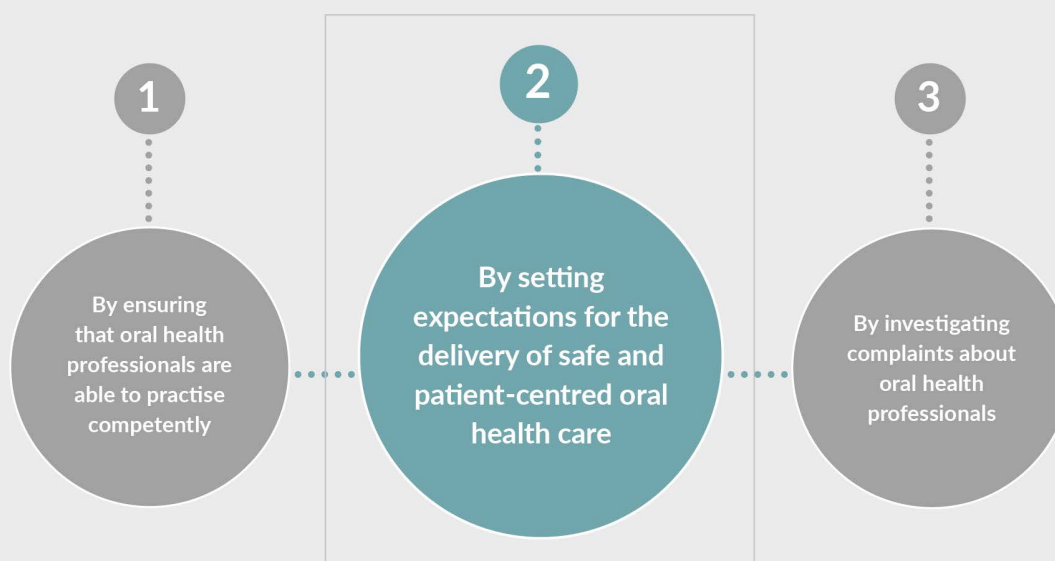


Expectations for clinical and ethical practice

Dental Recordkeeping Guidelines

Applies to Dentists, Dental Therapists &
Certified Dental Assistants

There are three main ways that the BC College of Oral Health Professionals protects the public:



Disclaimer: This document was developed by the former College of Dental Surgeons of BC before the amalgamation of BC's four oral health regulatory colleges in 2022 and the introduction of BCCOHP's *Professional Standards for the Oral Health Team* (Professional Standards), effective June 30, 2025. The Professional Standards define the minimum expectations for professional and ethical conduct, performance, and behaviour for regulated oral health professionals in BC.

While BCCOHP is in the process of rescinding and replacing all legacy practice resources with unified standards, this document remains applicable.

Dental Recordkeeping Guidelines

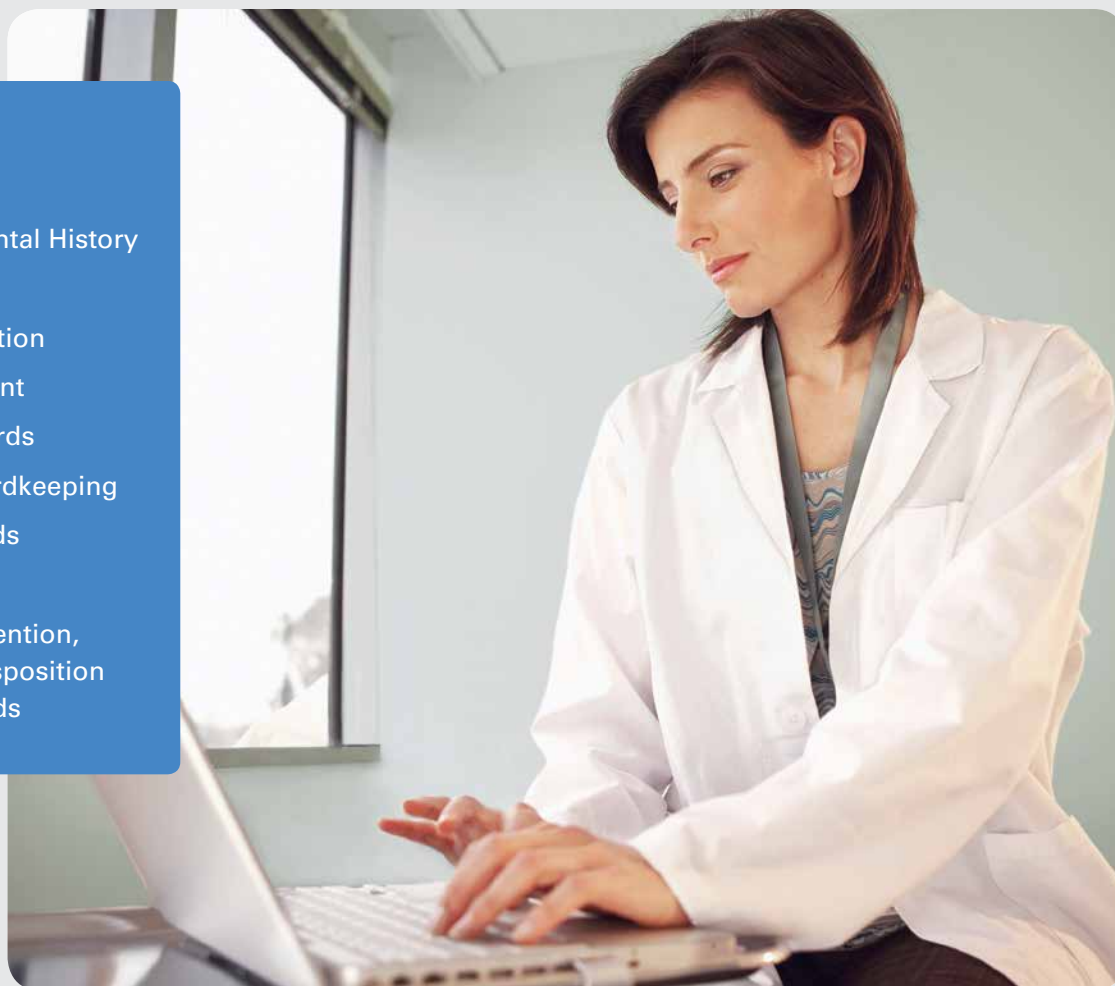
April 2013

Practice Guidelines of the College of Dental Surgeons of BC (CDSBC) should be considered by all B.C. dentists and certified dental assistants in the care of their patients. It is the responsibility of all practitioners to maintain accurate patient records as recommended in this document.

It is important to note that these Guidelines may be used by CDSBC or other bodies in determining whether professional responsibilities and appropriate standards of practice have been maintained.

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Introduction



Professional, ethical and legal responsibilities dictate that a complete chart and record documenting all aspects of each patient's dental care must be maintained. Good records facilitate the provision of effective clinical care and ensure the continuity and comprehensiveness of oral/dental health services.

Patient records must be accurate, well-organized, legible, readily accessible and understandable. If the practitioner of record were for any reason to become unable to practise, another dentist should be able to easily review the chart and carry on with the care of the patient.

These Guidelines are designed to provide assistance to practitioners and comfort to the public that dental patient information is both accurate and confidential.

Risk Management

In recent years, the requirements for dental records 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

These Guidelines are designed to help practitioners meet legal requirements for dental recordkeeping. They also have application in several areas of responsibility of the CDSBC regarding standards of practice and quality assurance. The statutory committees of CDSBC that consider allegations

of professional misconduct – the Inquiry and Discipline Committees – may use this document as a reference when considering a particular case.

It is important, therefore, that dentists and CDAs carefully read this document and take the necessary action to ensure that their dental recordkeeping complies with the recommendations contained in these Guidelines. Once a practitioner 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.

It is the CDSBC's opinion that practice guidelines should be sufficiently flexible to allow practitioners to exercise their judgment with respect to particular situations. Accordingly, the terms "appropriate" and "pertinent" have been used throughout these Guidelines to indicate where professional judgment is expected.

Purposes of Records

A dental record should provide an accurate picture of the patient's general health, as well as oral/dental status and any patient concerns and requests. It should include the proposed treatment plan and any treatment performed, as well as all supporting documentation. Outcome of treatment should be documented and any deviations from expected outcomes should be recorded on the patient chart at the 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.

Basic Assumptions

- Patients have a right to expect that their dental 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 practitioners.

- It is appropriate, where patient consent has been obtained, to share dental and medical records with other health professionals as necessary to ensure continuity and quality of care.
- Every dental team member involved in a patient's care should 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 should only be disposed of in a manner that ensures that the confidentiality of the information is maintained.

Essentials of Recordkeeping

The extent of detail required for each record will vary, however, certain baseline data should be common to all dental patients.

This information includes:

- accurate general patient information;
- a medical history that is periodically updated;
- a dental history;
- an accurate description of the conditions that are present on initial examination, including an entry such as "within normal limits" 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, study models, reports from specialists;
- all clinical diagnoses and treatment options;
- a record that all reasonable treatment planning options were discussed with the patient;
- the proposed and accepted treatment plan;
- a notation 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; and
- an accurate financial record.

General Recordkeeping Principles

In keeping and maintaining acceptable patient records, a prudent practitioner would 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 study models, should be properly labelled, dated and the interpretation of the findings documented when considered appropriate by the practitioner.
- 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 or government-appointed advocate as appropriate. This fact should be noted in the patient record. In complex or difficult cases, it is advisable to have such informed consent signed.

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, primary care physician, emergency contact name and number, and insurance information, if applicable.

Medical and Dental History



Medical History

A general medical history should be reviewed and initialled by the treating practitioner and dated at the initial examination. The information should be updated regularly based on the patient's age and history and the update noted in the patient record.

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, the following checklist may be helpful:

- 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;
- 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, leukemias;
- 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; and
- any other conditions or problems of which the clinician should be made aware.

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.

Some practitioners may choose to have the completed history signed by the patient or, in the case of a child, by the parent or legal guardian.

Updating the Medical History

Based on their age and history, appropriate questions for updating the patient's medical information could 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 new heart problem diagnosed or had any change in an existing heart problem?
- 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?

Dental History

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.

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.

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 for patient consent before the disclosure or transfer of any patient information or dental records to any third party, including to other family members.

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 (see page 13).

Privacy Compliance

Dentists need to be aware of the requirements of the *Personal Information Protection Act* of British Columbia (PIPA) and other laws dealing with privacy. Any discussion of the latter is beyond the scope of these Guidelines, which are confined to a brief summary of PIPA.

The purpose of PIPA is to govern the collection, use and disclosure of personal information by organizations, including dental offices. All dentists must comply with the requirements of PIPA regarding patient information and dental records, including the disclosure and transfer of patient information and dental records.

Under PIPA, a dentist must either assume the role of Privacy Officer or assign this role to an individual within the practice. Privacy Officers are required to:

- put in place information handling practices;
- prepare and make available a written public statement about the dental office's information handling practices;
- prepare a policy for their office, including a description of the purpose(s) for collecting personal information and how it will be used and disclosed;
- ensure that employees and all other agents are appropriately informed of their obligations under PIPA;
- take reasonable steps to ensure personal information in the practice's custody or control is protected against theft, loss, unauthorized use, disclosure, copying, modification, and disposal (this includes ensuring proper security for any off-site work with patient information or dental records, or remote access to such information or records);
- ensure that patient information and dental records in the dentist's custody or control are retained, transferred, and disposed of in a secure manner and in accordance with PIPA; and
- ensure that patient inquiries regarding the handling of their personal information or access requests under PIPA are answered promptly and appropriately.

The foregoing brief summary is not and cannot be considered to be definitive legal advice, and in all cases, dentists should consult with their own legal counsel.

Dentists may wish to review the full text of PIPA. An unofficial copy is available at www.bclaws.ca (ensure that the version of PIPA reviewed is current). Some further information about compliance with PIPA is at oipc.bc.ca/resources/guidance-documents/.

Patient consent, preferably in writing and signed by the patient, should be obtained for the disclosure of any patient information or dental records to, or the obtaining of any patient information or dental records from, another dentist, the patient's physician, or an authorized representative. There may be situations where verbal consent may be acceptable, provided such consent is documented in the patient's chart; appropriate professional judgment about what form patient consent should take is, of course, required in each case.

- **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 Evaluation** – Where appropriate.

As part of a complete oral examination, it is important to 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” for most of the areas.

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**

While the choice of patient record or chart form is left to the individual practitioner, it is important that there is sufficient space to record all relevant information 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 updates as necessary.

Changes in clinical findings noted at subsequent re-examination or emergency appointments should be recorded in writing in the patient record or noted on a separate odontogram.

Radiographs and Dental Records

Radiographs are an important part of the patient record. They should be clearly labelled with the patient's and the dentist's name, dated and be of acceptable diagnostic quality. All radiographs taken in a dental office should be noted, including any retakes or problems encountered.

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 and dental history 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.

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 also be reviewed and documented regularly.

It is recommended that a statement regarding caries risk and the periodontal status of the patient based on the history and examination 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 study models and/or the results of any tests or consultations, should be noted in the patient record. Where possible, all diagnoses should be stated specifically. It should also be recorded that this information was communicated to the patient.

The **treatment plan** should list the recommended services to be performed for the patient and should 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. Some indication should also be provided as to:

- 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;
- 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 extended or complex treatment plans.

For extended or complex treatment, 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.

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 express. 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 is required that 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.

Guidelines for Obtaining Consent

The standard for obtaining informed consent used to be what a reasonable prudent practitioner 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.

In order for consent to be informed, the dentist must provide the patient with certain information: the diagnosis or problem noted, the treatment alternatives available (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, 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.

Regardless of whether the patient consents in writing or orally, the dentist should keep a record of the nature of the conversation, the information provided and the patient's decision.

Other Significant Consent Information

- There is no age of consent in B.C. If the dentist is of the opinion that a patient is capable of providing his or her own consent to treatment, then the dentist can rely on that consent. Consent for payment of the treatment may be a separate issue.
- 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.

- Consent is not required in emergency situations defined under the *B.C. Health Care (Consent) and Care Facility (Admission) Act*, where a health care provider may provide health care to an adult without the adult's consent if:

- (a) it is necessary to provide the health care without delay in order to preserve the adult's life, to prevent serious physical or mental harm or to alleviate severe pain;
- (b) the adult is apparently impaired by drugs or alcohol or is unconscious or semi-conscious for any reason or is, in the health care provider's opinion, otherwise incapable of giving or refusing consent;
- (c) the adult does not have a substitute decision maker, guardian or representative who is authorized to consent to the health care, is capable of doing so and is available; and
- (d) 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.

complete and comprehensive description of the patient's ongoing care. 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;
- 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, outcomes, prognoses and follow-up requirements.

Treatment Records



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), and provide a

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.

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.

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.
- 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.

Referral Documentation

Notations of referral to a specialist, as well as copies of any reports/correspondence to and from specialists should 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 should be noted, detailing the dates of service and 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.

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.

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.

Electronic Recordkeeping



The use of electronic recordkeeping by dentists, including digital radiography, has grown substantially in B.C., 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.

It is important to note that electronic records must comply with all requirements of traditional paper records as outlined in other areas of these Guidelines.

Electronic Recordkeeping System Requirements

Dentists may make and keep electronic records provided certain guidelines are adhered to. Practitioners 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.

Note that diagnostic or study models are considered part of the patient record and must be retained in their original analog or digital form; photographs are not acceptable.

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 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 for the preceding two years.

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, practitioners 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 practitioner is unable to provide covered services, including the obligations to make further payments and the application of payments that were previously made.

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, WorkSafeBC, ICBC, Ministry of Housing and Social Development).

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. Practitioners should be aware of provincial and federal legislation governing business records such as the *Income Tax Act*.

Dentists must take adequate steps to protect narcotics and controlled drugs in their possession from loss or theft. It is recommended that narcotics and controlled drugs 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 place used for the purpose of conducting their professional practice and in an area in that place 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. The register should also be kept in a secure area in the office, preferably with the drugs.

- Whenever drugs in the above-mentioned classes are used or dispensed, a record containing the name of the drug, number 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.
- Duplicate 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.

Drug Records



The following information or a copy of the prescription must be included in the patient record:

- date and method
- name, strength, quantity and form of drug
- directions for use of drug (except administration)
- condition being treated and/or dental treatment provided

Ownership, Retention, Transfer and Disposition of Dental Records



Ownership of Records

Under common law, and in the absence of an agreement to the contrary, the 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.

Retention of Records

The *Limitation Act* sets the time limits people have to sue one another in civil court. This has implications for the length of time dentists must retain patient records. A new *Limitation Act* was introduced in British Columbia, effective June 1, 2013.

General Guidelines

Dentists must now maintain complete patient records as follows:

- Records for which the most recent entry was created on or after June 1, 2013 must be kept for 16 years from the date of last entry.
- Records for which the most recent entry was created before June 1, 2013, must be kept for 31 years (the ULP under the former *Limitation Act*, plus one year for service) from the date of last entry or until June 1, 2029 (whichever comes first).

In addition to clinical records, other records that must be retained include appointment records, lab prescriptions and invoices. Diagnostic or study models are also considered part of the permanent patient record and must be kept for the prescribed period.

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

Exceptions

The above guidelines do not apply to minors and persons under a disability. In these cases, the limitation periods do not begin running until the person turns 19 or until the disability ends.

- **Minors**

Records relating to minors must be retained for 16 years after the day the minor reaches the age of 19.

- **Persons Under Disability**

The *Limitation Act* defines a “person under a disability” as someone who is incapable of or substantially impeded in managing their affairs. Records relating to persons under disability must be kept for 16 years after receiving formal notice that the person’s disability has ended.

In many cases, formal notice will not be provided and it will be difficult or impossible to know if or when the disability has ended. In those cases, records must be kept indefinitely.

This information is provided only as a general guide, and should not be taken as legal advice. There are additional exceptions in cases involving fraud, concealment, acknowledgement, and where a notice to proceed has been delivered. Dentists who have specific questions about the *Limitation Act* should review the legislation and consult a lawyer.

The new *Limitation Act* deals with records for which the most recent entry was made on or after June 1, 2013. Transition rules apply to records for which the most recent entry was made before that date.

For most claims involving dental treatment, a person generally has two years from the time they ought reasonably to have discovered the harm to file a lawsuit. This is known as the basic limitation period (BLP).

Since some harm isn't discovered immediately, the *Limitation Act* also has an ultimate limitation period (ULP). The new Act has reduced the ULP from 30 to 15 years. This means that, subject to some exceptions, a lawsuit can't be filed more than 15 years after the harm was caused, regardless of when it was discovered.

Once harm is discovered, a claimant has two years (the BLP) to file a lawsuit, provided that not more than 15 years (the ULP) has passed since the harm was actually caused.

In summary, a lawsuit can potentially be filed as long as 15 years after a dentist has completed treatment. Once filed, a claimant has an additional year to serve the lawsuit, so a dentist may not have notice of the lawsuit for up to 16 years.

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, study 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 practitioner. If the new dentist requests records electronically, they may be provided in that format.

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.

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. 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.

For more information and resources about dental recordkeeping, including sample charts and patient questionnaires, visit www.cdsbc.org.



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Regulating dentists and certified dental assistants in the public interest

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This document has been reprinted with permission based on the **Dental Recordkeeping Guidelines** published by the Royal College of Dental Surgeons of Ontario. Some modifications have been made to the original text to reflect requirements in British Columbia.