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SUBMISSION
Guidelines on Dental Records

Dental Board of Australia
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Thank you for the opportunity to provide a submission on the Dental Board of Australia's (the Board) proposed changes to the Guidelines for Dental Records (the Guidelines). This author has considerable experience over many years in the assessment of the suitability of dental records:

- Dental Health Services Victoria's (DHSV) manager responsible for clinical relationships with Victoria's community dental agencies, including oversight of dental record keeping self-audits conducted by the community dental agencies and The Royal Dental Hospital of Melbourne from 2009 until 2018;
- Co-author of DHSV's Dental Record Keeping Self-Audit Guide, published annually 2010-2018;
- Board-approved auditor of dental records of registered practitioners in 2019 and 2020.

This submission has not been endorsed by DHSV, but represents experiences by this author's recent extensive employment at that service.

This submission proposes the retention of the Guidelines on Dental Records.

1. Are the current guidelines necessary?
2. Do you agree with the proposal that the Board retires the current guidelines?

Communication is one of, if not the most, important component of a health practitioner's responsibility. Indeed, the Board's recent podcast on vexatious notifications emphasises the importance of communication. Dental records, if correctly recorded, are the evidence of the dental practitioner's transactions with the patient.

This author, being a Sessional Member of the Victorian Civil and Administration Tribunal, has participated in hearings where assessment of dental practitioners' dental records has been shown to be inadequate. Whilst this has led to concerns with appropriate informed consent of the aggrieved patients, it is the compliance, or not, with dental record keeping guidelines which has been noted:

- [13] The recorded clinical findings were scant, being restricted to tick-boxes with two comments appended, and an odotongram (sic) containing only a notation about recurrent caries on teeth 11 and 21. Details of extensive dental work to Ms AB's teeth were not recorded. This includes nine root canals, multiple crowns and a bridge (and some of the crowns were subsequently reported by others as having fractured porcelain). Futher (sic), there was no record of a complete periodontic charting, nor a full mouth radiographic survey as might have been expected.[1]
- [41] We note the concern of the auditor in October 2012 that he found not one instance of any record of a patient being advised of the advantages, disadvantages, risks, possible complications of treatment, nor of advice regarding alternatives to treatment, or the number of visits or longevity of the treatment. We share this concern. No dental practice can be allowed to operate in this way in the modern world. It is a dereliction of a dentists (sic) duty of care to his patient.[2]

Accreditation of health service providers is a way of measuring compliance with codes and guidelines and instructions. Both private and Victorian public dental services embrace accreditation, although undertaking accreditation for private dental services is not obligatory. The components of accreditation require the collection of evidence to support the compliance with accreditation standards. National Safety and Quality Health Service (NSQHS) Standard 1.9.2 requires:

> The design of the patient clinical record allows for systematic audit of the contents against the requirements of these Standards[3]

[1] Dental Board of Australia v Fibishenko (Occupational and Business Regulation) [2011] VCAT 1835 (28 September 2011)
[2] Dental Board of Australia v Zehtab-Jardid (Review and Regulation) [2014] VCAT 80 (21 January 2014)
[3] https://www.safetyandquality.gov.au/sites/default/files/migrated/NSQHS-Standards-Guide-for-Dental-Practices-and-Services-November-2015.pdf, accessed 21/01/2020

An NSQHS suggested strategy is to

ensure that the patient dental record complies with relevant standards, guidelines and policies that apply to dental record documentation such as the Dental Board of Australia's Guidelines on dental records.[4]

Additional strategies include:

- [1.9.1] all aspects of dental care can be documented, including:
  - medical history
  - correspondence from other healthcare professionals
  - examination and test results
  - radiographs
  - photographs
  - treatment options
  - treatment plan
  - the informed consent process[5]
- [1.18.2] review of patient dental records for documentation of the informed consent process[6]
- [4.6.1] the procedures for obtaining and documenting an accurate and current medication history that includes allergies and previous adverse drug reactions.[7]

DHSV's Dental Record Keeping Self Audit Guide additionally links further NSQHS standards with components in the Board's Guidelines. For example,

- [3.2.a.xii] a medicine/drug prescribed, administered or supplied or any other therapeutic agent used

is linked to Standard 4.5.1 *The performance of the medication management system is regularly assessed*, and to Standard 3.14 *Developing, implementing and regularly reviewing the effectiveness of the antimicrobial stewardship system*;

- [3.3.a] referrals to and from other practitioners

is linked to Standard 6.3.1 *Regular evaluation and monitoring processes for clinical handover are in place*; and

- [3.2.a.xi] instrument batch (tracking) control identification

is linked to Standard 3.17.1 *A traceability system that identifies patients who have a procedure using sterile reusable medical instruments and devices is in place*.

Compliance with, and evidence of, NSQHS Standards is an accepted, and often expected, part of modern health practice. In the absence of the Board's Guidelines specifically detailing individual components, it would be difficult to achieve accreditation without adding significant work practices.

Community dental practices in Victoria are routinely not managed by a registered dental practitioner. In those instances, managers would not be conversant with the Board's Code of Conduct requiring that dental practitioners are responsible for *maintaining clear and accurate health records for the continuing good care of patients*[8]. In undertaking an audit to ensure that the practitioners are compliant, non-dental managers do require a checklist to assess or critique dental practitioners' record keeping.

Such a checklist exists in the current Guidelines, and is readily used as a resource by practitioners and practice management. This checklist will survive, even if the Guidelines are retired, so that audits, by other than the practitioner creating the record, can occur. Retention of the existing Guidelines by the Board will allow updating to occur as processes and systems evolve.

This author disagrees with the Board's assumption that the Guidelines have *created an unrealistic expectation that all aspects of guidelines must be met to satisfy the requirements of the Board*. In my engagement as a Board-appointed auditor, I have recorded Not Applicable to some components of the Guidelines, without this decision being contradicted.

Consistency between auditors is important to maintain reliability and ensure processes are performing similarly. Different interpretations can be made of the requirements of the Code of Conduct section 8.4.a *clinical history, clinical findings, investigations, information given to patients or clients, medication and other management*. For example, it is far more beneficial to specify that record keeping requires <u>all</u> of the *name, quantity, dose, instructions*[9] of medications rather than just *report … medication*[10].

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[4] Ibid p45
[5] Ibid p44
[6] Ibid p57
[7] Ibid p118
[8] https://www.dentalboard.gov.au/Codes-Guidelines/Policies-Codes-Guidelines/Code-of-conduct.aspx, accessed 21/01/2020, section 8.4
[9] https://www.dentalboard.gov.au/documents/default.aspx?record=WD10%2f1398&dbid=AP&chksum=IkenNC8OCIXJA96kR0OfqA%3d%3d, accessed 21/01/2020, section 3.2.a.xii
[10] https://www.dentalboard.gov.au/Codes-Guidelines/Policies-Codes-Guidelines/Code-of-conduct.aspx, accessed 21/01/2020, section 8.4.a

The Board often requires audits of practitioners as part of conditions imposed upon the practitioner. The audits are undertaken by a variety of auditors approved by the Board, but there is no inter-auditor reliability or comparison currently in place. Retention of the existing Guidelines by the Board will provide a base upon which different auditors can rely.

This author agrees with the consultation paper's discussion on the *Behaviours* domain.

This author disagrees with some of the consultation paper's discussion on the *General principles to be applied* domain. In this domain, the current Guidelines include some details that are not documented anywhere else. For example, *how to manage corrections* is not explained elsewhere within the Code of Conduct or the proposed fact sheet. It is often helpful that a history of the dental recording be visualised; without a directive that *Corrections made to records must not remove the original information*[11], newly registered practitioners would not be aware that this is an expectation.

This author has expressed elsewhere for the retention of the *Information to be recorded* domain.

3. Is the content of the fact sheet helpful, clear and relevant?
4. Is there any content that needs to be changed, added or deleted to the fact sheet?

In consideration of the proposed fact sheet, I have disregarded my arguments above for the retention of the Guidelines. However, removal of a perfectly adequate document and replacement with a fact sheet appears to defeat the Board's intention of not creating *a further level of regulation when expectations are adequately stipulated in the Code of Conduct*[12].

The proposed fact sheet is not helpful to someone attempting to maintain quality patient health records. The fact sheet simply appears to contain or be based on a summary of paragraphs derived from the Code of Conduct or other Board documents.

Key things you need to know

- The Code of Conduct is correctly referenced in this fact sheet, as this is the most important document relevant to the practice of dentistry.
- Continuing professional development (CPD) need not be referred to in the fact sheet, as the Board does not endorse or recommend CPD. By articulating that CPD courses on record keeping are available, it could be construed that attendance at such a CPD course is required to satisfy the requirements of the Board.
- Whilst Professional Indemnity Insurance (PII) is a requirement of practice, it has nothing to do with maintaining patient health records. It only comes into play when there are allegations of sub-standard records. The reference to PII is not required in the fact sheet.
- Compliance with state and territory legislation is fully covered in the reference to the Code of Conduct (first bullet above), and need not be reiterated again.
- Compliance with privacy legislation is fully covered in the reference to the Code of Conduct (first bullet above), and need not be reiterated again.
- Understanding the principles of maintaining health records is fully covered in the reference to the Code of Conduct (first bullet above), and need not be reiterated again.

Resources to help you

The Code of Conduct has already been acknowledged (first bullet above). It is redundant to rewrite that sections 2.1, 2.2, 3.3, 3.4, 3.5, 3.13, 3.14, 3.16, and 8.4 are applicable, as all registered practitioners are already meant to be fully conversant with all components of the code.

I urge the Board not to retire a document that has served dental practitioners well (in Victoria from 2003), and undeniably helps to protect the public and manage any risks.

Sincerely,

Colin D Riley

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11 https://www.dentalboard.gov.au/documents/default.aspx?record=WD10%2f1398&dbid=AP&chksum=IkenNC8OCIXJA96kR0OfqA%3d%3d, accessed 21/01/2020, section 2.10

12 https://www.dentalboard.gov.au/documents/default.aspx?record=WD19%2f29301&dbid=AP&chksum=XFEdgxjrt2ysdc21rDHPGg%3d%3d, accessed 21/01/2020, section 25.