COLLEGE OF DENTAL HYGIENISTS OF MANITOBA

PRACTICE DIRECTION:
Record Keeping

September 2021

The College of Dental Hygienists of Manitoba, Professional Practice Committee is responsible for developing professional resource documents for dental hygienists. Council approves these documents, of which, the purpose is to explain, enhance, add, or guide dental hygiene practice in accordance with The Dental Hygienists Act and Regulations. It is the responsibility of the dental hygienist to understand and comply with these documents.

College of Dental Hygienists of Manitoba Practice Direction for Record Keeping

Purpose

This practice direction 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 outlined in this document.

Background

- 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.
- Documentation of comprehensive assessment findings, dental hygiene interventions, services, recommendations, and referrals, is evidence of, and rationale for the clinical decisions and care provided.
- Appropriate client records demonstrate professional accountability and compliance with the CDHM Practice Standards and Competencies.

Requirements

Fundamental Elements of Record Keeping

- Client records must be accurate, well-organized, legible, understandable, and readily accessible.
- Client records must contain precise and factual accounts of all interactions and discussions between registered dental hygienists and their clients.
- Complete and accurate client records allow other health care professionals to easily review and understand information, enabling continuity of client care.

Dental Hygiene Process of Care

- The Dental Hygiene Process of Care – Assess, Plan, Implement, Evaluate – is a systematic cyclical process and each step must be documented in the order that it is provided.
- Complete and accurate record keeping should include (when applicable) the following information:
    - Appointment date
    - Past and current medical conditions
        - date of last physician appointment
        - current vital signs

- Current medications
- Adverse reactions/allergies
- Client's last dental examination
- Client's chief concern
- Client's oral health behaviours
- Dental hygiene assessment findings
    - extra and intra-oral examination
        - oral cancer screening
    - periodontal examination and interpretation
    - hard tissue examination
    - radiographs: name of prescribing dentist, type of radiograph(s) and quantity, area taken, and interpretation
    - caries risk profile
    - contributing habits or conditions
        - Including smoking, vaping and tobacco use
- Detailed explanation of all the client-centred dental hygiene planned interventions and services, including oral anesthetic, and products used.
- Well-defined discussions, suggestions, and recommendations
- Specific notes and signature(s) regarding informed consent or refusal
- Information detailing medical consults and/or referrals
- Total time spent with client
- Signature or initials by dental hygiene provider

Fundamental Principles of Record Keeping

- All handwritten entries must be legible with permanent ink.
- All handwritten and electronic entries should be signed or initialed by the dental hygiene provider
- Corrections or modifications to entries must only be made by the provider of the service.
- Handwritten changes or deletions are to be made using a single line stroke through the entry to be modified, and all changes must be initialed by the provider.
    - To preserve the integrity of the record, avoid using correcting products.
- Handwritten amendments are added as a clear late entry.
- Changes or amendments to electronic records are added as a clear late entry.
- 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
- Registrants must never alter a client record after a complaint or legal action has been initiated, unless a clinical fact is missing, and a clear late entry is made to the record.

Informed Consent

- The process of informed consent is the client's acceptance of planned interventions following a discussion with the dental hygienist regarding the assessment findings 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 proposed treatment, including time estimate, material effects, and costs
    - Significant risks and side effects of the proposed treatment
    - Alternative treatments
    - The consequences of not having the treatment
- The client must have enough information to make a rational choice and give permission for the plan to be carried out.
- Informed 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

- Once 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 client may decide to decline all or part of the proposed dental hygiene care plan.
- Where appropriate, the dental hygienist will engage the client in conversation, listen and evaluate the client's reasons for declining the services, and if the client makes an informed refusal, it must be documented in the client's permanent health record.
- Like informed consent, it is always best to have the client sign a declaration of informed refusal.

Applicable Legislation

According to the Manitoba Personal Health Information Act[1] (PHIA):

- 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 must recognize and abide by the authority of PHIA to govern 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.

According to the CDHM Competencies[2], 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) (Assessment #58)
- communicates the plans of services/programs to relevant others in accordance with privacy guidelines (e.g., health care providers, client's agent or family, administrative staff, etc.) (Planning #15)
- obtains informed consent for the dental hygiene care plan from the client and/or agent (e.g., therapy, pharmacotherapeutic agents, anaesthetics, etc.) (Planning #16)
- record the dental hygiene care plan (e.g., in writing, electronically, etc.) (Planning #17)
- reviews past documentation to ensure accuracy, legibility, comprehensiveness, and compliance with privacy legislation (Evaluation #14)

According to the CDHM Practice Standards[3], dental hygienists:

- 1.7 Recognize client rights and the inherent dignity of the client by obtaining informed client consent, respecting privacy, and maintaining confidentiality
- 1.12 Maintain documentation and records consistent with regulatory requirements
- 2.1 Locate, review, and update previous information
- 2.2 Collect baseline information using appropriate methodology
- 2.6 Record assessment finings and interpretation
- 2.7 Maintain records and data in a secure information management system

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

References

1. Manitoba Personal Health Information Act (1997). [online]. Available at: <https://web2.gov.mb.ca/laws/statutes/ccsm/p033-5e.php > [Accessed 24 April 2021].
2. College of Dental Hygienists of Manitoba (2007). Dental Hygiene Competencies. [online]. Available at: <https://cdhm.info/practice-resources/> [Accessed 24 April 2021].
3. College of Dental Hygienists of Manitoba (2007). Dental Hygiene Practice Standards. [online]. Available at: <https://cdhm.info/practice-resources/> [Accessed 24 April 2021].

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