legislation requires that businesses safeguard an individual's collected personal information, store it safely, and restrict the disclosure of that information. An individual's personal information is controlled by HIA. For non-health related services, the patient/client's information is controlled by PIPA.

Denturists, who intend to use an individual's personal information for non-health related purposes, must first obtain a completed PIPA Consent Form from the involved patient(s), specifying the intended use of the information prior to the collection and use of any personal information.

The PIPA Consent is to be a separate form which forms part of the patient's record at your office. A patient is only required to complete this form once, unless he or she indicates at some future date that they wish to change the authorization for use of some of the collected information. In such a case, a new PIPA Consent Form is to be completed and must specifically identify changes from the initial consent.

The HIA describes the requirements pertaining to:

- collection of a person's information
- who can collect the information
- who can view and use the information
- the protection of the information
- disclosure of the information (i.e., to the patient, family, other healthcare providers)
- access to the information
- privacy impact assessments
- in office policies regarding the handling of health information

The Office of the Information and Privacy Commissioner of Alberta has produced "*A Practical Guide to the Health Information Act*", a good reference source for requirements related to the *Health Information Act*.

Confidentiality

In Alberta, the HIA, PIPA and PIPEDA require that healthcare professionals maintain patient information as confidential and that they must have consent from the patient for use of their information.

All staff members must be advised of the requirements of confidentiality and the legal obligation to obtain patient consent prior to transferring or releasing any patient information to a third party. It is the denturist's responsibility to ensure that employees comply with the requirements of HIA.

All patient records are:

- Located and maintained in secured storage
- In an environment that maintains the integrity of the record
- Not readily viewable by the public or other patients
- Not left unattended or in public areas of the clinic
- Destroyed appropriately only after the expiration of the required retention period of ten years from last date of any denturist services having been provided

The following are the basic assumptions related to patient recordkeeping:

- Patients have a right to expect that the information contained in their patient record will be maintained as confidential at all times by the denturist and any staff as per applicable legislation.
- Patients have the right to obtain a copy of their records or to review their record in its entirety.
- Unless permitted or required by law, distribution/sharing of any information in the patient record will only be done if consented to by the patient and further, only in a discretionary manner to ensure the continuity and required level of care for the patient.
- Transfer of patient records from one practitioner to another will only be done when legally required or in the “selling” of a practice.
- Eventual disposal of a record will only be done after the expiration of the required retention period, and then in such a manner as to ensure the confidentiality of the information is maintained.

THE PATIENT RECORD

Patient Chart vs Patient Record

The patient chart is a collection of patient specific information and items pertaining to an individual, including but not limited to all written or electronic clinical (i.e., notes, consents, referrals, prescriptions, photographs, test results) and business (i.e., records regarding financial, insurance, and/or business matters) information relating to a patient.

Patient charts have four general purposes:

- Managing Patient Care: documentation pertaining to the denturist-patient relationship (initiation of and any ongoing treatment).
- Documenting Business Aspects: financial records related to services provided including insurance transactions.
- Communicating Patient Information: about the patient record including communication with other healthcare professionals and their employees.
- Providing Evidence. This includes evidence in malpractice or other litigation and in professional conduct processes and proceedings.

The patient record includes:

- The patient chart
- Other pertinent patient information (i.e., diagnostic model(s), impression(s), appointment schedule).

Maintaining the Patient Record

The patient record is a legal document, regardless of the process used for recording the information. To prevent the possibility of misinterpretation of entered information, and to ensure that another healthcare provider may continue care, if required, it is essential that all entries be:

Legible:	be printed cleanly in pen, or typed, utilizing accurate spelling, grammar, and punctuation
Consistent:	be systematically organized
Accurate:	be truthful, factual, and without prejudice or exaggeration.
Language:	the language of record must be English.
Concise:	be recorded in short, succinct sentences
Clear:	the meaning of any entry should be immediately clear to any reader (medical terminology and abbreviations notwithstanding)
Chronological:	be dated and recorded in the order in which they occurred
Signed:	whether hard copy or electronic records via digital signature, each entry in the record must be signed by the denturist, and the provisional denturist or student, as applicable. Software programs must allow the user to place digital signatures onto each entry.

The use of recognized symbols/abbreviations can assist in maintaining brevity and clarity of the entries; however, to lessen the possibility of misinterpretation of the recorded information, the use of symbols and/or abbreviations should be limited.

With a computer software program recordkeeping system, it is prudent to have a program that has the functions to spell check and allow the dictionary to be supplemented.

Type of Chart

The choice of patient chart/form and recording methodology rests solely with the denturist. All types of records (i.e., paper-based, electronic) must comply with all recordkeeping requirements.

Regardless of the type chosen, it is essential that there be adequate space to record all relevant and required information from the initial examination, as well as room to document ongoing procedures, changes and updates, as necessary.

The ability to easily add pages to a hard copy patient record is highly recommended. Multiple visits will require a substantial amount of space to record progress notes. The ability to add supplemental sheets to a patient record will facilitate a consistent recordkeeping methodology.

Editing Records

When information in a patient record is updated or corrected, the following must be maintained within the record:

- The original entries
- The identity of the person entering the update or correction
- The date of the update or correction

Please note, in alignment with the above:

- An entry must not be erased.
- An entry must not be blacked-out or otherwise obscured (i.e., correction fluid, correction tape)

When an entry is to be corrected, a straight-line strike-through of the original information must be done in ink, in such a manner that leaves the original entry legible, and initialed and dated by the person making the correction.

When space permits, the new information must be entered on the same line above the entry that was struck through. If there is insufficient space to legibly write above the original entry, the new information must be entered into the next available chart line or area, and a clear indication – such as the use of an arrow – must link the amendment to original entry.

Where applicable, corrected information requires notation explaining the reasoning and/or justification for the correction.

When changes involve any form of patient consent, the patient must also provide their signature to the changes.

All corrections and updates must be clear and legible. If there is not sufficient room at the initial site of correction, reference to the location of further notes is required.

Patient request for change to record

In accordance with applicable legislation, a patient may request a change to their patient record identifying incomplete or inaccurate records. In response to this, the denturist may:

- Correct the factual inaccuracies and notify all applicable parties of the correction.
- Write an amendment to the patient record and notify all applicable parties of the correction.
- in accordance with the HIA, the denturist may refuse to make an amendment or correction to the patient's chart. This refusal must be documented, in the patient chart, with rationale.
- When the denturist is unwilling to make a change to a patient record as a result of the patient's request, the patient may write a statement outlining the reasons for disagreement and request that the statement be included in their patient record, subject to all applicable privacy legislation.

PATIENT RECORD REQUIREMENTS

It is understandable that required or requested treatments will vary depending on the individual patient and as such, the amount of information contained in a patient record and the depth of detail will also vary. However, there are minimum requirements for what must be recorded for each patient. The minimum requirements are specific to and dependent on the venue in which patient treatment takes place.

Patient Signature

On specific items, it is prudent to obtain the patient's signature and to record the date on the patient record. Such items would include, but are not limited to:

- Initial health history and all updates
- Consent forms
- Instructions provided for major procedures/treatments
- financial arrangements
- patient refusal of recommended treatments or referrals to other practitioners

When Providing Direct Patient Care

When a patient is physically present in the denturist's office, or when a denturist attends to a patient in an out-of-office location, the denturist shall ensure the following becomes part of the patient record, as appropriate:

I. signed consent form
II. personal information about the patient
III. patient's health history
IV. clinical examination record
V. diagnosis, treatment plan(s), and prognosis
VI. progress notes
VII. radiographic information
VIII. financial information
IX. appointment schedule record

When Providing Indirect Patient Care

When a patient is not physically present (such as when another individual provides a patient's denture for repair), the denturist shall ensure the following becomes part of the patient record, as appropriate:

- personal information about the patient
- patient's health history (if available)
- progress notes
- Information/education presented to the patient (via attending individual), whether verbal and/or written
- financial information
- referrals

I. INFORMED CONSENT

Informed consent is based on the right of each person to determine what will be done to their own body. In this each person has the right to refuse, consent to and withdraw consent to any treatment or service.[3] Consent does not merely consist of providing the patient with a document to read and sign. Consent requires that you discuss the proposed treatment plan with the patient and patient representative, where appropriate, so that they may make an informed decision.

Informed consent occurs when a patient has been specifically informed of all aspects of a treatment that a reasonable person in the same circumstance would want or need to know - including the estimated costs - and they have voluntarily agreed to proceed with the treatment (either by implied or express consent). The consenting party must be aware that they have the right to withdraw their consent at any time.

For a patient to be able to provide informed consent, all applicable information must be explained to the patient in a language or manner that the patient can understand.

When obtaining consent, the following, at minimum, is explained to the patient and/or patient representative, where appropriate:

- The diagnosis
- All viable treatment options - including no treatment
- Initial prognosis and indication of the expected outcome/success of all treatment options
- Recommended treatment and the justification for the recommended treatment
- Materials to be used
- Risks or possible complications associated with each treatment option
- Fees related to the recommended treatment, and where applicable, the anticipated estimated portion covered by third party insurance
- Financial terms and agreements
- Recommended referrals to other practitioners

Implied consent

Implied consent is usually granted through the patient's actions or words. For example, when a patient voluntarily attends for treatment, understands and is fully aware of what is being done or will be done, allows themself to be treated, and does not object to or refuse treatment.

Implied consent is appropriate when the patient attends to the denturist's clinic or place of business and the denturist is performing a non-invasive procedure where there is no risk of harm to the patient.

Express consent

Express Consent is clear and unequivocal consent for treatment, whether verbal or written, provided to the denturist by the patient or patient representative. Express consent must be obtained when there is a potential risk to the patient, even if the likelihood of complications is low.

[3] ADA&C guide for patient records and informed consent

Below are situations which include, but are not limited to, situations where a denturist is required to obtain express consent. It is prudent for the denturist to obtain written express consent for:

- Complex/lengthy treatment plans
- Major services such as those involving surgery
- Treatments with known risks
- Cases that involve referral of the patient to other practitioners
- Cases in which the patient is referred to you by another practitioner
- Cases where the patient refuses recommended treatment(s)
- Cases in which the patient has unrealistic expectations of treatment outcomes

Third party consent
There are situations in which a patient cannot or does not have the legal capacity to provide informed consent for their treatment.

Dependent Adults
An adult patient (18 years of age or older) may not be legally able to make decisions on their own behalf and may be under the care of a legal guardian.

The *Adult Guardianship & Trusteeship Act* (AGTA) became law in Alberta in 2009. AGTA provides decision-making options for healthcare providers, patients, and their families to use to ensure that consent for healthcare services is obtained from the appropriate decisionmaker(s).

If a dependent adult attends your clinic with an individual who identifies themself as the legal guardian of that patient, but who lacks documentation to confirm the guardianship, you must take additional steps to determine guardianship status prior to providing any treatment. Written consent to treatment must be obtained from a guardian prior to providing any service to a dependent adult patient.

If a denturist is under the belief that a legal guardian has made a decision on behalf of a dependent adult which is not in the best interest of the patient, the denturist must seek legal counsel and advice.

Minors
The age of majority in Alberta is 18 years of age. Anyone younger than this age is considered a minor. Despite this age, case law has established that minors aged 16 and over have *defacto* medical decision-making authority, unless they do not understand the implications of the decision or appreciate its consequences. As such, the denturist must have a discussion with the minor aged patient to determine if they are a mature minor and able to make their own medical decisions in their best interest.

If a minor is younger than 16 years of age, or is not a mature minor, consent from a legal guardian is required prior to any procedure being performed. Usually, minor aged patients attend a denturist clinic with a parent or guardian. If the denturist is unsure if the accompanying adult is a legal guardian of the minor, the denturist must take additional steps to determine guardianship prior to providing any treatment. Written informed consent to treatment must be obtained from a guardian, in compliance with applicable legislation, prior to providing any service to a minor.

The *Family Law Act* became law in Alberta in 2003. This Act has rules for determining who the legal guardian of a minor aged individual is.

If a denturist is under the belief that a legal guardian has made a decision on behalf of a minor which is not in the best interest of the minor, the denturist must seek legal counsel and advice.

II. PERSONAL INFORMATION

A patient's record must include personal information as outlined below. This information must be reviewed and updated, if appropriate, as below, or upon notification by the patient of a change to their information:

- Full legal name
- Date of birth
- Gender identity
- Home physical and mailing address
- Home, mobile and work telephone numbers, as appropriate
- Name and telephone number of patient's primary healthcare provider, if applicable
- Name and telephone number of patient's dentist, if applicable
- Name and telephone number of previous denturist, if applicable
- Name and telephone number of referring health care provider, if applicable
- Legal guardian/responsible individual, if applicable)
- Emergency contact name and phone number(s)
- Billing information (i.e., individual or agency responsible for patient account, insurance information)

The patient's personal information must be reviewed and updated, if appropriate, at regular intervals:

- Once per calendar year (if the patient attends annually); or
- Upon the patient's return to your office after a period of more than one year; or
- Upon notification by the patient of any change to their recorded information.

Updated entries must include both the date of updating and the signature of the patient/patient representative.

III. HEALTH HISTORY

A patient's health history, including both medical and dental information, supplements the findings of the clinical examination, providing the denturist with information needed to formulate the treatment plan, and to determine a prognosis. This history is obtained, in writing, prior to the initial appointment with the denturist and is signed by the patient or patient representative, as appropriate. If the patient cannot provide written history, the patient representative or a clinic staff member may record this history as relayed to them by the patient. During the appointment, the denturist reviews this information with the patient/patient representative. The denturist initials that this review was completed.

Denturists must ensure that their health history forms request:

- only information appropriate to the provision of professional services
- the required information specifically pertaining to patients who have or require dental prosthetics

The goals in obtaining a complete and accurate health history are to:

- identify any significant medical condition(s), and/or drug interaction or drug side effect, to determine the level of risk in treating the patient at that time
- provide an indication of the patient's level of stress, and determine whether it might affect how the treatment is best provided to that patient
- determine if the treatment can be provided safely
- provide additional information for consideration with the findings of the examination
- provide additional information for consideration in treatment planning
- provide information on the patient's previous dental experiences and dental knowledge
- provide an indication of the patient's level of concern with and knowledge of their oral health

Any conditions which are or may be pertinent to the treatment being proposed and/or provided must be conspicuously noted in the chart.

Responsorial areas of the chart must be in a positive/negative response format, utilizing "closed" (yes/no) questions.

The patient's health history must be updated at regular intervals:

- Once per calendar year (if the patient attends annually); or
- Upon the patient's return to your office after a period of more than one year; or
- Upon notification by the patient of any change to their recorded information.

Updated entries must include both the date of updating and the signature of the patient/patient representative. The denturist and patient review all updates together, and both the denturist and patient/patient representative must sign or initial the updates. It is essential that there be sufficient room for the recording and updating of entries, and for adding the required signatures associated with the collected information.

IV. CLINICAL EXAMINATION

The patient record must contain a clinical examination chart in which the conditions present on the initial clinical examination of the patient are recorded by the denturist or recording staff member. The initial record of these findings must remain unaltered.

At a minimum, the following must be evaluated, and the findings recorded, where applicable. When performing extraoral and intraoral examinations it is prudent to utilize a systematic form or worksheet to ensure routine methodology is followed.

Extraoral examination	• General physical appearance • Head • Lips	• Neck • Lymph nodes
Temporomandibular joint complex	• joint and/or masticatory muscle tenderness or soreness • range of vertical opening	• range of lateral movement • presence of clicking, popping and/or crepitus
Intraoral examination	• appearance of mucosa • ridge classification • residual ridge condition • tori (if present) • tongue size, mobility, and condition	• resiliency and depth of floor of mouth • pharynx and tonsils • saliva quantity and viscosity • soft and hard palate condition • lateral throat form
Evaluation of existing prosthesis	• centric relation and centric occlusion • interocclusal distance • tooth contact in lateral excursions • tooth contact in protrusive excursions	• classification of current occlusal relationship • condition of prosthesis, including the base, teeth and/or framework.

Implantology information	• information about placement (date, surgeon)
	• information about implant (type/make, size, retention, abutment)
	• information about cemented bridges
		• for screw-retained
		  • bar type, age, manufacturer
		  • retention and abutment type
		  • multi-unit abutments (lot #, location)

Dentition and periodontal evaluation	• status of remaining dentition • missing dentition • oral hygiene assessment • tooth mobility measurement	• tissue color, position, shape, texture & consistency. • bleeding and/or exudates
Radiographic evaluation	• any radiographic findings, if applicable	

Periodontal screening and tooth mobility measurement records
When providing a patient with partial denture treatment(s), (or when appropriate and applicable) a current periodontal probing record or periodontal screening and tooth mobility measurement record should be incorporated into a patient's record.

Such records may be completed by the denturist if they have the knowledge, skills, and judgements to conduct periodontal screenings and tooth mobility measurements safely, competently, and ethically. Alternately and with the consent of the patient, a copy of the current record could be obtained from the patient's dentist or hygienist.

These records are:

- a permanent part of the patient record
- The original record must remain unaltered.
- updated periodically by the denturist or other oral healthcare professional. Updates must be recorded onto a new form.

DIAGNOSIS, TREATMENT PLANNING, AND PROGNOSIS

Diagnosis
The diagnosis must be recorded in the progress notes section of the patient chart.

Treatment plan
The recommended and consented to treatment plan must be recorded in the patient chart. It may be incorporated into the progress notes section of a patient chart. Alternately, the treatment plan may be a separate form contained within the patient record. In cases where consent is being given for an extensive treatment involving numerous appointments, referrals, surgeries, and/or extended post-delivery follow-up, it is prudent that the treatment plan be a separate document, and that this document include signed, expressed consent.

The treatment plan must list the services that are proposed for the patient. Treatment options must be discussed and reviewed with the patient and that discussion duly recorded.

For extensive treatment plans, it is prudent that the following also be recorded and discussed:

- A schedule of the appointments.
- A timeline for the treatment from initial appointment to anticipated completion.
- A brief description of the services to be provided at each appointment.
- If applicable, any condition(s) being monitored, and that the patient has been made aware of the condition(s) being monitored.

If the patient does not agree to the treatment plan in its entirety, the denturist must record this in the patient chart along with a consent form that outlines the agreed upon care and services.

Prognosis
The prognosis must be recorded in the progress notes section of the patient chart, and/or in a separate treatment plan document.

Should the prognosis change during the course of treatment, the change must be noted and recorded in the patient chart. This change must be discussed and reviewed with patient.

It is prudent to describe the prognosis one of the following four terms:

Excellent	It is highly likely that the patient will be successful with the provided treatment (very minor or no concerns).
Good	It is probable that the patient will be reasonably successful with the provided treatment (some minor concerns).
Guarded	It is likely that the patient will have some difficulty with the provided treatment but may overcome the difficulties with time.
Poor	It is very likely that the patient will have difficulty with the treatment and will likely experience long-term, ongoing problems (major concerns).

If a denturist chooses to utilize terms other than those indicated above to describe and document a prognosis, a secure and easily accessible “legend” which fully describe and defines the terms use, must be maintained.

Prosthodontic treatment includes diagnosis, treatment planning and provision of services. The three phases that occur before prosthodontic treatment include:

1. The Diagnosis
    - Identification of the disease and/or problems present.
2. The Treatment Plan and provision thereof
    - Removal of the disease process and/or problems present;
    - Restoration of stomatognathic function and aesthetics; and
    - Monitoring and maintenance of the patient's general oral health
3. The Prognosis

1. DIAGNOSIS
The diagnosis is formulated based on objective information from:

- The clinical examination
- The patient's dental and medical histories
- The results of any diagnostic aids such as study models or radiographs
- Reports from other healthcare providers

The diagnosis

- must consider subjective information expressed by the patient, for example, the chief complaint(s) identified by the patient
- is the regulated member's professional opinion of the cause(s) of the symptoms (the disease and/or problems present). It is based on findings from the clinical examination
- must be recorded in the progress notes section of the patient chart by the Regulated Member or by a staff member recording on instruction from the Regulated Member.

2. TREATMENT PLAN
The treatment plan is based on information gathered from the examination and diagnosis.

The treatment plan:

- must be recorded in the progress notes section of the patient record by the regulated member, or by a staff member recording on instruction from the regulated member
- may be a separate form contained within the patient record
- must list the services to be performed for that patient

NOTE: The proposed treatment should incorporate the following criteria wherever possible:

- Removal of the identified disease or diseases present, considering the urgency and order of that treatment
- Maintenance of aesthetics, function, and phonetics
- Achievement and maintenance of maximal dental/oral health for the patient in their given set of circumstances
- Prevention of recurrent disease, malocclusion, and/or future degenerative changes to the stomatognathic system.

It is prudent that treatment plans take into consideration the severity and urgency of the patient's condition, and that plans be supported by clinical findings and accurate records.

Treatment options must be discussed and reviewed with the patient, and that such a discussion is subsequently duly recorded.

The more complex the treatment plan is the more information that must be presented to and discussed with the patient. Fees for treatments quoted to the patient must be directly correlated to the complexity of the planned treatment.

For extensive treatment plans, it is prudent that the following also be recorded:

- A schedule of the appointments
- A timeline for the treatment from initial appointment to anticipated completion
- A brief description of the services to be provided at each appointment
- any condition(s) being monitored, and further, that the patient has been made aware of the condition(s) being monitored, if applicable

In cases where consent is being given for an extensive treatment involving numerous appointments, referrals, surgeries, and/or extended post-delivery follow-up, it is prudent that the treatment plan be a separate document, and that this document include signed expressed consent.

The treatment plan can be on a separate form or document which becomes a part of the patient record. Alternately, the recommended treatment plan and the consented to treatment plan can be incorporated into the progress notes section of a patient chart.

3. PROGNOSIS

Denture Prognosis [4] is defined as:

"*An opinion or judgment given in advance of treatment for the prospects for success in the fabrication of dentures and for their usefulness.*"

Prognosis may be described as:

- Excellent: It is highly likely that the patient will be successful with the provided treatment (very minor or no concerns).
- Good: It is probable that the patient will be reasonably successful with the provided treatment (some minor concerns).
- Guarded: It is likely that the patient will have some difficulty with the provided treatment but may overcome the difficulties with time.
- Poor: It is very likely that the patient will have difficulty with the treatment and will likely experience long-term, ongoing problems (major concerns).

If a regulated member chooses to utilize terms other than those indicated above to describe and document a prognosis, a secure and easily accessible "legend" which fully describe and defines the terms use, must be maintained.

The prognosis must:

- be determined with consideration to objective anatomical and physical considerations, and to subjective considerations such as the patient's psychological acceptance and expectations of the treatment

[4] *The Glossary of Prosthodontic Terms.* The Journal of Prosthetic Dentistry & The Academy of Prosthodontics, Volume 94, Issue 1:64; 2005

- be recorded in the progress notes section of the patient record, and/or in separate treatment plan document/form, by the regulated member or a staff member recording on instruction from the regulated member.

Should the prognosis change during the course of treatment, the change must:

- be noted and recorded in the patient record
- be discussed and reviewed with patient

V. PROGRESS NOTES

Progress notes are a required descriptive record of the progression of treatment, both what happened clinically at the appointment or interaction, as well as any related technical events that require documentation.

- Progress notes generally include:
- The patient's subjective information
- The denturist's objective assessment/analysis
- The treatment proposed/provided to the patient
- The prognosis
- Planned future procedures
- Denturist and patient signatures, where appropriate

Details of every appointment for direct patient care must be entered into the patient's progress notes[5] including any limitations of the treatment(s) that are discussed. Any correspondence received that relates to the patient must also be recorded in the patient's progress notes.

Recording

Progress note entries should be made on the day the appointment occurred, as close to the patient's appointment as possible. The amount of information recorded will be dependent on the treatment being provided. It is prudent to record the entry immediately upon completion of the appointment, or upon the completion of the review of the received correspondence.

Methodology

Although the style and content of progress notes will vary from denturist to denturist, the information recorded in the Progress Notes must align as below:

For single-appointment procedures

For single-appointment procedures (i.e., repair, adjustment), the progress notes for that encounter include two components:

- Initial Note: done at the start of the appointment/procedure and indicates what treatment is planned.
- Final Note: It is possible that issues may arise during the appointment that necessitates a change/addition to the planned treatment. The final note is done at the end of the appointment/procedure, and indicates what treatment was provided and what information was presented to the patient.

For multiple-appointment procedures

When treatment requires that a patient attend multiple appointments, the progress notes are one of three types:

- Initial Note: entered during and/or upon completion of the first appointment with the patient, whether that appointment is for a consultation, an examination, or for other procedure.
- Ongoing Treatment Note: entered during and/or upon completion of each appointment in a series of treatments for the patient.

[5] This may be entered either by the denturist or by a staff member recording as per the denturist's instruction.

- Final Treatment Note: entered during and/or upon completion of the final appointment in a series of treatments for the patient.

Personal comments
Aside from already noted components, denturists may include appropriate personal comments regarding the patient and/or their families in the patient chart. All personal comments must be accurate and relevant to the care that is or will be provided to the patient. Be reminded that patients have the right to review or to obtain a copy of their record, including all personal comments recorded therein.

Patient information/education
Information presented to a patient must also be documented in this section of the patient chart, and where appropriate, a written copy of the information provided to the patient must also become part of the patient record.

If presented information is a standardized letter or brochure, then the entry into the progress notes section must specify which letter or brochure was provided[6]. Further, an example of all standard letters and brochures must be maintained and secured in an easily accessible location in the clinic.

Referrals
Any referral made to another healthcare professional must be recorded in the progress notes. As this includes disclosure of the patient's personal information consent must be obtained from the patient or patient representative prior to disclosure of the patient's information. This consent must be recorded with the referral in the progress notes.

The referral entry into the progress notes must include:

- the name of the professional to whom the referral was made
- date and purpose of the referral
- a description of the information disclosed in the referral.
- documentation of patient consent for information disclosure prior to the disclosure.

Any referral letters, reports and/or other correspondence, including electronic correspondence, received from the referee practitioner must also be retained within the patient record.

Recall appointments
Denturists systematically recall patients for follow-up care, checkups, and general monitoring. Record of these appointments must be entered into the progress notes. This includes:

- recommended date for the patient to be recalled
- purpose of the recall appointment
- missed or cancelled recall appointments, whether denturist or patient initiated

Notes from recall appointments must be recorded in the chart. These notes document:

- updated health history which includes:

[6] When information is complex or critical, it is prudent to have a comprehensive discussion about the information with the patient, and to present the information in writing.

- updated health information
- signature or initials from the denturist and provisional denturist or student, as applicable, that the updated health history was reviewed with the patient.
- patient signature
- The type and findings of examination provided.

Professional consultation
If during a patient's treatment the denturist consults with another healthcare professional, any conversations of this nature regarding the patient must be recorded into the progress notes.

Refusal of treatment or referral
If a patient or patient representative refuse to consent to a recommended treatment or referral to another practitioner, this refusal must be recorded into the progress notes. Whenever possible, it is prudent to have the patient or patient representative provide their signature at the end of the entry documenting the refusal.

Dissatisfied patient
If a patient is dissatisfied with the care and services provided, any interaction, including attempts to resolve the issues of the patient's dissatisfaction, is recorded in the progress notes.

If a denturist becomes aware that the patient is planning to or has initiated legal action correspondence with the denturist's Professional Liability Insurance provider should be recorded in the progress notes.

Termination of denturist/patient relationship
Justification(s) for the termination of a denturist/patient or denturist/client relationship and any steps taken to ensure that all legal aspects of the relationship have been fulfilled must be recorded into the progress notes.

Such steps include:

- Completion of any procedures which are in progress.
- Formal notification to the patient/client via confirmable delivery a method, indicating:
    - the termination of the denturist/patient or denturist/client relationship
    - that you will provide them with only emergency treatment for a period of two months from the date of the letter
    - names of denturists in the patient's vicinity and/or the vicinity of the terminating denturist's clinic
    - a copy of their patient record will be transferred to a new practitioner upon provision of written consent.

Such correspondence must be recorded in the progress notes.

Patient record access
Should the patient record be appropriately requested for viewing or copy, by the patient or patient representative, this access must be recorded in the progress notes. This note must indicate consent, date, time, and individual to whom a copy of the record, or part thereof, was shared or released.

VI. RADIOGRAPHIC INFORMATION

Referral
Denturists must use their professional judgement when considering the benefit vs. risk of ordering radiographs. A copy of the radiograph requisition must be retained on the patient's record. The denturist is responsible to refer the patient to an accredited diagnostic imaging facility or dentist office.

Images
Analog film, if provided, or an unprocessed digital exposure must be maintained in the patient record along with any processed images.

When using an electronic recordkeeping system, all images must be stored to ensure the integrity and reproducibility of the image.

Reports
All radiographic reports must be maintained within the patient record.

VII. FINANCIAL INFORMATION

Financial information, including arrangements and transactions, are an integral part of the patient record. Financial information must be included as a discrete section within the patient chart.

The financial information for each patient must include:

- A copy of all written and signed financial arrangements and agreements with the patient.
- The dates of services, procedures and/or codes.
- The amounts of all fees charged.
- The dates, amounts, and method(s) of all payments made.
- An itemized list of external invoices, such as fees from commercial laboratories.
- Copies of all insurance claim submissions, statements or other documentation including forms from the preceding ten years.
- Signature/initials of the individual who made each entry into the financial record.

In addition, the financial information in a patient's record must indicate who is responsible for the patient's account. If an alternate person is responsible for the patient's account, this agreement must be in writing, detail the components of the agreement, signed by the involved parties where available, and recorded in the patient's chart.

VIII. APPOINTMENT SCHEDULE RECORD

A patient's appointment schedule must be retained as it forms part of a patient record. This includes those appointments attended by the patient and any missed or cancelled appointments.

Appointment records, in hard copy or electronically, must be maintained for a minimum of 10 years, with consideration of indefinite retention if possible.

For generated appointment schedules, it is prudent that a hard copy be printed and maintained, or at minimum, a separate encrypted backup of the electronic record of the appointment schedule is maintained.

OTHER CHARTING CONSIDERATIONS

Symbols and Abbreviations

To prevent possible misinterpretation of recorded information, symbols and abbreviations should not be used or should be limited in use.

If a denturist chooses to use symbols and/or abbreviations in patient records, all symbols and/or abbreviations must be consistent throughout all patient records. Any used abbreviations or symbols must be industry accepted (i.e., WNL <within normal limits>, CUD/CLD <complete upper denture, complete lower denture>).

If the denturist uses abbreviations or symbols, an easily accessible "legend" which fully identifies and defines the abbreviations and symbols must be maintained.

Terminology

The terminology used in patient recordkeeping must be standard medical terminology utilized by the profession. The HIA requires that a practitioner, who has received a request for access to health information, explain any term, code, or abbreviation used in the record.

It is recommended that the *FDI System (Federation Dentaire Internationale)* be employed in charting to identify natural dentition.

Odontograms

Patient charts, for patients with natural dentition, must contain an odontogram large enough to allow for the charting of all pertinent clinical findings.

Although the choice of the type of odontogram is solely that of the denturist, the College recommends the use of an anatomical odontogram. Regardless of the type, a single type of odontogram should be adopted for use with all patients to ensure consistency.

As with all other information documented in the patient record, the initial visit odontogram must remain unaltered.

Subsequent changes to the status of the dentition should be charted on a separate odontogram or recorded using a different colour of ink than was used for the initial information. All entries or additions to an odontogram must be dated and signed/initialed by the denturist.

ELECTRONIC RECORDKEEPING

An electronic recordkeeping system provides a means to record and store personal and health information about a patient. This system must ensure the protection of this data from unauthorized use or alternation while providing timely and appropriate access to authorized individuals in order to provide safe, competent, and ethical denturist care and services. An electronic recordkeeping system is composed of both software with which to manage the acquired data and hardware which allows the access to and storage of the data.

Access to Electronic Records

There may be several people within a practice setting who have authorized and appropriate access to the patient's electronic record. The use of the record by each of these individuals must be tracked and so each of these users must have a unique identifier with a separate username and password.

Each interaction with the system by an authorized user must be tracked and recorded. This information, called metadata, includes:

- the identifier of the person accessing the record
- the identity of the record being accessed
- an accurate date and time stamp for the interaction
- the purpose for the interaction

Denturists and other staff must not share their credentials or passwords.

It is the record custodian's responsibility to ensure that access to records is appropriate. This may involve instituting levels of permission in an electronic system that are appropriate to the tasks to be completed by the staff member or individual accessing the patient record. This access may also be controlled through physical barriers.

Two-factor authentication
In order to limit unauthorized access to patient records, it is highly recommended that access to a patient record be managed and safeguarded through two-factor authentication.

Audit trail
An electronic recordkeeping system must have one or more audit trails in place for the system to show continuity of the data. An audit trail records all activity and changes (addition, deletion, amendment) that have taken place in an electronic record and is imperative in establishing the integrity of the patient record. It includes:

- the identity of the person making the change
- the patient identity
- the date and time of the change
- the location (terminal, IP address) from which the change was made
- description of the change that was made.

Further, the audit trail:

- must be operational at all times
- must not be modifiable
- is part of the patient record and must be retained as such
- must be exportable and printable as required.

Software

Electronic recordkeeping software must support basic functions to meet the required standards of recordkeeping. The system must ensure:

- Recorded information can be accurately retrieved, displayed, and printed.
- Each patient's clinical and financial records can be accessed and is searchable by patient name.
- Clinical and financial information for each patient can be retrieved, displayed, and printed in chronological order, for specified dates and/or periods of time.
- Information is unalterable shortly after being entered.
- A continuous audit trail is maintained which adheres with the access requirements above and:
    - Indicates any changes to the recorded information
    - Maintains an original content record when information is changed, updated, or deleted
    - records every clinical and financial entry for each patient
    - Reveals the digital signature of individual who made each entry.
- Access is password protected or has another form of unauthorized access prevention.
- With a computer software program recordkeeping system, it is prudent to have a program that has the functions to spell check and allow the dictionary to be supplemented.

Hardware

- Computer screens must be placed to ensure safeguarding of confidential information.
- Access to computers and devices (desktop or portable) containing practice-related data must be restricted to authorized individuals, and the use of screen savers, passwords, etc., is required.
- Denturists must take all necessary steps to ensure the safeguarding of computer equipment from electrical failures or fluctuations (surges), theft, fire, water damage, or any other hazard.
- It is prudent to perform a daily encrypted backup of the records and to remove a copy of the backup from the premises.
- It is recommended that a hard copy of the data be maintained in a systematic chronological manner. All necessary steps must be taken to maintain security of the copy and the information contained therein.

Portable devices

The use of an electronic recordkeeping system easily allows the patient data to be transferred to a portable device. No or minimal patient data should be stored on a portable device. If any data is stored on a portable device the denturist must ensure that the data is either strongly encrypted or de-identified.

Wireless devices

Due to the susceptibility of wireless transmissions being intercepted, the denturist must ensure that any data sent via a wireless connection be either strongly encrypted or de-identified.

Electronic Financial Records

These records provide an accurate and current representation of the patient's account and includes:

- Appropriate procedure codes with fees charged
- Payments that were received and by what method
- Any adjustments to the account

Images

Any images (i.e., radiographs, photographs) that are kept as part of the patient record must be stored with the same due care and attention and metadata as text entries. The images must be exportable in a manner that protects the integrity of the image.

Data Backup

The denturist must ensure that any data is backed up:

- regularly to an off site secure location
- to a removable recording media
- and includes a method for data recovery, protection against loss, damage, corruption, and/or inaccessibility to any or all patient information.

The denturist should periodically check to ensure that the back up and retrieval system is operational and free of issue.

Contingency Plan

In the instance where the electronic recordkeeping system is compromised, the denturist must have a contingency plan in place to ensure continuity of business operations and patient care.

Data Migration

Where a denturist is either initiating the use of an electronic recordkeeping system or is migrating to a different system, they must ensure the integrity and safety of all patient records.

RECORD MAINTENANCE AND DISPOSAL

Record Security

Patient record security relates to the methods used to protect patient information from unauthorized viewing, modification and/or destruction whether accidental or intentional. Privacy legislation has detailed requirements for the securing, storage, and disposal of patient information. It is a denturist's responsibility to understand their legal requirements related to the handling of patient records.

Physical security

Patient records must be handled appropriately within the clinic.

- Records are not to be left unattended in public areas of the clinic.
- Only authorized individuals may access the records.
- Denturists must have and employ written policies in place to deal with access, release, transmission, and destruction of patient records.
- All employees must sign a confidentiality agreement to be in place both during and after employment ceases. These agreements must be retained by the clinic indefinitely.
- Reasonable precautions must be employed to safeguard records from damage due to fire and other hazards.

Transmittal security

Denturists are required to have written policies in place that deal with the transmission of patient information sent in hard copy or electronically.

These policies must address:

- what type of information can be transmitted
- acceptable modes of transmission
- the utilization of security features for email programs
- the use of encryption
- other related security features

Record Storage and Retention

Record storage

Denturists are responsible to store patient records in a manner that protects patient confidentiality. This may be through administrative, technical or physical controls. Appropriate storage and protection of patient records will reduce the possibility of their misplacement, damage, and/or loss. If patient records are to be removed from the clinic for storage off-site, security and protection of the integrity of the records must be ensured. A secure controlled environment with restricted access is required.

A record of which files have been stored and the location of the storage must be maintained at the clinic for tracking and reference.

Record retention

Patient records must be retained and remain accessible for a minimum of 10 years from the conclusion of the denturist/patient or denturist/client relationship. If the patient is a minor, the record must be retained for a minimum of 10 years from the date at which the patient reaches the age of majority.

In the event that the patient becomes deceased, the retention period and requirements remain unchanged. A deceased patient's record must be retained for a minimum of 10 years from the date on which treatment was last provided to the patient. If the patient had a legal guardian, it is prudent to provide notice to the legal guardian as to where the record is being retained.

Retention requirements are the same regardless of the method of patient recordkeeping (paper-based or electronic).

Selling or Closing a Practice

When a denturist sells their clinical practice including patient records, they are responsible to:

- ensure that the new owner is aware of the requirements for patient record retention.
- provide indication to the new owner of how much of the minimum 10-year retention period has elapsed in for each patient record.
- A note must be made in the patient chart as to the change in custodian and applicable date.
- A letter must be sent to all present and former patients, at least 30 days in advance of the change, advising them of:
    - the change of custodian
    - reason for the change
    - the effective date.
    - contact information for new custodian
    - where their records will be kept

If notice cannot reasonably be given due to factors outside of their control, the receiving custodian must notify patients of the change.

When a denturist sells or closes a practice that does not involve a transfer of custodianship:

- The denturist must maintain the patient records for a minimum of 10 years.
- These records are required to be:
    - retained and maintained in a protective environment to prevent damage
    - easily accessible should record retrieval be necessary
- A letter must be sent to the patient, at least 30 days in advance of the change, advising them of:
    - the change of location of their records
    - reason for the change
    - the effective date
    - contact information in order to request a copy of their records
- Notification must be provided to the College within 30 days of its closure, with a written indication of the location of stored patient records.

Record Access

The denturist is the custodian of the patient record; however, the information in the patient record belongs to the patient, not the denturist. With this lens, the denturist must maintain the patient records in a form that allows for access and for the ability to make a copy; this includes electronic data.

Before a denturist releases information from a patient record, they must obtain signed written consent from the patient or legally authorized patient representative to release the information, except in specific situations where required by law.

When requested, and appropriately authorized, the party requesting the patient record, or part thereof, must be provided with a copy of the documents as the integrity of the original record must be maintained. Original documentation or items are not released. It must be recorded in the patient record that a copy has been made, the authorization of the requesting party and the date and time that the request was made and executed. These situations include:

1. the patient requests that their record be transferred to another practitioner
    a. upon receipt of written consent from the patient, the denturist must provide a copy of the record, in its entirety, to the new practitioner.
    b. The denturist may choose to provide this service for a reasonable fee but must not delay the execution of the transfer because of patient of nonpayment. This payment becomes a secondary matter.
2. the patient requests a copy of their own record
    a. the denturist must provide a copy of the record, in its entirety, to the patient.
    b. The denturist may choose to provide this service for a reasonable fee but must not delay the execution of the transfer because of patient of nonpayment. This payment becomes a secondary matter.
    c. it is prudent to allow the patient to review their record while the denturist or knowledgeable staff member is in attendance. Through this, terminology, symbols and/or abbreviations contained within the record can be interpreted and explained.
3. The patient's representative requests a copy of the patient's record
    a. Access to a dependent adult patient or minor's record must be requested in writing and signed by the legally authorized patient representative.
    b. The denturist then must release a copy of the record to the legally authorized patient representative.
    c. The denturist may choose to provide this service for a reasonable fee but must not delay the execution of the transfer because of patient of nonpayment. This payment becomes a secondary matter.
4. the College requests a copy of a patient record with due cause.
    a. the denturist must provide a copy of the record, in its entirety, to the College.
    b. the denturist does not require patient consent to do so
5. request regarding a forensic matter
    a. A denturist may receive a request for an antemortem patient record to aid in identifying a deceased individual
    b. The denturist must provide the record in its entirety, or requested part of, to the forensic investigator following the provision of their formal authority to access the patient record. Where any doubt exists, the denturist is advised to consult legal counsel.

In a situation where the denturist has a prolonged absence from practice (i.e., illness, retirement, death), the denturist must have appropriate measures in place that allow for the patient to access their patient record.

Record Disposal

If the patient record information is no longer required and the retention period has expired, the record may be disposed of in a manner that will ensure that confidentiality is safeguarded. The record custodian must authorize the disposal of any records.

Suitable methods for disposal include:

- Confidential return of the record to the individual patient.
- Physical destruction such as shredding or incineration in a controlled process whereby any residual material does not contain any readable personal information.
- Rendering the personal information into a form which can no longer be identifiable.

It is required that a record of which files have been disposed of, and the date and the method of their disposal, be maintained at the clinic from which they were disposed.

Any electronic devices that have stored patient records must not be sold or given away by the denturist.

GLOSSARY

Client	Refer to College Standards of Practice for definition
College	College of Alberta Denturists
Direct patient care	When a patient is physically present in the denturist's office, or when a denturist attends to a patient in an out-of-office location
Evidence informed decision making	the process of distilling and disseminating the best available evidence from research, practice and experience and using that evidence to inform and improve public health policy and practice[7]
Indirect patient care	When a patient is not physically present (such as when another individual provides a patient's denture for repair)
Patient	Also refers to client – refer to College Standards of Practice for definition
Patient chart	a collection of patient specific information and items pertaining to an individual, including but not limited to: All written or electronic information, notes, records, consents, documents, referrals, laboratory prescriptions, photographs, and/or test results relating to a patient's treatment; and All written or electronic information, notes, records, or documents regarding the financial, insurance, and/or business matters relating to a patient and his/her treatment; and All radiographs.
Patient record	includes: The patient chart; and Other pertinent patient information such as diagnostic model(s), impression(s), and their appointment schedule.
Staff	Any individual employed by the regulated member or other practitioner

[7] Public Health Agency of Canada: Evidence-Informed Decision-Making: Information and Tools.

REFERENCES

Standards of Practice: Patient Records. (2015). Alberta Dental Association & College. Edmonton: Author. Available at: https://www.cdsab.ca/wp-content/uploads/2019/01/Standard-of-Practice-Patient-Records.pdf.