College of Dental Hygienists of Manitoba's Practice Guideline: Record Keeping

This practice guideline is to inform registrants of the College of Dental Hygienists of Manitoba (CDHM) about the current regulations for record keeping. It is the professional responsibility of the registered dental hygienist to maintain complete and accurate client records as recommended in this document.

Overview

As healthcare professionals, registered dental hygienists of Manitoba have a professional, legal, and ethical obligation to ensure they establish and maintain complete and accurate client records that document all aspects of the dental hygiene process of care. Systematic and thorough record keeping supports the provision of effective and comprehensive clinical care, continuity of care, and collaborative practice. Therefore, diligent record keeping facilitates the provision of safe, quality, client-focused oral health care and education.

From a legal perspective, comprehensive assessment findings, dental hygiene interventions, services, recommendations and referrals must be documented, or there is no evidence to support their occurrence. Without proper documentation, it is almost impossible to defend yourself, the care you provided, and the rationale for your clinical decisions.

Appropriate client records demonstrate professional accountability and compliance with the *CDHM Practice Standards and Competencies.*

Fundamental Elements of Record Keeping

Client records must be accurate, well-organized, legible, understandable, and readily accessible.

Client records must also contain precise and factual accounts of all interactions and discussions between registered dental hygienists and their clients.

In the instances where care may need to be provided by a different health care professional, a good client record allows for easy review and understanding of information for continuity of the client's comprehensive care.

Dental Hygiene Process of Care

The Dental Hygiene Process of Care is utilized to assess, plan, implement and evaluate policies, processes, interventions and outcomes of the client's oral/overall health. The

utilization of each step must be documented as it pertains to the dental hygiene process of care. This is essential for the safe and effective delivery of dental hygiene care.

Best practice is to document the care in the order that it is provided. Proper record keeping should include (when applicable) the following information:

- Appointment date
- Past and current medical conditions
    - date of last physician appointment
- Current medications
- Adverse reactions/allergies
- Client's last dental examination
- Client's chief concern
- Client's oral health behaviours
    - tobacco habits
- Dental hygiene assessment findings
    - extra and intra-oral examination
        - oral cancer screening
    - periodontal examination and interpretation
    - hard tissue examination
    - radiographs: name of dentist who prescribed, what type, how many, what area taken and interpretation
    - caries risk profile
    - contributing habits or conditions
- Detailed explanation of all the client-centred dental hygiene planned interventions and services
- Well-defined discussions, suggestions, and recommendations
- Specific notes and signature(s) regarding informed consent or refusal
- Detailed explanation of all the client-centred dental hygiene interventions and services that were provided and completed, including products used
- Information detailing medical consults and/or referrals
- Total time spent with client
- Signature or initials by dental hygiene provider

Fundamental Principles of Record Keeping

To achieve best practice standards, the following principles are to be followed:

- All entries completed by hand must be legible with permanent ink (no pencil)
- All entries, by hand and by electronic means, should be signed or initialed by the dental hygiene provider

- Changes or deletions are to be made using a single line stroke through the entry to be modified
    - to preserve the integrity of the record, the altered entry is not to be covered with correcting products
    - any changes must be initialed.
- Corrections or modifications to entries must only be made by the provider of service
- Client name or chart number is to be designated on all documentation pages
- Abbreviations may be used, however, a legend with defined language must be recorded and present on-site

Informed Consent

The process of informed consent is the client's acceptance of care following a discussion with the dental hygienist regarding the proposed dental hygiene care plan and risks of not receiving care. Informed consent should not be viewed as a one-time only activity but as an ongoing process in which the client is informed continuously and reminded of the terms of care. For informed consent to be achieved, the client must be knowledgeable about what the dental hygienist plans to do. The client must have enough information to make a rational choice, and give permission for the plan to be carried out. The consent cannot be obtained through fraud, deceit, or misrepresentation.

Although implied consent is given when a client voluntarily comes to the oral care setting and sits in the dental chair, this consent applies only to the assessment and planning components of the dental hygiene process of care. The dental hygienist cannot assume that the client consents to any further care.

Once verbal consent is obtained, it must be documented in the client's permanent health record. If written consent is obtained, it should be signed by both parties and kept in the client’s permanent file. Consent must be obtained before implementing the dental hygiene care plan.

Alterations to the treatment plan may become necessary as treatment progresses. Any alterations should be clearly documented along with a notation that the changes were discussed and accepted or declined by the client.

Informed Refusal

After the dental hygienist has provided the client with all the information necessary regarding the proposed dental hygiene care plan and the risks of not receiving care, the possibility exists that the client may decline all or part of the proposed dental hygiene

care plan. Client refusal must be analyzed to determine how or why the client arrived at that decision. The dental hygienist should engage the client in conversation, listen and evaluate the client's reasons for declining the services.

If, after this discussion, the client makes an informed refusal, it must be documented in the client's permanent health record. Similar to informed consent, it is always best to have the client sign a declaration of informed refusal.

Confidentiality and Privacy Compliance

Client information and records contain sensitive personal information and must be kept in confidence. The healthcare provider has a professional duty to protect the privacy of individuals. A client's personal information and record must be protected from any unauthorized use or disclosure, except as required by law or where the client has given their express consent, ideally in writing.

Manitoba dental hygienists need to be aware of the requirements of the *Personal Health Information Act* (PHIA). PHIA came into force on December 11, 1997 and governs the collection, use, disclosure, retention, disposal and destruction of personal health information.

The PHIA recognizes both the right of individuals to protect their personal health information and the need of health information trustees to collect, use, and disclose personal health information to provide, support, and manage health care.

The Personal Health Information Act (PHIA).

http://web2.gov.mb.ca/laws/statutes/ccsm/p033-5e.php

CDHM Competencies and Practice Standards

According to the *CDHM Practice Standards*, registrants of the CDHM will:

- recognize client rights and the inherent dignity of the client by obtaining informed client consent, respecting privacy, and maintaining confidentiality[1]
- maintain documentation and records consistent with regulatory requirements[2]
- locate, review, and update previous information[3]
- collect baseline information using appropriate methodology[4]
- record assessment finings and interpretations[5]
- maintain records and data in a secure information management system[6]

According to the *CDHM Competencies*, registrants of the CDHM have the ability to:

- document all records accurately, legibly, comprehensively, and in compliance with privacy legislation throughout the dental hygiene process of care (i.e. during assessment and diagnosis, planning, implementation, and evaluation)[7]
- record the dental hygiene care plan (e.g. in writing, electronically, etc.)[8]

This practice guideline reflects current knowledge and is subject to periodic review and revisions with on-going research.

References

1. CDHM Practice Standards (Professional Responsibilities) 1.7 page 4.
2. CDHM Practice Standards (Professional Responsibilities) 1.12 page 4.
3. CDHM Practice Standards (Dental Hygiene Process: Assessment) 2.1 page 4.
4. CDHM Practice Standards (Dental Hygiene Process: Assessment) 2.2 page 4.
5. CDHM Practice Standards (Dental Hygiene Process: Assessment) 2.6 page 4.
6. CDHM Practice Standards (Dental Hygiene Process: Assessment) 2.7 page 4.
7. CDHM Dental Hygiene Competencies, (Assessment) #58, page 7.
8. CDHM Dental Hygiene Competencies, (Planning) #17, page 8

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Bibliography available upon request.