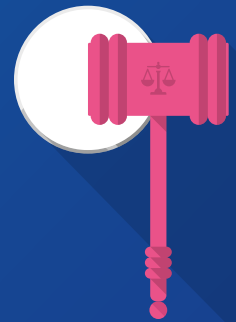


THE PRIVACY ACT

AUSTRALIA



AUSTRALIAN PRIVACY PRINCIPLES

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1.0 INTRODUCTION

The *Privacy Amendment (Private Sector) Act*, an extension of the scope and operation of the *Privacy Act 1998* established minimum national standards of privacy practice in the private healthcare sector and changed the way in which all members of the dental team must view the issue of clinical records.

The impact was quite fundamental for dentistry, because prior to this it had been a well-established principle in Australia (supported by a succession of case law up to and including a High Court decision in the case of *Breen v Williams*) that healthcare providers had no obligation to supply patients with copies of their medical (or dental) records.

The Privacy legislation was further amended by the *Privacy Amendment (Enhancing Privacy Protection) Act 2012* which was enacted on 12 March 2014 in order to provide for a more open and transparent handling of personal information, provide a mechanism for dealing with complaints, create national consistency and provide the Office of the Australian Information Commissioner (OAIC) greater power

This evolution of the privacy legislation has almost certainly influenced the profession's attitude to clinical record keeping, as for many, a patient's records had previously been looked upon as being a convenient notepad of dates, treatments and fees charged and received. The fact that most practices refer to clinical records as "*the patient's notes*" is quite revealing, because that's essentially what so many records had been; little more than a convenient aide memoir for the clinician, often full of idiosyncratic "shorthand" and indecipherable text.

Usually (but not always) these "coded" notes meant something to the author, but if the patient came to be seen by another dentist at the practice, then he/she might have great difficulty in understanding the details of the patient's previous treatment.

The new legislation has given the patient a statutory right of access to their records. They have a right to inspect them, whether held in paper (hard copy) form or electronically, and if they request it, they must be provided with copies of the records (and x-rays) and/or printouts of any records which are held on computer.

It is important to understand that the patient's "records" in the context of the legislation, are not restricted to the clinical treatment records (notes) themselves. X-rays, models, photographs, pathology/radiology reports, correspondence etc, all form part of the "record".

There are some limited exceptions to the automatic right of access to the records. For example, correspondence about the patient's treatment which passes between you and DPL, or between you and DPL's lawyers, or between these lawyers and DPL, if it forms part of "*existing or anticipated legal proceedings*" is not disclosable.

2.0 THE AUSTRALIAN PRIVACY PRINCIPLES (APPS)

Central to the structure and operation of the Act are thirteen broad principles that must be complied with which are summarised below. Additional information can be found in Privacy fact sheet 17 – Australia Privacy Principles.¹

Some unfamiliar new terms and phrases arise within the APPs (like “collection” and “use” and “disclosure” as they relate to personal and health information), and these terms have a specific meaning under the legislation. They are actually quite logical and in many respects the APPs simply reinforce and formalise what most dental practices were doing already.

13 Australian Privacy Principles an overview

Part 1 – Consideration of personal information privacy

APP 1 – Open and transparent management of personal information.

A dental practice must have a privacy policy available in an appropriate format, and provided at no charge which covers;

- a. The kinds of information to be collected or held
- b. How this will be collected
- c. For what purposes the information collected, held or used.
- d. Disclosure to any other persons or agencies – the identity of the agencies, what is disclosed and for what purpose.
- e. The process to enable an individual to access the information.
- f. A consent process for the collection of the information.
- g. Identification of any situations for which consent is not required, eg, in an emergency.
- h. The process by which an individual may complain about a breach of the Australian Privacy Principles.
- i. Whether information is to be disclosed to overseas recipients, and which countries this would be to.

APP 2 – Anonymity and pseudonymity.

Under these regulations, individuals must be given the option or not identifying themselves, or using a pseudonym unless compelled through a court /tribunal order or it is impractical for the patient to remain anonymous.

This APP can be met by example, by enabling patients to call and enquire about the services or process of a practice without providing their name or by stating the personal identity boxes (such as name and address) on online contact forms are not mandatory. However, it would be impractical to enter into a therapeutic relationship with a patient who has not provided you with their name or details of their medical history for example and APP2 would therefore not apply.

Part 2 – Collection of personal information

APP 3 – Collection of solicited personal information.

You may only collect personal information that is reasonably necessary for the practice’s functions/activities, ie, for the provision of dental services.

Sensitive information, such as information about a patient’s health, can only be collected if the individual gives consent for this. The consent may express, for example through a signed consent form, or implied which would be inferred from the patient’s actions in the circumstances, but in either case the patient must;

- Be adequately informed about the information you are collecting and why before giving consent to this
- Give consent voluntary and specifically to the concurrent circumstances
- Have capacity in a legal sense to give consent (see our advice booklet on Consent for further discussion surrounding this).

APP 4 – Dealing with unsolicited personal information.

If you or your practice receive unsolicited personal information which you could not have collected under APP3 and which is not contained in a Commonwealth record then you must, as soon as practicable, and only if it is lawful and reasonable to do so, destroy the information or ensure that it is de-identified.

1. oaic.gov.au/resources/individuals/privacy-fact-sheets/general/privacy-fact-sheet-17-australian-privacy-principles.pdf

APP5 – Notification of the collection of personal information.

You must notify patients about your collection of their personal information, including why you collect this information, the consequences if you do not collect it and the existence of your privacy policy. This notification may simply take the form of a notice in the waiting room and/or on your website.

Naturally, if a patient does not speak English as a first language, then more rigorous or additional steps may be required to ensure that they have a full understanding of this.

Part 3 – Dealing with personal information

APP 6 – Use or disclosure of personal information.

You may only disclose any information for the particular purpose for which it was collected (the ‘primary’ purpose), and for dental practices this would be the provision of healthcare services to a patient. There are however some exceptions or ‘secondary purposes’. The most likely exceptions to apply to dental practice are;

1. If the patient has consented to a secondary use or disclosure
2. The patient would reasonably expect the secondary use or disclosure, and that is related to the primary purpose of collection, or;
3. In the case of sensitive information, directly related to the primary purpose
4. The secondary use or disclosure of information is required or authorised by or under an Australian law or court order.

APP7 – Direct marketing.

Generally, a dental practice cannot only use or disclose personal information for direct marketing purposes. However, if the practice has collected the information directly from the patient and has sought the patient’s permission to use their information for direct marketing this becomes permissible.

Regarding the use of a patients information enable a dental practice to market directly to them, this is acceptable providing the practice provides a simple way for the patient to ‘opt out’ from receiving direct marketing communications, or the patient has not made a specific request to the practice not to receive direct marketing information from them.

APP 8 – Cross border disclosure of personal information.

Before personal information is disclosed overseas, an example of which would be to an off-site electronic data storage provider, a practice must take reasonable steps to ensure that the overseas recipient does not breach the APP’s.

Appropriate documentation or independent legal advice can be sought to verify this.

If you are not satisfied that the recipient country has similar privacy laws to Australia then you should not disclose the information in the first instance. Then, you can move forwards to enter into a contract with the overseas recipient that requires them to comply with the APP’s and/or obtain consent for the patient to disclose their information to an overseas recipient.

If sensitive information is being sent overseas you must;

- Obtain consent of the patient to do so
- Notify the patients as to where this information is being sent and what privacy protections are in place, and
- Advise them that the privacy protections available under Australian law may not apply if they consent to the transfer of their information to an overseas location.

AAP 9 – Adoption, use or disclosure of government related identifiers.

Government related identifiers include Medicare numbers and PCEHR identifiers, and there are only very limited circumstances in which a practice may adopt to use this as their own identifier for the patient

Part 4 – integrity of personal information

APP 10 – Quality of personal information.

A practice must take reasonable steps to ensure that the personal information that it collects, uses and discloses is accurate, up to date and complete. Example of this may include updating contact details and health history forms.

APP 11 – Security of personal information.

A practice must take reasonable steps to protect the personal information it holds from misuses, interference or loss; and from unauthorised access, modification or disclosure.

Reasonable steps may include:

- Protection with robust IT systems including firewalls, virus protection, frequent password updates, backups and appropriate maintenance of both hard and soft ware.
- Procedures to ensure appropriate staff access levels, preferably password locked and appropriate and safe use of the internet and email
- Staff confidentiality agreements
- Building security and alarms.

Part 5 – Access to, and correction of, personal information

APP 12 – Access to personal information

A practice is required to provide personal information held about an individual on request (unless a specific exception applies).

Prior to releasing this information, for example a copy of the clinical records, the practice must first verify that the request was made by the individual concerned. The information must then be released within 30 calendar days, and must be provided in the manner requested by the individual if it is reasonable and practicable to do so; soft or hard copy for example. If you are unable to provide the information in the manner they have requested, the patient must be advised in writing.

It is acceptable to impose a reasonable fee for the provision of information in order to cover administrative time and additional charges such as photocopying and postage. The legislation emphasises that this amount cannot be excessive.

APP 13 – Correction of personal information.

- You are required to correct personal information that is found to be incorrect.
- You may also notify other organisations of a correction to personal information that was previously provided.
- You must respond to a request to correct personal information within 30 calendar days and cannot impose a charge for this.

An online checklist entitled *Privacy Act reforms: Checklist for APP Entities (Organisations)* is available to assess whether your policies and procedures comply with the Privacy legislation and can be found at [oaic.gov.au/privacy/privacy-resources/privacy-business-resources/privacy-business-resource-2-privacy-act-reforms-checklist-for-app-entities-organisations](https://www.oaic.gov.au/privacy/privacy-resources/privacy-business-resources/privacy-business-resource-2-privacy-act-reforms-checklist-for-app-entities-organisations).

3.0 HOW IT WORKS IN PRINCIPLE

3.1 Privacy Policy

Under Australian Privacy Principle 1 – the Principle of Open and transparent management of personal information – the dentist must take reasonable steps to let a patient know what sort of personal information the practice holds, for what purposes, and how it collects, holds, uses and discloses that information. Dentists and dental practices will have a legal obligation to provide documentation that clearly sets out the policies for the management of the personal information they hold about their patients and former patients.

This document is described as a **Privacy Policy** which could be:

- A sign in the practice
- A leaflet or printed sheet eg, in the waiting area (that can be taken away by patients, or handed out if someone asks for it)
- A website or homepage.

An example of a ‘Model’ Privacy Policy is provided at Appendix A, to give you an idea of what it might look like. It is up to each individual practice to decide how to present the information and to personalise it to the style of the practice (see comments at 3.2 below). Individuals must be able to access the policy easily and be able to understand it. Where a patient’s first language is not English, or where a patient has disabilities or literacy/learning difficulties, reasonable steps should be taken to ensure that the information is communicated and as far as possible, understood by the patient.

3.2 Requests for access

Patients should be encouraged to put any request for access to their records in writing. This is particularly important when a second party is making the request on behalf of the patient, and with the patient’s authority. A model request form is provided at Appendix B, which can be modified and tailored to your own requirements.

You may find it helpful to provide the patient with some explanatory notes when they ask for more information about these issues, or request access to their records. An example of such a document is provided at Appendix C, which can help to establish a clear understanding of what the patient can, and cannot expect. Having such a document also helps to avoid any uncertainty or inconsistency of approach amongst members of the practice staff.

Although the thrust of the new legislation is to establish minimum national standards of privacy practice, it has been designed in a way which allows individual organisations as much flexibility as possible in how they will achieve the Australian Policy Principles in their own practice, to suit the clinical setting (practice, or hospital, or Government clinic) and to suit its individual style – not all practices are the same.

3.3 Explanations

Good privacy practice would give the patient an opportunity to discuss their records if they want to, and to be given explanations of any entries by the healthcare provider or staff member. On rare occasions, it may be helpful or more appropriate for this explanation to come from an independent clinician, and in such cases the dentist whose records are under consideration should **facilitate** access, with the patient’s consent, by passing the records (or copies thereof) to the independent clinician for the purpose of these discussions. These records still remain the property of the original dentist.

3.4 Amendment requests

If the patient believes that information about them, held in their paper or computerised records is incorrect, inaccurate, incomplete or out of date, they will have a new statutory right to ask the dentist to correct any relevant entries. Where the healthcare provider, or the holder of the records (eg, a private hospital or clinic) does not accept the patient’s proposed corrections/amendments, then they can leave the original record unamended, but agree to include the patient’s statement separately within the record, noting that the facts are in dispute.

In other countries where patients have had access to their health records for some years, it didn’t take long for practitioners to realise that clinical records are not written for the benefit of the clinician, but are in fact an integral part of patient care.

Consequently, one should be aware of the patient’s new rights under this legislation. Records should contain factual information, not emotional outbursts. If patients discover abusive or inappropriate comments in their records, it is highly likely that they would retaliate with a formal complaint against the dentist.

3.5 Administration

Dentists can charge for the time involved in providing this access, and they can also ask the patient to meet the administrative costs of photocopying, or of having models and x-rays copied (if this is requested by the patient). However, the Act requires that this administrative fee must not be set at an excessive level which is designed to discourage an individual from accessing their records.

3.6 Complaints and compliance

Complaints relating to any aspect of privacy or the failure to comply with the APPs, are directed to the Office of the Australian Information Commissioner. In general, the Act requires these complaints to be investigated and a determination made. The Commissioner has powers to compel the release of documents, the interviewing of witnesses, and the attendance of any party at compulsory conferences, but the emphasis will be upon a voluntary resolution of any problems between the parties involving (where necessary) a conciliation process which will be overseen by the Commissioner.

Available sanctions are a finding of breach, a warning, a requirement to comply and/or make restitution to the patient, or an award of compensation that will be enforceable through the Federal judicial processes. The fines that can be levied are up to \$340,000 for individuals and \$1.7 million for organisations.

3.7 Further information

More information is available from the Office of the Australian Information Commissioner (OAIC). The guidelines are available in hard copy form, upon application, or alternatively can be accessed at oaic.gov.au.

4.0 THE IMPORTANCE OF RECORDS

One of the most frustrating aspects of the dentolegal work undertaken by DPL is finding a member's position undermined by the lack of supportive information in the patient's clinical records, even when the treatment provided has been of a high standard.

DPL places great emphasis on risk management, and this information pack is designed to highlight common problems and misunderstandings regarding clinical records, to suggest practical ways of overcoming them, and to provide a platform for improving the quality of clinical record keeping generally.

The importance of clinical records has been brought sharply into focus, partly by a steady increase in complaints and litigation, and more specifically by the bringing into force (on 21 December 2001) of the *Privacy Amendment (Private Sector) Act 2000*. The steady march of consumerism makes patients more ready to question the treatment provided for them, and clinical records are coming under increasing scrutiny in complaints to AHPRA/ HSC/OHO and similar bodies. They are often the focus of investigations by various Health Funds, in litigation of all kinds, and in matters which are brought to the attention of the Dental Board.

The irony of record keeping and paperwork generally is that it is the part of dentistry which most practitioners hate; consequently, they spend as little time as possible on it, perhaps because it is often seen as a distraction from (and less important than) the main "task", ie, the clinical work itself. This can leave the practitioner exposed and vulnerable to problems on all fronts.

Every member of the dental team can play a valuable part in ensuring that the practice's record keeping is of a high standard. Poor record keeping can make it difficult or impossible to defend claims of clinical negligence, or professional misconduct; it can lead to disputes over money and can cost the practice large sums of money. It can cause mistrust and confusion, and can lead to complaints. It can waste endless hours of "fire-fighting" to resolve problems caused by poor record keeping, and it can even lead to the most serious (and fatal) consequences.

4.1 What is a clinical record?

The Dental Board guidelines on Dental records set out a comprehensive list of what should be included in a clinical record in contemporary Australian dental practice² and should be read in conjunction with this section.

A clinical record consists of any or all of the following:

- Clinical notes (record cards/envelopes) including medical history
- X-rays (and associated tracing, if relevant), MRI and other scans

- Investigations (Pathology reports, Radiology reports, Pulse oximeter print-outs etc.)
- Models
- Photographs (including intra-oral camera images, whether in printed or digital form)
- Correspondence
- Other information eg, laboratory tickets, appointment cards, etc.

Computerised records are considered in due course, but it is important to realise that the APPs apply equally to all forms of record.

4.2 What should a written record contain?

- (a) Up-to-date medical history
- (b) The date, diagnosis and treatment notes every time the patient is seen, with full details of any particular incidents, episodes or discussions
- (c) Monitoring information such as BPE/TPS/CPITN scores, periodontal probing depths and other indices, tracking of oral pathology and other conditions
- (d) All payments made by the patient
- (e) All correspondence to and from the patient, or any third party (specialist, other dentists, doctor, etc.)
- (f) Consents obtained and warnings given
- (g) Findings/diagnosis on X-rays –particularly if discovered after the patient has left the surgery
- (h) Drugs given and dosages
- (i) Anything else you consider to be relevant.

2. dentalboard.gov.au/Codes-Guidelines/Policies-Codes-Guidelines.aspx

4.3 How much detail is needed for treatment notes?

It is commonly believed that clinical records are notes made solely for the dentist's own benefit – this is not the case. Records should be kept as a clear summary of what you did, and why, and should be sufficiently clear and logical to be understood by any third party who might read them. Patients may now request access to copies of their records, then seek a second opinion from another clinician, based upon your records and x-rays etc. Clinical records provide the best and most lasting evidence of the professional care and ethical attention you have provided for a patient.

At one extreme is the half page of A4 which dental school/hospital staff often write in their clinical notes. At the other extreme is the brief illegible graffiti which even the writer has trouble in deciphering at a subsequent visit. The worse scenario of all, of course, is no records at all.

It is important to appreciate the key aspects, so that you spend your time ensuring that these are covered, even if you spend less time on the more trivial details, or “optional extras”.

Remember that people who have never met you will often be judging you from the kind of picture that is presented by your clinical notes and records. In this context, most reasonable observers would consider it acceptable to use abbreviated notes, and some medical “shorthand” is a fact of life and widely accepted in medical/hospital practice. You are probably already using terms like LA – GA – c/o – o/e – TTP – l/s – (perhaps many others); or when prescribing, abbreviations such as qds – bid, etc.

However, you should remember always to give a full and detailed report of any incidents, episodes or discussions (no shorthand here) eg, *“patient felt faint after local anaesthetic. Made supine. Fully recovered and pulse normal after three minutes”* or *“patient complained of palpitations after local anaesthetic (aspirating 2% lignocaine, 1:80,000 adrenaline) or “patient requested extraction but agreed to filling after some discussion”*.

In computerised practices – particularly those working within Health Funds – it is common to see item numbers (from the ADA Glossary) used in the treatment history instead of a full treatment description. This practice should be avoided, not least because the Health Fund might raise a challenge on the basis that there is no record of what you actually did, in circumstances where they are suggesting that the item number you claimed is not applicable to the procedure you carried out. The fund could argue that the record shows only what was claimed, not what was done.

While the content of the notes is obviously paramount, the presentation of the notes/records conveys either a picture of care, attention to detail and organisation, or of a lack of it. Computerised records have the advantage that they should at least be clear and well presented; in any paper records, handwriting should be clearly legible.

Notes which are spread across several duplicate cards with “notes missing” entered here and there, does not inspire confidence and it begs the question of whether you had the main notes, medical history and X-rays available on the day you carried out a certain important procedure which had been written up on a “duplicate” card.

Let us now look at some of these key aspects of treatment notes in a bit more detail.

4.4 Contemporaneous record

The most essential requirement is a dated entry, summarising the treatment provided for the patient, your diagnosis/report/ observations etc. Positive signs (what you can discover for yourself) and symptoms (what the patient tells you about the problem) are important, so also is the absence of them (tooth **not** tender to percussion, lymph nodes **not** enlarged, **no** swelling, **not** painful, **no** change in medical history, etc).

If you speak to the patient on the phone, or refer the patient, or speak to his/her doctor, or indeed do anything concerned with the patient, remember to write it down and date the entry.

“Contemporaneous” means “recorded at the time”, and it is easier than one might think, to identify entries made after the event, or to recognise record cards which have been re-written or altered. The importance of an audit trail for computerised records is covered separately at 4.12. Records should be in diary sequence with other dated entries, and no attempt should ever be made to “cover one's tracks” by altering or “improving” an original record card entry, or by substituting a modified record card for the original. Such efforts can easily transform a small problem into a major one, or even into a criminal matter.

4.5 Medical history

Everybody realises the importance of taking a full, written medical history at the time of the first examination of a new patient. The problem often arises, however, that at subsequent recall examinations (check-ups) the medical history is not formally updated, and no written entry is made on the notes to the effect that you have confirmed that the medical history is unchanged. This important information needs to be up to date not only for medicolegal reasons, but also to comply with APP11 (Security of personal information).

4.6 Correspondence

Always keep copies of any correspondence with the patient, referral letters to specialists, and other correspondence. When writing any letter, try to picture the image it might convey subsequently to the patient, or to others who are reading it later under different circumstances. Choose your words carefully or you may live to regret them!

4.7 Consents and warnings

Records are inextricably linked with the topic of consent, and they should meticulously document each stage of the consent process:

1. First and foremost, respect any patient's fundamental right to decide whether or not they wish to proceed with any dental treatment. This right is enshrined in many acts and regulations.
2. Assess the patient's competence to consent, bearing in mind their age and their ability to understand;
 - (a) the nature of the proposed treatment
 - (b) its purpose
 - (c) any risks and limitations
 - (d) comparisons with any alternative treatment options which are available (including that of doing no treatment at all).
3. Satisfy yourself regarding the authority of the patient (or that of anyone else acting on the patient's behalf) to give consent to the proposed treatment.

4. Provide the patient with as much information as is appropriate and relevant (and as is required by the patient) regarding the points at 2(a) (b) (c) (d) above. Invite questions from the patient, and answer any such questions fully, truthfully and fairly, trying to avoid making any dismissive comments about any possible risks.
5. If the patient is undecided, it is prudent to defer treatment. Be prepared to offer a second opinion or further discussion.
6. Keep good and careful records of all matters concerning the question of consent. This may or may not include a consent form; such a form should be seen as an adjunct to the consent process, not as an alternative to the sharing of information that should be central to the process.

DPL is often asked by our members why we do not publish "approved" consent forms for use in various situations and circumstances. Such requests fail to recognise that consent is a **process** of exchanging information, between dentist and patient, and not simply a question of getting a signature on a piece of paper. For DPL to provide consent forms would imply that to obtain the patient's signature on such a form would be a valid consent; unless the consent process has been properly carried out, however, the form might have no legal value.

Separate, more specific written consents should be obtained for certain procedures:

- (a) General Anaesthetic and treatment carried out under it
- (b) Sedation (IV/RA) and treatment carried out under it
- (c) Implants
- (d) Surgery (especially impacted lower third molars).

In each case, the consent form should incorporate or be accompanied by formal written warnings about necessary precautions (eg, not eating or drinking for a period of time, not driving afterwards, being accompanied by a responsible person etc.) or possible adverse reactions or consequences. In the case of "elective" procedures, it is sensible to include a brief summary of the reasons for carrying out the procedure, including what might happen if the procedure were **not** to be carried out at all.

The ideal solution is for these warnings to be written as a standard sheet, for the patient to be given a copy of this, and for the patient to sign a formal confirmation that they have received a copy of the relevant warning. This could conveniently take the form of a self-adhesive sticker affixed to the notes, eg, “ADVICE SHEET 5 GIVEN TO PATIENT”, which the patient then signs and dates. Alternatively, the warnings could be printed on the reverse of the consent sheet, so that identical copies are held by the patient and the dentist.

Although a formal consent form is not necessary for something as routine as a simple extraction, it is still a good idea to give the patient written (as well as verbal) post-operative instructions/advice. It helps to avoid problems and complications, and apart from anything else it is a caring approach and in the rare instance of severe haemorrhage or post-extraction osteomyelitis, you (and your defence solicitors!) may be thankful that you took the trouble.

Similarly, a sheet for patients having their first inferior dental block infection, or after endodontics, or after extensive crown and bridgework etc, may be appropriate, and particularly logical if you do a lot of a certain kind of work, where such warnings and explanations are appropriate. The effort is more than justified by the time it will save you in the long run.

4.8 Drugs and dosages

Most GDPs routinely use a standard local anaesthetic like 2% lignocaine with 1:80,000 adrenaline but on occasions they will administer something else eg, plain lignocaine with no vasoconstrictor, or perhaps Citanest with Octapressin.

Whether or not you feel that such routine administration is worth writing down in full, the purist will maintain that you should. Complete local anaesthetic records would include the volume given in ccs/mls. Either way, you should adopt a standard approach to your record keeping so that you can state with confidence precisely what drug you had administered on a given date, and in what dosage. Ninety-nine times out of 100 the briefest and most cursory reference will be enough because you can demonstrate that “X” is your standard procedure. Once in a blue moon it won’t be nearly enough – do you want to take the chance?

Drugs for general anaesthesia and sedation should always be recorded in detail. The route (eg, intravenous, inhalation) should be confirmed and the injection sites identified. Problems in locating a suitable vein, or in connection with anaesthesia/sedation should be described in detail, as should any problems during the procedure or the recovery phase. So also should the prescription of any item be recorded in full (name of drug prescribed, dosage, frequency and duration), together with warnings given (eg, to avoid alcohol).

4.9 X-rays

It is prudent to take X-rays of any tooth you are planning to extract surgically, to root fill or to provide extensive treatment such as crowns. Ensure that you have checked the X-ray before proceeding. Failure to take X-rays when indicated, taking poor X-rays and/or failing to check/report upon X-rays is a common basis for findings of clinical negligence. Many problems with x-rays arise from faulty processing and it is advisable to carry out a regular audit/evaluation of the quality of your x-rays. X-rays should be stored safely and securely, and clearly dated. Remember also that all the APP’s apply to x-rays just as much as to written records

If you scan x-rays into your practice computer, or use digital radiography (radiovisiography), the same safeguards apply as described at 4.4 page 10 as regards the need to ensure that the x-rays are contemporaneous and have not been digitally altered or enhanced, or where this has been done for legitimate reasons, a clear audit trail records what modifications were made, when, and by whom.

4.10 Investigation and reports

One of the aspects of clinical treatment which is often overlooked, is not the treatment itself, but rather investigations and reports which either lead to the treatment, or which form a necessary part of the follow-up after treatment.

These investigations and reports in a medico-legal context, are part of and parcel of the careful, professional, thorough and competent approach which we are all expected to provide – our “duty of care”.

Follow-up contacts are not always necessary for mundane and everyday procedures, but are advisable in certain instances for medically compromised patients, or following those procedures where complications are more likely to occur. Some follow-ups will involve seeing the patient again, while others may take the form of a phone call to check that all is well.

In all cases, ensure that anything significant that you discover from your investigations, or from your follow-up, is properly recorded in the clinical notes.

4.11 Payments and receipts

It is sensible to record all estimates/fee quotations, all requests for payment and all payments made, in the patient's notes; this helps to avoid uncertainty, confusion and possible dispute.

It should be made clear what each payment relates to, and/or whether the payment is a deposit, or a fee for a broken appointment, for example.

Keep a detailed record of every contact with the patient in connection with fee collection (eg, if the patient promises to send a cheque by a certain date, or promises to ring you back to discuss their unpaid account, then fails to do so). Here, the new right of access to records can be a positive advantage, as the patient can see how things appear from the other side.

4.12 Computerised records

It is up to you how to keep your clinical records, and in your own best interest that the records should be as full and as comprehensive as possible. Many practices now keep some (or all) patient data on computer, and this either duplicates or replaces manually held information. Even if you keep some or most of your records on computer, you may still need some manual records eg, for non-digital X-rays, correspondence etc.

It is no defence in law that your computer broke down or you lost data, for whatever reasons. It is up to you to ensure that you can always produce, whether directly or indirectly (created from computer records), all the same information that has been discussed in this information pack so far. Being computerised is no justification for cutting corners in record keeping – indeed, quite the reverse.

The less detailed the information, the less useful it will be when trying to defend a claim for negligence or professional misconduct, so it is worth asking yourself whether you are comfortable with the quality and quantity of the records you are keeping and the safeguards and controls (eg, computer back-up) you are operating in order to protect them. Another area of particular importance is the need to be able to demonstrate that dated records are contemporaneous and cannot be amended at a later date.

Many clinicians fail to appreciate that changes to records may still be captured on, and retrievable from, the hard disk, even when the original entry is deleted or modified. Computerised records need to have a robust and secure audit trail, showing who made each entry, at what time, on what day etc. The same details should be available for each historical entry, so that the whole evolution of the final version of the records can be tracked with certainty.

Without this safeguard, the value of the records may be seriously reduced.

4.13 Professional confidentiality

It is openly acknowledged in the guidance notes, which have been published alongside the Amendments to the *Privacy Act* that healthcare professionals already operate within an ethical code of confidentiality. Compliance with the new Act is in most cases achieved by continuing with the existing high standards of professional confidentiality.

Employers (practice owners) should take steps to ensure that all staff employed by the practice, understand the importance of professional confidentiality and the new privacy guidelines. It is sensible to include reference to this in the contract of employment for each employee, and to ensure that each employee receives a copy of the practice's Privacy Policy. Ideally, this should be explained and discussed at a practice meeting involving all members of the practice team, to ensure that a consistent approach is adopted which complies with the new legislation. Members of staff should understand that it is the dentist who is the holder of the record, and only the **dentist** should respond for requests to access to it. Having a standardised procedure and documentation (see Appendix) will make life considerably easier for the larger practice.

4.14 How long should you keep records?

There is no short answer to this, as it depends upon why you need them. Different kinds of action against dentists have different limitation periods (time limits) before they become statute barred. The Dental Board of Australia currently suggests seven to ten years as a minimum for an adult patient, however consideration should be given to retaining the records for much longer, particularly if the patient had not reached the age of majority when you commenced their treatment. Instead of thinking of a good reason why you might need to keep records, you should be thinking of extremely good reasons why you might no longer need to keep them. Remember that the records may be your property, but the patient has a right of access to them, which is difficult to achieve if you have destroyed them.

Remember also that the new Privacy Legislation requires you to protect the patient’s “sensitive information” even in the process of archiving or ultimately destroying the records.

The storage/space implications of this are frightening, and a particular problem arises in the case of orthodontic models for children, where it would be prudent to keep models for at least ten years after the child attains the age of 18 (ie, until age 28).

If in doubt, contact DPL Australia for advice.

4.15 Missing notes

Everything we have said so far relies upon having the patient’s record to hand when you need it. Unfortunately, notes do go missing even in the best-regulated circles. It has even been known for a Health Fund or even a Dental Board to “lose” records, registration forms, claim forms, correspondence and X-rays – as many practitioners know to their cost.

Many practitioners attempt to cover themselves when notes cannot be found, by writing up a duplicate card or insert, in the hope that this can then be added to the main record when it comes to light. This –while certainly a step in the right direction and far better than keeping no record at all –can produce a different kind of problem whereby the record gets split into two, three or more sections and serious consequences can so easily result if, for example, the “missing” section could have reminded you that this patient has had rheumatic fever, is allergic to penicillin, takes steroid medication, or has a history of hepatitis B or HIV. These examples impact upon APP10 – Quality of personal information and also APP11 – Security of personal information.

When X-rays and other records have to be stored, a duplicate set of notes is a safe and sensible answer, but is it dangerous to accept this as anything more than a temporary expedient, with the priority remaining to find the actual notes as soon as possible.

Where only clinical notes have to be written up, a desk-diary type of record can be kept, with the patient’s name, date of birth etc. and a note of exactly what you would have written on the notes themselves. This then becomes a permanent contemporaneous record which can easily be transferred across to the main record and cannot get mislaid like a loose duplicate card could do.

4.16 Back-ups and safeguards

When you think about it, your appointment book and/or day list, any receipt stubs, laboratory tickets and many other kinds of everyday information could all be a valuable double check on dates/days of attendance, treatment provided, payments made, etc and occasionally they can be essential in unravelling a chain of events which is confused by the absence of a single entry or date in the clinical record itself. These sources of information are a valid part of the total “record” of a patient’s treatment. Don’t confuse “record card” with “record”.

Think about all the different kinds of records you have and whether or not you keep them (or for how long) so that you can maintain the most effective back-up system without duplicating work unnecessarily.

4.17 The team approach

Neither you nor your staff should ever advertise the fact that a patient’s records are missing or mislaid; it does not inspire confidence and it makes a patient even more likely to adopt a confrontational stance or even to consider litigation.

Keep your back-up records and make every effort to regain the integrity of the notes as soon as possible. Do not accept missing notes as being inevitable or acceptable or your staff will soon start to think the same way. Always emphasise the importance and seriousness of clinical records to all your staff and help them to help you by setting up efficient systems for making and keeping records, and by sticking to the chosen protocol yourself.

Remember always that any record you make may now be seen and read by others. Records should be written and maintained in the knowledge that one day, they may be read out in Court, or at the Dental Board.

5.0 SUMMARY

1. Clinical records are an essential part of good clinical practise and good practice management. They are now covered by federal legislation in the form of the *Privacy Act*.
2. Dentists and staff alike must understand the legal significance and importance of records, and realise the serious problems that can arise from a casual approach to records and record keeping.
3. Even the best clinical records are of little use without an effective filing system and organisation, and even this will not solve your problems unless everybody follows the rules.
4. Clinical notes should, as a general rule, never leave the practice premises. This could violate APP11 (Security of personal information) unless special precautions are taken.
5. Clinical records are confidential, but dentists and staff should appreciate the significance of the new Privacy Legislation. The **dentist** is the “holder” of the record, and only the dentist should ever give a patient access to their dental records.
6. The original records and X-rays are the property of the practice, and should never be released direct to a patient. They may be provided on request to a protection organisation such as DPL, or to DPL’s lawyers, who may then copy the records and X-rays, keeping the originals safe. Whenever you forward original record cards or x-rays to DPL or anyone else, always use a secure form of recorded delivery for this and/or request a written acknowledgement of delivery. Requests for copies of the records may be received from patients, a child’s parents, the patient’s solicitors, and occasionally even the police – see (8).
7. In certain Health Funds, records (the originals) **must** be provided to the Fund on request, for audit purposes. **Always** take copies of records before releasing the originals to anyone.
8. In some States there is additional, directly related legislation which places further obligations upon clinicians. In Victoria, for example, the *Health Rights Act* imposes a specific requirement for dentists to keep clear, accurate and up to date information about their patients and the treatment they receive.
9. Poor or inadequate record keeping is no longer a private matter, or simply an ethical/performance issue; a dentist can face triple jeopardy because he/she can face challenge, investigation and statutory fines from the Health Services Commissioner (or equivalent agency in certain states and territories), as well as the Office of the Australia Information Commissioner and the Dental Board.
10. If in doubt about any circumstances when the release of records has been requested, contact DPL for advice.

If you have any questions about the way we keep and use your personal and health information and records, please feel welcome to ask us. Our contact details are on the back page.

Further information on your rights under national privacy legislation, is available from the Office of the Australian Information Commissioner.

APPENDIX A

MODEL PRIVACY POLICY (suggested text)

In this practice we want to provide you with the best possible care and treatment. To help us to do this, we need to find out more about you, about your general health (including any medication you might be taking), and about your concerns and preferences.

Every time we see you, we make notes relating to your consultations and treatment here, which include dates, details of any discussions we have with you, and of treatment provided. There may be exchanges of correspondence between this practice and other healthcare professionals involved in your care and treatment. Our administration staff will also keep financial records relating to our professional fees for services you receive from us. Where necessary, this further information might need to be shared with people outside the practice to assist the practice with fee collection.

We collect this information, and we keep it safely in confidential records within the practice. At this practice we keep some of these records on paper, and other on a computer (**delete or amend as appropriate**). Your records include any x-rays we might take for you, any special reports we might request (eg, from a specialist) and correspondence with specialists and other third parties relating to your care and treatment.

In order to safeguard your interests, we recognise our responsibility to treat all this information as confidential, and to respect your privacy and your right to know what information we are holding, who might see it (and under what circumstances) and what we use it for. Within this practice we have a Privacy Policy which is as follows :

1. Information such as your name and address is used when we need to write to you about your treatment, or to process accounts or for other administrative purposes relating to the treatment you receive here. It may be seen or used by members of our practice staff, or by third parties who assist or advise the practice, but only for the above purposes.
2. Information about your health and other information of a personal nature, may be shared or disclosed with other healthcare professionals where we believe this is necessary for reasons connected with your treatment.
3. Every effort is made to keep your personal and health information up to date. You can help us by letting us know of any changes in your personal details (name, address etc) or health/medication.

4. Various precautions are taken to keep your records safe, secure and confidential while they are stored here. We would be happy to explain these to you upon request.
5. You can ask to see the records we hold about you, and other people can make such a request on your behalf, with your prior agreement. We will do our best to explain any parts of your record, to help you to understand what they mean.
6. If, upon seeing your record, you think that any of the information is incorrect or inaccurate, you can ask us to change it.
7. Although all the records we keep about you (including x-rays etc) remain the property of the practice at all times, you do have a right to request a copy of any part of, or all of your records. There is a formal process for this, which will be explained to you at the time your request is made.
8. A fee may be payable in several of the situations at (5), (6) and (7) above. This fee might vary according to the amount of time/administration involved in dealing with your request.
9. There may be certain situations where we might be required to release information about you, your health and your treatment, such as emergency situations, or to satisfy legal or contractual requirements (for example, if any of your treatment is being provided through a Health Fund).
10. Case studies, lectures and professional meetings form an important part of the ongoing training and development of dentists and practice staff, for the ultimate benefit of all the patients we treat. Steps are taken to ensure that the identity of any patient whose records might for used for this purpose, is not revealed outside the practice.

If you have any questions about the way we keep and use your personal and health information and records, please feel welcome to ask us. Our contact details are on the back page.

Further information on your rights under national privacy legislation, is available from the Office of the Australian Information Commissioner.

APPENDIX B

MODEL FORM

Application for Access to Health Records
Privacy Amendment (Enhancing Privacy Protection) Act 2012

Details of the record to be accessed:

Hospital/General practice

Patient:

Surname/Given name

Forename(s)

Date of birth /..... /.....

Hospital/Practice reference no, if applicable

Access required to the following:

Record in respect of treatment provided on or between
..... /..... /..... (approximate date) /..... /..... (approximate date)

X-rays (specify).....

Other (specify).....

Details of applicant (if different from above):

Name:

Surname

Forename(s)

Declaration: * delete as appropriate

* I declare that the information given by me is correct to the best of my knowledge and that I am entitled to apply for access to the health record referred above under the terms of the Privacy Act.

* I am the patient

* I have been asked to act on behalf of the patient and attach the patient's written authorisation

* I am acting in loco parentis and the patient is under age 16 and (is incapable of understanding the request) (has consented to my making this request).

Certification: I certify that I am (Name)

.....

of (address)

.....

.....

and that I have known the applicant for years as an employee/client/patient/personal friend and have witnessed the applicant sign this form.

Signed Date /..... /.....

Official use only

Fee \$ quoted /received/not appropriate

Signed Date /..... /.....

Health professional authorising access

(Name)

Request for access acknowledged on (date) /..... /.....
(within 14 days of request)

Access provided on (date) /..... /.....
(within 30 days of initial request)

Further action:

Explanatory notes given to patient Yes/No

Corrections requested Yes/No

Applicant notified outcome Yes/No

Copies provided Yes/No

Copying fee (\$.....) Yes/No

Comments and details of copies provided Yes/No

Additional comments

Fee received (\$.....) Signed Date /..... /.....

APPENDIX C

MODEL EXPLANATORY NOTES

ACCESS TO RECORDS – YOUR QUESTIONS ANSWERED

These explanatory notes should be given to any patient who requests access to their records.

In compliance with the Amendment to the *Privacy Act 2000*, which took effect on 21 December 2001, and further the *Privacy Amendments (Enhancing Privacy Protection) Act 2012*, enacted on 12 March 2014 it is part of this practice's published Privacy Policy that our patients have a right of access to their dental records. The procedure for this is as follows:

1. Applications for access should be made using our practice's standard form. Copies are available from reception.
2. In many cases, it may be possible to let you see your records immediately. Although you can make your initial request to any member of staff, only the dentist can authorise the access, and it would depend upon how much time the dentist had available when you make such a request.
3. If for any reason it is not possible to allow you to inspect your records immediately, we will acknowledge your request within 14 days, and arrangements will be made for you to be able to see your records within 30 days. These are your rights under the *Privacy Act*.
4. Your dentist will be happy to explain any terms or other details in your records that you do not understand.
5. If you would like to receive a copy of any part, or all of your records (including any x-rays, photographs, models, or any other part of your records which can be copied), we will try to supply this to you within 30 days of receiving your completed application form. Copies of certain items can take a little time to produce, especially if you have been a patient here for some time and/or of your records are extensive.
6. If, upon seeing your records, you feel that any information they contain is inaccurate, you can ask us to correct any relevant entries. In situations where we cannot agree to make any changes you are requesting, you can ask us to include within our records, a statement from you indicating what corrections you had requested.
7. A fee is payable for access to your records, for any time taken to explain them to you, and to cover any associated administration / copying costs. You will be told what this fee is likely to be when you make your application for access, or within 14 days of making your request. These fee may be payable before access is provided.

Please contact DPL if you need any further information in relation to any of the information in this booklet. Contact details are on the back page.

How to contact us

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