Patient Information and Records Practice Standard

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Dental Council
Te Kaunihera Tiaki Niho

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1. Introduction

1.1 The patient's treatment record is legally regarded as "health information" and is an integral part of the provision of dental care. A record of each encounter with a patient will improve diagnosis and treatment planning and will also assist with efficient, safe and complete delivery of care considering the often chronic nature of dental disease. The treatment record will also assist another clinician in assuming that patient's care.

1.2 The treatment record may also form the basis of self protection in the event of a dispute associated with any treatment provided and it may also form the basis for some types of self monitoring or audit systems used in quality review systems.

1.3 Additionally, the treatment record may assist in patient identification or other aspects of forensic dentistry.

1.4 The management of all personal information in New Zealand is covered by the Privacy Act 1993. Where the information concerns a patient's health, the Health Information Privacy Code 1994, a special code of practice issued under the Privacy Act, applies. The Health Information Privacy Code 1994 ("HIPC") carries the same force of law as the Privacy Act. It provides rules for all oral health professionals whether they are in their own practice, or working as associates or as employees, on the handling of health information relating to identifiable patients.

1.5 The HIPC defines "health information" in relation to an identifiable individual as:

(a) Information about the health of that individual, including that individual's medical history.

(b) Information about any disabilities that individual has, or has had.

(c) Information about any services that are being provided, or have been provided, to that individual.

(d) Information provided by that individual in connection with the donation, by that individual, of any body part, or any bodily substance, of that individual.

(e) Information about that individual which is collected prior to or in the course of, and incidental to, the provision of any health or disability service to that individual.

1.6 This **Patient Information and Records Practice Standard** is a review of the rules of the HIPC and an explanation of how these rules specifically relate to oral health professionals. It is not intended as a substitute for the HIPC. Where this practice standard is inconsistent with the HIPC, the HIPC prevails. The HIPC is available at the web site of the Office of the Privacy Commissioner (*www.privacy.org.nz*). The Office of the Privacy Commissioner will also provide on request a copy of the HIPC with a commentary for assisting in interpretation.

1.7 Part 2 of this practice standard sets out the nature of health information and the treatment record. Part 3 sets out and reviews the specific Rules from the Health Information Privacy Code 1994. Part 4 provides a checklist to assess compliance with this practice standard.

2. Health information and the treatment record

2.1 There are many features which make health information a unique and special form of information. Most health information is collected in a situation of confidence and trust in the context of a health professional/patient relationship, and therefore must be regarded as highly confidential.

2.2 Some health information is also highly sensitive and can include details about an individual's body, lifestyle and practices which are particularly intimate or which could, if improperly disclosed, be misused. Health information may also be required long after it

has ceased to be needed for the original purpose, and accordingly a minimum period for retention of the record is an important consideration.

2.3 In the dental setting, health information is generally maintained in the patient's treatment record. The patient's treatment record is: *An account in any permanent form collected methodically and preserving information of oral health and any associated financial transactions that serve as legal evidence of that information.*

2.4 The patient's treatment record therefore encompasses two parts:

- those parts relating to the service or treatment provided, and
- those relating to any associated financial transactions.

2.5 The patient's treatment record includes (but is not limited to):

- Clinical notes including any charting that has been made
- Completed medical history questionnaires
- Documents relating to informed consent
- Copies of any correspondence with or relating to a patient
- Radiographs and/or any tracings or measurements relating to these
- Study models and other models used in the construction of orofacial prostheses
- Any special tests including histopathology and/or microbiology reports, blood screens, saliva testing, CAT or MRI scans and reports from any other radiological investigation
- Digital information relating to computer assisted restoration design processes
- Clinical photographs or digital images
- Records of any financial transactions.

2.6 The patient's treatment record must contain a record of **any and all treatment or service** provided within an oral health practice, whether it has been provided by an oral health professional or any other health practitioner or employee of the practice.

2.7 This record **must** include:

(a) The patient's full name, gender, date of birth, and address, and telephone number(s) including daytime contact numbers of family members, eg parent/guardian or representative

(b) If the patient is under 16 years of age, or does not otherwise have legal capacity, the name and address of the patient's representative (see Rule 2 part (b) of this practice standard for the definition of representative in this context)

(c) A concise and relevant signed medical history which is updated at appropriate intervals

(d) The date of any visit and also of any appointment made for which the patient has failed to attend

(e) Reason for the attendance

(f) Detail of any presenting complaint, relevant history, clinical findings, diagnosis, treatment options given, and final treatment plan agreed upon

(g) A concise description of any and all treatment or services provided

(h) Any medicines prescribed or dispensed including the quantity, dose and instructions.

2.8 The record **should**, in the interests of best practice, also include:

(i) A description of any procedure, including any materials used, variation from any standard or usual technique, and any general comments on the procedure undertaken. The detail of the description should reflect the complexity of the treatment or the seriousness of the potential outcomes.

(j) Any treatment recommended by the oral health practitioner that the patient has declined

(k) Consents obtained for treatment

(l) Advice given to the patient on any pre- and post-operative instructions and any likely treatment outcomes and/or complications

(m) Unusual responses to treatment reported by the patient

(n) Estimates or quotes for any fees involved

(o) Relevant comments by patients on concerns regarding treatment offered

(p) Any complaints made regarding treatment provided.

2.9 Entries into the treatment record are the responsibility of the oral health professional providing the treatment and should be identifiable to that clinician if more than one clinician is involved in the practice or providing for that patient's care. All entries must be indelible.

2.10 Written records must be legible and any abbreviations used should be standard. They must be readily understood by any third parties who access these records. The information held regarding individual patients must be accurate, up-to-date, complete, relevant and not misleading. Information which is subject to change over time (eg, address or telephone numbers) should be checked for accuracy and updated at appropriate intervals. Oral health professionals should keep a list of standard abbreviations and their meanings for use by others who may access these records.

2.11 Oral health professionals or associated staff **must not** alter or delete information recorded at an earlier date.

2.12 The principles applying to records extend to computerized records. They should be of the same standard and identifiable to a specific clinician. Computer records must be time-logged so that alterations made to them at a later date cannot be hidden. If codes are used, this information must be readily converted to plain language which can easily be understood by an outside observer.

2.13 In addition to the Privacy Act 1993, some other laws are applicable to the management of the patient's treatment record. These will be identified where appropriate under the review of the individual rules of the Health Information Privacy Code.

3. Interpreting the Rules of the Health Information Privacy Code 1994

This section is a "plain language" interpretation of the rules of the HIPC, adapted to the dental setting. Where any clarification is required, the reader should consult the HIPC and/or the associated commentary (go to *www.privacy.org.nz*).

Rule 1 Purpose of Collection of Health Information

(a) Health information about an individual **must** be collected for the purpose of the care and treatment of that patient or to assist in the administrative aspects of care giving or treatment. Health information **must** not be collected for any other purpose. An oral health professional may be asked to justify the collection of certain items of information.

Rule 2 Source of Health Information

(a) When health information is collected it should be collected directly from the individual concerned. The exceptions are:

(i) in situations where the individual authorises collection from someone else

(ii) where the collection from the individual prejudices their own interests, for example a patient with a severe mental disability

(iii) where collection is not reasonably practicable, for example when the individual is unconscious.

In these situations the person from whom the information is collected is known as their "representative".

(b) The Health Information Privacy Code defines a representative as:

- Where that individual is dead - that individual's personal representative
- Where the individual is under the age of 16 years - that individual's parent or guardian
- Where the individual, not being an individual referred to above, is unable to give his or her consent or authority, or exercise his or her rights – a person lawfully acting on the individual's behalf or in his or her interests.

(c) The oral health professional should take due care to ascertain whether someone claiming to be an individual's representative has legal authority to do so. If health information has been obtained from someone other than the individual concerned it is appropriate to record the source of such information.

Rule 3 Collection of Health Information

(a) When health information is being collected from an individual or their representative the oral health professional should take reasonable measures to ensure that those involved are aware that the information is being collected, its purpose and the consequences if all or part of the requested information is not provided. Measures may include:

- a verbal explanation
- a notice on display
- explanatory notes on standard forms
- an explanatory brochure.

(b) In most cases the fact of collection, and the purpose, will be obvious from the context. The first time information is collected from a patient the oral health professional must provide a full explanation of the purpose of the collection. Explanation may not be necessary on subsequent occasions unless the information sought subsequently pertains to a different circumstance, treatment or purpose of collection.

(c) The patient has the right not to supply any requested information. The patient **must** be made aware of the consequences of not supplying information that has been requested; might include, for example:

- That a particular treatment cannot effectively be continued
- That a claim cannot be granted or processed.

(d) The patient or their representative should be made aware of their rights to access, and if necessary correct, collected information (see also Rule 6 and Rule 7).

Rule 4 Manner of Collection of Health Information

(a) Health information **must** be collected in a manner which is lawful, fair and which does not unduly intrude on an individual's personal affairs. This means that the oral health professional must not give a misleading impression of the purpose of collection or offer any inappropriate inducements or threats to obtain information. Health information must not be elicited by coercion.

Rule 5 Storage and Security of Health Information

(a) It is the responsibility of the oral health professional to ensure that they and all associated staff keep a patient's information confidential.

(b) Information that has been obtained for one purpose shall not be used for any other purpose unless the oral health professional considers that use for that other purpose has been properly authorized by the patient or their representative, or the information is used in a form in which the patient is not personally identified.

(c) The exception to this rule is where use of the information is necessary to prevent or lessen serious and imminent threat to public health or safety, or the life or health of the individual concerned or another individual.

(d) Accordingly, information should be disclosed only with the permission of the patient except when the law requires otherwise. Oral health professionals should ensure that:

- all staff are familiar with the grounds for disclosure of patient information; and that
- these grounds of disclosure should be in written form and available to patients.

(e) The oral health professional **must** ensure the adequate physical security of the patient's record when that record is in use and when in storage.

(f) For physical records this includes simple precautions such as locking filing cabinets and locking unattended rooms where records are stored, and ensuring that any recently-completed medical history questionnaires are not able to be viewed by unauthorized persons.

(g) For computerized records, control must be exercised over storage, availability and use. Computer monitors should be positioned so that they cannot be seen by unauthorized persons. Back-up discs and/or tapes should be stored remotely from the main computer system, preferably off-site, and they should be rotated within the back-up protocol daily.

(h) In respect of computer records, the oral health professional and/or staff should ensure that:

- an individual's records are not able to be viewed, copied or downloaded via the internet if the practice has a connection to the internet. This may involve the use of some form of computer firewall.
- if an internet connection is present the record should be protected from malicious damage or corruption by using antivirus software
- all electronic correspondence remains confidential
- the back-up system is reliable and regular.

(i) Any telephone conversations about the records, with the patient or their representative, or with a colleague, must be confidential.

Rule 6 Access to personal health information

(a) Patients, including children, have the right of access to their record and the information contained therein. An individual can make a request to access their records in writing or verbally. Parents or guardians may make requests on a child's behalf but only in the child's interest, not in their own interest.

(b) In practice very few patients seek access to their treatment record. Requests for access are usually in relation to a complaint. The oral health professional in maintaining the treatment record should always do so assuming that the record may be read by the individual concerned at a later date.

(c) When a request for access is made, the oral health professional **must**:

(i) be satisfied as to the identity of the individual making the request, and their legal right to access the record

(ii) ensure that the information sought is received only by that individual or their representative. This may involve having the individual or representative sign a receipt for the information

(iii) ensure that a patient's representative has current authority and is properly authorized to obtain the information.

(d) The information requested can be made available in a number of ways including the provision of:

- an original document for inspection
- a copy of a document
- an excerpt or written summary of a document
- a verbal account of the contents of a document.

(e) The information should be made available in the form that the individual has requested. However, access can be made available in a different form if the form requested would impair efficient administration, or be contrary to any legal duty of the oral health professional or prejudice the interests of sections 27, 28 and 29 of the Privacy Act 1993. When information is not supplied in the form requested, a reason **must** be given.

(f) If there is good reason for withholding some of the information in the record, a copy of the record may be made available with appropriate deletions and/or alterations. An example of such a situation is where the record contains information about another individual. When records are made available with deletions, reasons for withholding the information **must** be provided.

(g) In accordance with the requirements of the Privacy Act 1993, it is the duty of the oral health professional to give reasonable assistance to an individual making a request for access to their record.

(h) When a request is made, the oral health professional must decide in what form to release the information and to notify the individual concerned. Decisions must be made as soon as is reasonably practicable and no later than 20 working days after receipt of the request. In that time the oral health professional **must** decide whether the request is to be granted or not.

(i) Where the time limit is to be extended the individual concerned **must** be informed as to the period and reason for the extension, and that they have the right to make a complaint to the Privacy Commissioner about the extension.

(j) A request for access may be refused if:

(i) the information is not readily retrievable. This must not be on the grounds of administrative inconvenience. In refusing access on these grounds the oral health professional may need to demonstrate that reasonable endeavours have been made to retrieve the record.

(ii) the information does not exist or cannot be found. Before refusing a request on these grounds it is advisable to discuss with the requester exactly what information is being sought.

(k) A payment shall not be demanded for complying with requests for access to records and the information contained therein, except in the circumstance where an individual makes a request in respect of the same or substantially the same health information more than once within a period of twelve months. In this circumstance the oral health professional may make a reasonable charge for making the information available on the second or subsequent requests. Any charge shall be based on administrative time and printing, postage, and other actual costs and if this is to exceed the sum of $30 the oral health professional must provide the individual with an estimate of the charge before dealing with the request.

(l) In a health care organisation where there are associated oral health professionals practising, and in the absence of an agreement to the contrary, the principal owner of the practice is responsible for compliance with the Privacy Act.

(m) The oral health professional **must** not disclose any aspect of the patient's treatment record unless they are satisfied that the person making the request is the patient or the patient's representative, and that they have the authority to make such a request. The oral health professional should use due discretion as to whether it is appropriate under the circumstances for a patient's representative to receive the record.

Rule 7 Correction of Health Information

(a) An individual patient or their representative may request that information in their treatment record be corrected. If this request is denied, the record should contain a statement of the correction sought but not made. Reasons for refusing to correct information may include, but are not limited by, the following:

(i) the oral health professional believes that the original information is correct

(ii) the information is clearly identified as opinion material and represents correctly the opinion held at the time

(iii) the information is believed to be correct at the time it was made, circumstances have changed and there are no means of verifying correctness.

(b) In taking reasonable steps to correct patient records the oral health professional must be sure the information is accurate, up to date, complete and not misleading. When a change is made it should be identifiable to the practitioner, patient or other person authorizing the change.

(c) No payment may be sought for requests for correction of the record or attaching additional information to the record.

Rule 8 Accuracy of Health Information

(a) The oral health professional must not use health information without first taking reasonable steps to ensure that it is accurate, up to date, complete, relevant and not misleading. The steps taken depend on the importance of the information with regard to the proposed use. The more important the information is to the proposed use, the more rigorous should be the steps to ensure that the information is accurate, up to date, complete, relevant and not misleading.

Rule 9 Retention of Health information

(a) An oral health professional shall not retain health information for longer than required for the purposes for which the information may lawfully be used but is not prohibited from retaining any health information as long as is necessary or desirable for the purpose of providing oral health services. As health information is often used for future diagnosis and care this rule does not limit the maximum duration of retention.

(b) The Health (Retention of Health Information) Regulations 1996, however, requires that health information must be retained for a minimum of 10 years from the date shown in the treatment record as the last date for which dental health services were provided for an individual. It is therefore unlawful for an oral health professional to permanently dispose of health information relating to an individual treated within the last 10 years.

(c) The obligation to retain health information does not prevent the transfer of that information to another oral health professional, to the individual concerned, or that individual's personal representative. Where health information has been transferred in these cases, the oral health professional ceases to be subject to the obligation to retain the information. Where health information is transferred to another oral health professional, that person holds the information subject to the obligation to retain the information as imposed by the Regulations under Rule 9(b) above.

(d) An oral health professional may, with the permission of the patient or the representative, transfer records to another practitioner and, in doing so, transfers any obligations relating to retention of those records to that practitioner. Where records are transferred in this manner it is prudent for the oral health professional to retain a copy of the record for situations such as a future complaint regarding the quality of care provided. The non-payment of any legitimate account is not an excuse for refusing or delaying the transfer of the information.

(e) Oral health professionals practising on their own account should make advance arrangements for the transfer of records prior to ceasing practice. Oral health professionals practising in a group arrangement do not have automatic right to ownership of any record should the practising arrangement cease, and should give some consideration as to what should happen to an individual’s treatment record should this situation arise.

Rule 10 Limits on use of Health Information

(a) Health information obtained for one purpose cannot be used for another purpose unless the individual concerned has authorized that use.

(b) Rule 10(a) does not apply where the information is to be used for health research and the information does not identify a particular individual. However if health information regarding an individual is to be disclosed for the purposes of a research programme, the consent of the individual concerned should be obtained unless it is not practicable or desirable to obtain that authorization.

Rule 11 Limits on Disclosure of Health Information

(a) There may be many circumstances where requests are made by other health care professionals, regulatory bodies or individuals, for disclosure of information regarding

identifiable individuals. The most common situation is where another health care professional makes such a request in order to provide health or disability services to an individual. Such disclosure is permitted by section 22F of the Health Act 1956 and there are only limited circumstances where such a request can be refused. The health care professional making the request does not usually need the patient's consent to make the disclosure but one important ground on which the request may be refused is if the oral health professional believes that the individual concerned would not want the information disclosed to the requester.

(b) Health information may be disclosed to a patient's representative but the request may be refused if the oral health professional has reasonable grounds to believe that the patient would not want the information disclosed to that representative.

(c) Under other legislation information can be requested from an oral health professional by authorities or other statutory or regulatory bodies. Prior to disclosure of any information the oral health professional should request in writing exactly what information is required and the statutory provision which requires the provision of the information in such a situation.

(d) The Children Young Persons and their Families Act 1989 also has provisions which allow and protect the release of information to a relevant authority or person in cases of suspected neglect or abuse of a young person.

Rule 12 Unique Personal Identifiers

(a) Unique personal identifiers are numbers, letters or combinations of these and are commonly used in computerized treatment record programmes or for the storage and retrieval of radiographs. The National Health Information (NHI) number is one example of a unique personal identifier. Health care organisations are entitled to employ their own unique personal identifiers within the organisation or practice, but identifiers given by another body for an unrelated purpose, for example a driver's license number or passport number, may not be used.

4. Compliance with the Health Information Privacy Code

(a) Health care organisations should ensure that there are one or more persons are responsible for:

(i) ensuring compliance with the Health Information Privacy Code 1994

(ii) dealing with requests pursuant to the Privacy Act 1993

(iii) liaison with the Privacy Commissioner regarding any investigations conducted under the Privacy Act.

(b) Patients or their representatives should be made aware of their right to complain directly to the Privacy Commissioner regarding an interference with their privacy. It is likely that the Commissioner would expect the complainant to have first approached the practice concerned asking for the matter to be considered. Elements of a satisfactory complaints procedure should include independence, the opportunity for both sides to be heard, and a prompt response to any concerns raised.

5. Checklist

The following checklist provides a form of self assessment for compliance with the suggested standards for record keeping.

(a) Confidentiality of health information is guaranteed.

(b) Only necessary information is collected.

(c) The reason why information is collected can be provided.

(d) Patients or their representatives are aware that information can be accessed and, if necessary, corrected.

(e) Records are complete and include:

- correct personal details
- regularly updated medical history
- history, observations, diagnosis and treatment
- advice given and any treatment advised but declined by patient
- treatment undertaken
- drugs dispensed or prescribed, dose, quantity and instructions
- consents obtained
- unusual responses to treatment reported
- estimates or quotes of fees

(f) Entries are made in permanent form and identifiable to the clinician.

(g) Records are legible, abbreviations are standard, codes can be readily converted to common terms.

(h) Computer records time-logged, secure and reliably backed up.

(i) Storage of records is:

- secure
- retention for minimum period of 10 years
- if disposing of records offer to patient
- dispose according to patient's wishes
- dispose preserving privacy.

(j) Access to records is appropriately handled:

- the identity of the person making the request is checked
- information is released only to the patient or their representative
- patient's representative has written authority
- requests for information are answered within 20 days.

(k) The health care organisation has a designated person to deal with privacy complaints.