Orthodontic records: collection and management
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1. Introduction

This booklet replaces advice sheets:
- Orthodontic Records Collection and Management.
- Principles of Confidential Patient Information Management.
- Use and Storage of Digital Photographs.
- Orthodontic Transfer Cases.

Health records are an integral part of effective patient care, their principal purpose is to record the management of a patient, documenting continuity of treatment and outcomes.

This document gives information regarding the collection and management of orthodontic clinical records and the transfer of orthodontic records. It specifies the principles, standards and guidance which apply to the orthodontist and all members of the dental team.

Maintaining and protecting patients’ information is one of the nine principles registered dental professionals must keep at all times. (General Dental Council ‘Standards for the Dental Team’, 2013).

2. Why are good clinical records important?

2.1 For effective and efficient orthodontic practice
Clinical records are used at every consultation and are designed to provide an accurate picture of patient treatment and care. Good clinical records are an important means of communication between different health professionals caring for the patient. Records must be contemporaneous, clear, concise and complete. They have most value when they are accurate, up-to-date and accessible when required.

2.2 For improving standards of patient care
Clinical records are a valuable resource because of the information they contain. Auditing clinical records is an important part of the clinical governance process and records should be written in a way that facilitates this process. Information within clinical records may also be used for research.

2.3 For responding to complaints
Clinical records can provide vital evidence if the standard of orthodontic care is called into question. Many clinical negligence claims are indefensible because records are inaccurate, illegible, too brief or missing. The orthodontist may have
done nothing wrong, but unless the clinical records support this, it can be difficult to defend a claim.

Any clinical record which records any aspect of the care of a patient can be required as evidence. The legal approach to record keeping tends to be ‘if it is not recorded it has not been done’.

3. What constitutes the clinical record?

Clinical records include any information created by, or on behalf of, a health professional in connection with the care of a patient. All healthcare professionals are responsible for any records that they create in the performance of their duties. Orthodontic records are a working tool for the orthodontist and can cover a wide range of material:

- Handwritten notes.
- Computerised records.
- Referral letters.
- Correspondence between health professionals.
- Correspondence from the patient (not relating to complaints).
- Emails.
- Record of telephone conversations (telephone consultations; advice given).
- Radiographs and other imaging records.
- Laboratory or radiography reports. These should be seen and evaluated before being filed in the notes. Abnormal results should be noted in the clinical record and any action recorded.
- Photographs, videos and other recordings.
- Orthodontic study models.
- 3D digital models.
- Statements concerning custom-made devices provided under the Medical Devices Regulations e.g. laboratory sheets.
- Consent forms.
- NHS forms.
- Legal reports and correspondence relating to complaints/claims should be filed separately, because they are not part of the patient’s clinical record.
4. Writing good clinical records

The orthodontic clinical record should enable another person to reconstruct your consultations with the patient and show how decisions related to patient care were made. Notes should include:

- Reason/s for referral.
- Patient’s presenting complaint.
- History (dental, medical and social).
- Details of the orthodontic examination.
- Description of radiographic findings and the results of any special tests.
- Orthodontic diagnosis - presented in clear, easily understood terms.
- Record of the level of treatment need e.g. IOTN.
- Treatment aims and options for treatment.
- Treatment plan/s (it should be clear from the notes how you arrived at this plan). A copy of the treatment plan/s must be given to the patient/guardian before the treatment commences and a copy, signed by the patient and/or parent, should be retained as part of the clinical records. (General Dental Council ‘Standards for Dental Team’, 2013).
- Changes to the treatment plan during treatment.
- Details of discussions with the patient and information given, including details of risks and benefits of particular treatments. It is important to include details of all options discussed. You must check and document that the patient and/or guardian understands the information you have given to them.
- Details of any consent that the patient and/or guardian has given.
- Details of discussions with the patient and/or guardian to confirm ongoing, valid consent, at each stage of any investigation and treatment, must be documented.
- Details of treatment undertaken at each appointment, including measurements as part of monitoring e.g. overjet.
- Details of any complications.
- Details of any questions asked by patient/guardian during consent process.
- Details of cancelled or failed appointments.
- Details of any discussions about patient’s non-compliance e.g. poor oral hygiene, failure to wear elastics as prescribed.
- Telephone messages and/or conversations relating to a patient’s care should be recorded in the patient’s notes.
It is not only the content of the notes that is important, but also the way the notes are presented and managed:

- There should be one set of clinical records for each patient.
- Records should be readily available.
- The patient should be clearly identified on all clinical records by a unique identifier which should be present on each record sheet.
- Written entries should be dated and signed. Printing the name after the signature, or using a pre-inked stamp, is advisable, especially where the patient receives treatment from more than one clinician.
- Writing should be in black ink, to allow photocopying, and should be clear and legible, so that records can be understood by anyone who may need to read and interpret them.
- All electronic records should clearly identify the author and should be dated.
- Entries should be concise; long enough to convey the essential information, but not too wordy.
- Records should be made contemporaneously e.g. at, or very close to, the time of treatment.
- Records should be kept up-to-date and filed chronologically.
- Records should be factual and not include unnecessary abbreviations, jargon, irrelevant speculation or coded expressions of sarcasm. Inappropriate observations about the patient’s or carer’s character or appearance should not be recorded.
- Only defined abbreviations should be used in the notes. Abbreviations must never be used on consent forms.
- For dento-legal purposes it should be possible to make hard copies of electronic records. When hard copy documents are scanned for storage it is important to ensure there is no loss of information.

5. Amending clinical records

- The original clinical records should not be changed unless the information is factually incorrect.
- It must be clear that the correction is a new note, not an attempt to tamper with or falsify the original record.
- If a mistake is discovered, an additional note should be added as a correction, stating the date of the amendment. Notes should never be erased, overwritten or inked out. Amendments to records should be immediately apparent using a single strike through, so that the previous entry is still legible, although obviously deleted, and the new entry clear, dated and signed.
Patients have a right under the Data Protection Act (1998) to have it noted on their records, if they dispute their accuracy. Records should only be amended if the original information was inaccurate, misleading or incomplete. If an entry in the record is changed, include a note, signed and dated, to say that the incorrect information was altered at the patient’s request.

Computer systems should also track any amendments and it should be immediately apparent if electronic data has been modified or altered. Although digital photographs, 3D scans and radiographs can be manipulated and enhanced on the computer, the original record must be preserved and safeguarded. There should be a full audit trail so that any amendments can be dated and alterations/erasures are not possible.

6. Radiographs, photographs, study models and 3D study models

Records such as radiographs, photographs, visual recordings and study models, either as hard copies or in digital format, complement the written record. To be of value, these records must be of good quality.

If clinical records are to be used for reasons other than clinical decision-making e.g. teaching, research, or audit, then the patient’s consent should normally be sought. Consent is always required when such records are used for publication. If systematic record collection is intended, ethical approval must be obtained.

6.1 Radiographs

Radiographs should only be taken when there is a clinical need (justification) and comply with IRMER guidelines (2006). All radiographs should be reported on and relevant clinical findings should be recorded in the notes.

6.2 Photographic records

6.2.1 Consent

Permission should always be sought from patients before photographs are taken. The DoH model consent policy (http://www.dh.gov.uk) states that expressed consent for photographs is not required where there is no prospect of the patient being recognized, and where the images are to be used within the clinical setting for education or research purposes, as long as this policy is well publicised. Where it may be possible to identify an individual, written consent is required.
When taking an image of a patient, it must be explained to them:

- Why the image is being taken.
- The intended use of the image.
- The arrangements for storage of the image.

The Institute of Medical Illustrators (IMI) has a model policy on photography (http://www.imi.org.uk). This states that it is not sufficient to rely on one individual’s interpretation as to whether a patient can be identified from a photograph and recommends that written consent should be obtained for all medical photography. It is good practice to reconfirm a patient’s consent, in writing, before using a patient’s photographs in a publication.

The IMI have produced a photographic consent form that allows for three levels of consent:
- Medical record use only.
- Medical record and teaching use.
- One specific purpose e.g. a publication.

Alternatively, the generic NHS consent form # 3, available at http://www.dh.gov.uk, can be used to gain consent for both photography and any orthodontic treatment the patient is to receive. This can be recorded under the heading ‘Name of Procedure’. In many Hospital and Community Trusts this consent form, or the Trust’s own variation, is already in use for orthodontic treatment. On the BOS consent form, specific consent for photography can be included under the heading of ‘Additional procedures which might be necessary’.

### 6.2.2 Consent for the publication of images

Written consent is essential for publication of any image but there is no blanket consent for publication. A patient ticking the publication box on the consent form does not entitle a clinician to publish the photographs in any publication. Consent should be gained for each specific publication of a patient’s photographs listing the title of each publication where the photographs will appear.

Many academic papers also appear as online content, meaning that clinical photographs consented for publication will appear on the internet. Patients must be made aware that once an image has been placed in the public domain it will be difficult to control its future use.
6.2.3 Young People aged 16-17

Patients aged 16-17 should be treated as adults when gaining consent for photography.

6.2.4 Withdrawal of consent

Patients who have consented to photography or filming have a right to withdraw that consent at any time. Visual recordings that form part of the healthcare record cannot be destroyed except under Retention and Destruction policies (see section 13: Destruction of clinical records).

6.2.5 Anonymity of images

Providing the appropriate level of consent is obtained, making pictures anonymous is no longer an issue. Blacking out a patient’s eyes in a photograph is not acceptable as a method of avoiding the need to gain informed consent, especially when publication of the image is intended.

6.2.6 Removable media

Digital images are stored either on the camera’s built-in memory or on removable media such as SD cards. Deleting files from these cards, using the delete or format function, does not permanently remove them. Only the ‘flags’ that mark where the files are on the card’s file structure are deleted. The actual image files remain and may be retrieved. Removable media that has been used to take patient images should never be loaned.

6.2.7 Copyright

Digital photography is based on written computer code and therefore, under copyright law, it is classed as a literary work. Digital images are thereby governed by the same rules that apply to any published material. Anyone who takes a digital image is the owner of that image and therefore owns the rights to it. No one else can use, reproduce or modify it without the permission of the owner. Organisations, such as NHS trusts, might insist on owning the copyright of their patients’ medical illustrations. However, a patient is entitled to copies of their photographs, as these form part of their dental records.
6.2.8 Digital image security

There are several methods of protecting the authenticity of digital images. These fall into two broad groups:

- Watermarking - this embeds a pattern within the image that cannot be seen by the eye, allowing any alteration of the image, in the form of cropping or rotating, to be detected.
- Digital signature - this works in a similar way, but the information is attached to the image in a user-defined part of the file or an independent file.

Some more sophisticated digital cameras have pixel-tracking software, which allows any manipulation of images to be traced. Some of the dedicated dental manipulation and storage software programs save the original image separate from any manipulated images.

The IMI state that, until the use of tracking software to protect the integrity of the image is common practice, the unaltered original image should be stored in an uncompressed format. Digital images form part of the patient’s confidential medical record and must be subject to the same safeguards as any other data.

In addition to protecting the integrity of an electronic image, physical security measures also need to be considered. Basic security measures need to be employed such as password protection and keeping computers and backup systems, such as removable hard drives, tapes and CDs, in a secure room.

Ensure portable computers are not left unattended in clinics or whilst travelling. If you are employed by a Trust, it is a requirement that images are only placed on Trust computers, including portable devices, and that any equipment or device on which images are stored are encrypted and only serviced/repaired by authorised personnel. If such a computer is to be sold, then it may also be a requirement of the Trust for the hard drive to be wiped clean of any data, by an authorised person, prior to sale.

The Information Commissioner’s Office (ICO; www.ico.org.uk) indicates data on memory sticks should be encrypted. This is also reflected in the GDC Standards for the Dental Team Guidance which advises that if sending or storing confidential information electronically, you should ensure that it is encrypted.

6.2.9 Summary of advice on photographic records

- Seek permission prior to taking digital images.
- It is prudent to obtain consent prior to the taking of any digital images of a patient but it is essential in cases in which the patient may be recognized from the image.
• Consent should be recorded using an appropriate BOS, Trust or practice consent form.
• Record in the notes that digital images have been taken.
• Ensure patients understand why images are being taken, how they are to be stored and used, especially if they are to be published or placed on a website.
• Comply with the Data Protection Act (1998). If you work in a Trust, seek advice from your local Data Protection Officer. If you work in practice, check that your current registration with the Information Commissioner’s Office covers digital photography.
• Make appropriate secure arrangements for the storage of images on encrypted computers, hard drives and memory sticks.
• Ensure that the original unaltered image is stored in an uncompressed format on a secure server which is backed-up on a routine basis.
• It is not appropriate to take clinical photographs on a camera phone. In most Trusts the use of camera phones to take patient images is prohibited.

6.3 Study models

Plaster study models should be of good quality and be marked with the date of the impression and the patient’s unique identification details.

6.4 3D digital study models from plaster originals

Companies are now marketing 3D scanners which are able to duplicate and store the information contained in a study model and allow a copy to be created at a later stage. ‘Assuming that accurate reproduction of the model can be achieved, without loss of information, the scanning and photographing of models may be considered acceptable in place of the original models’. (DPS website).

Recent research concludes that the same orthodontic information can be obtained from study models and photographs of study models for the purposes of medico-legal reporting (Stevens et al., 2006; Malik et al., 2009).

The advantages of 3D digital study model archiving are significant in terms of cost:

• No future requirement to purchase study model boxes.
• No storage space requirement.
• Working models only required.
• Ease of transfer of records when required.
The case for the use of 3D digital study models from plaster originals has been strengthened further by the direction of the NHSBSA Dental Services to require the submission of 3D digital images of the original models, in STL file format, since February 2014.

The Orthodontist or contract holder must ensure that:

- The original plaster models are in good condition (showing all erupted teeth with no voids, chips, breakages or other deficiencies) with good extension into the sulci.
- The original study models are clearly marked and accurately trimmed to verify the occlusion.
- The date of the impression is clearly marked on the original plaster models.
- The 3D digital images of the original plaster models are produced in STL file format. An individual file needs to be provided for each of the upper and lower arches. The orientation of each file should be such that when opened together the models are presented in the correct occlusion.
- The laboratory provides 2 password-protected CDs containing the 3D images in STL file format - one to be retained and one for forwarding to NHS Dental Services.
- The 3D digital images are checked before being sent to the NHS Dental Services to ensure that they accurately represent the patient’s dentition and occlusion.
- The original plaster models are retained until the NHS Dental Services reporting process has fully concluded.

The laboratory/3D digital image supplier must ensure that:

- The original plaster models are in good condition (showing all erupted teeth with no voids, chips, breakages or other deficiencies) with good extension into the sulci.
- The original plaster models are clearly marked and accurately trimmed to verify the occlusion.
- The 3D digital images accurately reproduce all of the features of the plaster originals.
- The 3D digital images are dated as per the date of the impression (not the date of the scanning).
- The 3D digital images of the original plaster models are produced in STL file format. An individual file shall be provided for each of the upper and lower arches. The orientation of each file should be such that when opened together the models are presented in the correct occlusion.
• The plaster originals are returned to the orthodontic contract holder in suitable packaging to ensure that damage does not occur in transit.
• The laboratory provides 2 password-protected CDs containing the 3D images in STL file format - one to be retained by the contract holder and one for forwarding to NHS Dental Services.

6.4.1 Storage of 3D digital images

As with all computerized records, it is important that digital images are securely stored and access to the images is subject to an audit trail to ensure that no allegations could be made that the images have been manipulated in any way.

7. Confidentiality and security

Patients have a right to expect that a healthcare professional will not disclose any personal information that is learnt during the course of their professional duties, unless the patient gives their permission or statute permits otherwise.

A duty of confidentiality is a professional, ethical, and often contractual obligation. The rights to privacy and confidentiality are enshrined in the European Convention on Human Rights, in the Data Protection Act (1998) and in common law. It is not just because the law demands it that we are concerned with this issue, rather that the law reflects what we know to be right; that privacy and confidentiality are important values to be protected. The functional purpose of confidentiality is probably the most important as it encourages patients to be honest with a healthcare professional, when they provide information. This benefits patients individually, and society collectively e.g. communicable diseases do not go untreated and unchecked because of people's fear about who might be told.

Confidentiality is an important duty, but it is not absolute. You can disclose personal information if:
• It is required by law.
• The patient consents.
• It is justified in the public interest.
7.1 The uses of patient data

Personal patient data cannot be used for any purposes other than healthcare, without the explicit consent of the patient. An exception to this is anonymized data which can be used with fewer limitations. All members of staff, clinical and non-clinical, are bound by this duty. Since 2011 in England it is a requirement for all health and social care providers, who carry out one of the 15 regulated activities, to be registered with the Care Quality Commission (CQC).

Providers will need to have policies in place on confidentiality, data protection and data security.

In Northern Ireland, it is also a requirement that dental practitioners who work outside the NHS are registered and regulated by the RQIA (Regulation and Quality Improvement Authority).

7.2 Data Protection Act (1998)

The Data Protection Act is the main legislation underpinning the principles of personal data management. Breaches of the Act are a criminal offence and can incur a considerable fine, or even a custodial sentence. A data controller is a person who, alone, jointly or in common with others, determines the purpose and manner in which any personal data is to be processed.

‘Processing’ refers to the obtaining, storing, holding, using, and disclosing of information which can identify a living human being and it refers to both paper and digital records. Medical and dental information is classified as ‘sensitive personal data’ in the Data Protection Act and is subject to more stringent conditions than other data.

The data controller is required to notify the Information Commissioner’s Office (Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF; http://www.ico.gov.uk) and comply with the eight Data Protection Principles:

- Processed fairly and lawfully.
- Processed for one or more specified and lawful purposes.
- Be adequate, relevant and not excessive.
- Accurate and, where necessary, kept up to date.
- Kept for no longer than is necessary for the purpose for which it is being used.
- Processed in line with the rights of individuals.
- Kept secure with appropriate technical and organisational measures taken to protect information.
- Not be transferred outside the European Union unless there is adequate protection for the personal information being transferred. Patients moving abroad, outside the EEC, where there may be an inadequate level of protection in relation to the processing of personal data, must be fully informed and should consent to their data being transferred.

Under the Data Protection Act, the data controller must take reasonable steps to guarantee that data is safe from unauthorised access, disclosure, tampering or loss. This will include installing security arrangements such as password protection, the use of encrypted devices, regular computer back-ups for digital data and ensuring that all individuals, who have access to the records, are instructed about the need for confidentiality.

### 7.2.1 Dental practice and the Data Protection Act (1998)

All dentists in general and specialist practice should be registered with the Information Commissioner, even if their practice is not computerised, because they hold personal information that is filed in such a way that it can be directly traced to the patient. The introduction of digital images would require a change in notification, not a new entry. Advice should be sought from the Information Commissioner’s Office (www.ico.gov.uk).

In the practice setting, principal orthodontists, associates, and single-handed orthodontists are all required to be individually registered as data controllers. Where associates work in more than one practice only one notification is required together with a list of the other sites of work. Where a legal partnership exists the practice is required to register as a single controller. Assistants and locum orthodontists, depending on their contractual relationship, are not required to be individually registered if using the data for healthcare purposes, but will usually be contractually obliged to abide by the data protection principles. In addition, all clinicians, regardless of where they work, are bound by an ethical duty of confidentiality.

### 7.2.2 Hospital Trusts and the Data Protection Act (1998)

In most Trusts, clinicians will already be covered by the Trust/University data registration, provided they comply with the local rules of the Trust. Trusts treat the storage of data extremely seriously and now state that data should not be stored on any portable devices unless it is within an encrypted folder. Free encryption software can be downloaded from www.truecrypt.org. In some Trusts, employees,
including trainees who copy and store images for their own purposes, may be considered independent data controllers and will be required to register with the ICO. It is therefore important that you seek advice from your Trust’s local Data Protection Officer.

7.3 Security

It is the responsibility of all healthcare professionals to keep all orthodontic records safe. All clinical records should be kept in a secure environment. Unauthorised or unlawful access should not be possible. That means restricting access to authorised personnel and ensuring that records are kept physically safe. Care should be taken to ensure that unintentional breaches of confidence do not occur. Even if names and addresses are removed, the combination of date of birth and postcode can allow individuals to be identified.

- Do not leave files/computer terminals unattended or unsecured. Log out or lock your screen when leaving your desk.
- Avoid transmitting information to the wrong person or fax machine.
- Do not allow sensitive conversations to be overheard.
- The need for a case note tracking mechanism if records are passed on to a third party.
- Fire precautions - an alarm system, sprinklers and ‘no smoking’ signs.
- Preventing damage from damp, flooding or pests.
- Staff awareness of duty to prevent unauthorised disclosure and guard against people seeking information by deception.
- Passwords, encryption software and restricted access for staff.
- Never share your Username and Password information.
- The need to back up all computer data to prevent accidental loss.
- Computer repairs - ensure these are carried out on the premises or in a secure environment with a confidentiality agreement. Also consider if the software provider has access to the records.
- Keeping records in locked cabinets.

8. Social media

Facebook, Digg, Leakernet, MySpace, Hi5, Last.FM, Twitter, YouTube, Blogs etc. Social media is an increasingly powerful way of engaging and communicating with target audiences, peers, professional bodies and the public. This accessibility
has many benefits but it also comes with some risks. Staff using social media in a personal capacity may not appreciate that their postings and tweets can relatively easily be linked back to their place of work and compromise patient confidentiality. Information regarding patients must not be posted on any social media or blogging sites.

If professional social media is used to discuss anonymised cases, for the purposes of learning and best practice, it is the duty of the individual to ensure that the patient cannot be identified. It is also important that appropriate professional boundaries between clinicians and their patients are not jeopardized by interactions via social media (e.g. by becoming Facebook ‘friends’). The key principle is to presume that anything you post can be read by anyone, anywhere in the world. Even if privacy settings are set to maximum, that will not prevent a friend/follower from retweeting or posting your content.

Be aware that social media can blur the boundaries between personal, public and professional lives. Be conscious of your online image and how it may impact on your professional standing - patients and employers, both current and future. You have exactly the same ethical and legal duty to protect patient confidentiality on the internet and social media as with any other media. It would be highly inappropriate and a breach of patient confidentiality, to post informal, personal or derogatory comments about patients or colleagues on social media or other public internet forums. Defamation and contempt of court laws can apply to any comments posted on social media/the internet, in either a personal or professional capacity. (BMA guidance document: ‘Using social media: practical and ethical guidance for doctors and medical students’ - at http://bma.org.uk).

8.1 Email

Confidential information can only be sent by email using NHS addresses. NHS accounts are encrypted end-to-end automatically so the user does not have to do anything.

Important points to consider when using email:

- Confirm the email address of the recipient.
- Confidential or sensitive information should not be sent to shared or group email boxes unless you are completely sure of the group members and their security arrangements.
- Clinical images can be sent between NHS accounts and it is advisable that they should be password protected using an encryption system such as WINZIP.
8.2 Fax

One of the most common breaches of confidentiality occurs when documents containing patient identifiable information are sent by fax machine. The fax machine you are sending your information to could be sited in an open office or even a corridor. Fax machines likely to receive confidential material, should be sited in a secure room or cupboard. It is not advisable to send faxes containing patient information outside office hours.

9. Ownership of records

- NHS Trust records are the property of the individual NHS Trust.
- NHS General Dental Services records should be considered to be the property of the individual orthodontist or primary care organisation, although NHS authorities have certain rights of access to these records.
- Records for private patients are the property of the individual orthodontist but the legal position regarding the ownership of private patients’ radiographs is uncertain.

Orthodontic patients sometimes request their records because they are moving away or for another reason. Under the Data Protection Act, patients are entitled to a copy of the information retained – not the original records. Subject to the practice arrangements the records may be owned by the practice rather than an individual associate orthodontist.

9.1 Who is responsible for retention of records on sale of practice?

The clinical records are normally considered to be the property of the practice. When a dental practice is sold, the clinical records would normally be considered to be part of the goodwill of the practice and the contract for sale would usually include provisions for the transfer of ownership of the records along with everything else. Naturally, this would also include the transfer of the responsibility
for the safekeeping of the records. However, it is not unknown for the new practice owner to feel that since they had had no previous involvement in the care of those patients, then they have no legal responsibility to retain their records.

It is therefore prudent to include a clause in the contract of sale to protect the vendor in such circumstances, stipulating that the new owner undertakes to safeguard the records on behalf of the vendor and agrees to disclose copies to the vendor or the vendor’s indemnity provider, if requested to do so, in the future. In this way, resolution of a subsequent complaint or claim would be facilitated. Patients also have the right to be told where their clinical records are being held and who is responsible for them.

10 Access to clinical records

10.1 The Patient

Under the terms of the Data Protection Act (1998), any patient, although they do not have ownership of their clinical records, has a right to access or view them within 40 days of a written request (delivered by post, email or fax). Once identification of the requesting patient is confirmed, the records can be released, although the original records should not be taken out of the practice/hospital. In some circumstances a fee may be charged to patients for accessing their records. The maximum charged will depend on the format of the records e.g. electronic or paper based. The Information Commissioner’s Office and the Medical and Dental Protection Organisations are able to provide the latest information on charges. There is a maximum fee and this needs to be able to be justified. The patient making the access request must be advised of the charge in advance.

Access by competent patients should be allowed unless it is likely to cause serious harm to the patient or another person, or the records refer to another person (excluding healthcare professionals) who has not given consent to disclosure. Only those with established parental responsibility may have access to a child’s records, and only if it is in the child’s best interests and not against a competent child’s wishes.

The legislation covering access to medical records does not affect your freedom to deal informally with an approach for access. If you are happy to show a patient their records and you have no concerns about any harm that may result to themselves or others, then there is nothing to stop you doing so. You do not need to follow a formal procedure.
10.2 Disclosure

It is your professional duty to respect the confidentiality of all information you hold about a patient. You may be asked to disclose a patient’s records to certain individuals or authorities e.g. relatives and carers, social services, police, solicitors, the courts. Except in exceptional circumstances, always seek the patient’s consent to disclose any information about them to others.

For consent to disclosure of records to be valid, the patient must understand:

- To whom the information will be disclosed.
- What information will be disclosed.
- The purpose of disclosure and any significant foreseeable consequences.

For further information on consent please see BOS Advice Sheet: ‘Consent in Orthodontics’.

If the patient allows their information to be shared you must ensure that anyone with whom you share the information understands that the information is confidential. Only share the minimum information necessary for its intended purpose.

You should respect the wishes of a patient who has not given permission to disclosure, unless this can be justified to be in the public interest. Even though strict adherence to the principles of confidentiality should be observed at all times, there are some extreme cases where a breach of confidence can be justified:

- Court Order - Where a court order requests that personal data be released, this should be complied with, however, care must be taken that only the minimum data is revealed and only to the bodies specified in the order.
- Police Request - The police are not automatically entitled access to personal patient data unless they produce a court order. The clinician must satisfy himself/herself that there is a definite public interest justification and document it clearly in the patient’s notes. If in doubt, legal advice should be sought.

10.3 Inter-professional transfer

It is permissible to liaise with other healthcare professionals involved in a patient’s care without explicit consent, but where possible it is advisable to ensure that the patient is content with the disclosure. In any circumstances where a decision is made to release confidential information, always fully document the request and
the reasons for the release of the confidential information. If you are in any doubt about how to act, contact your defence union or the legal department in the Trust in which you are employed.

10.4 Deceased patients

The duty to respect patient confidentiality extends beyond death. The coroner has a right to access the records of a deceased patient, but in most other situations you will need to obtain authority from an executor of the will or a next of kin, unless it is to aid identification.

10.5 Litigation

If you, as the orthodontist holding the records, are the subject of litigation and a request for records disclosure is made, it is advisable to act through your defence union. The GDC Standards for the Dental Team (2013) requires any dentist to cooperate with any formal enquiry into the treatment of a patient.

10.6 The use of patient data in research/teaching/audit purposes

Research, epidemiology, public health surveillance, health service planning and education and training are among the important secondary uses made of patient information. Each of these uses can serve important public interests. For many secondary uses, it will be sufficient and practicable to disclose only anonymised or coded information. When identifiable information is needed, or it is not practicable to remove identifiable information, then the patient’s expressed consent is required. During the approval process of a research study these issues are often investigated through ethics committees.

You may disclose identifiable information without consent if it is required by law, if it is approved under section 251 of the NHS Act (2006) or if it can be justified in the public interest and it is either:

- Necessary to use identifiable information.
- Not practicable to anonymise or code the information.
- Not practicable to seek consent (or efforts to seek consent have been unsuccessful).

When considering whether the public interest in disclosures for secondary uses outweighs patient’s and the public interest in keeping the information confidential,
you must consider:

- The nature of the information to be disclosed.
- What use will be made of the information.
- How many people will have access to the information.
- The confidentiality and security arrangements in place to protect the information from further disclosure.
- The advice of a Caldicott Guardian or similar expert adviser, who is not directly connected with the use for which disclosure is being considered.
- The potential for distress or harm to patients.

Caldicott Guardians are senior people in NHS, local authority social care, and partner organisations, who are responsible for protecting the confidentiality of patient information and enabling appropriate information sharing.

When considering applications for support under section 251 of the NHS Act (2006) in England and Wales, the National Information Governance Board considers:

- The feasibility of doing the research or other activity with patient’s consent or by using anonymised or coded information.
- Whether the use of identifiable information would benefit patients or the public sufficiently to outweigh the patient’s right to privacy.

### 10.6.1 Northern Ireland

The Privacy Advisory Committee in Northern Ireland can advise on some of the same considerations; but it has no statutory powers and so cannot give lawful authority to disclosures of identifiable information without consent. In the event of a complaint or challenge, its advice on best practice might play an important part in any assessment of the propriety of a disclosure.

### 10.6.2 Scotland

The Privacy Advisory Committee in Scotland performs a different role, and doctors here should seek the advice of Caldicott Guardians, defence unions or professional bodies if they are unsure about whether disclosures of identifiable information for secondary uses can be justified in the public interest.

You should only disclose identifiable information for research if that research is approved by a Research Ethics Committee. You should alert Research Ethics Committees to disclosures of identifiable information without consent when applying for approval for research projects.
10.7 Other aspects

- Patient identifiable information includes anything which can identify a patient and includes name, address, postcode, photos, NHS number, date of birth and anything else by which a patient may be identified, for example, rare diseases, unusual statistical analyses, videos etc.
- The Confidentiality NHS Code of Practice supports this answer and states that `staff should not normally take patient records home'. However, the statement continues to state `that where this cannot be avoided, procedures for safeguarding the information effectively should be locally agreed’ demonstrating that the guidelines are not always entirely clear and clinical judgment should be used for each case.
- All envelopes used in patient correspondence should be marked private and confidential.
- When receiving telephone calls, the health professional should always confirm the identity of the person they are speaking to. Ideally, if someone has called you and you are not sure who they are, it is advisable to ring them back using a verifiable telephone number.

11. Records Transfer

If it is known that a patient is moving out of your area in the near future it is preferable for the patient to defer starting orthodontic treatment until after they have relocated.

In most instances patient transfer is an uneventful process. However, just occasionally problems do arise and this is usually due to one of the following:

- A non-orthodontic referral route e.g. self-referral or from a general dental practitioner.
- No case records.
- A long period without appliance adjustments.

As a result the new orthodontist may be unaware of the starting malocclusion; the stage of treatment; the appliance system; the aims of treatment and the financial arrangements or otherwise that were entered into with the previous orthodontist.
11.1 Transfer Process

There are a number of ways of locating an orthodontist in the UK:

- Personal knowledge of a colleague in the area to which the patient is moving.
- Contacting the Orthodontic Department of the hospital closest to the patient’s new address.
- The BOS online directory: http://members.bos.org.uk/FindATreatment. This can be searched by town, postcode and even country to give a list of dentists in the area who are members of the British Orthodontic Society.
- The GDC Orthodontic Specialist list. This can be searched by town and/or postcode to provide a list of orthodontists on the UK Specialist List: http://www.gdc-uk.org/Pages/SearchRegisters.aspx.

Once the new orthodontist has agreed to accept the patient a more formal transfer can take place.

When transferring a patient, sufficient information should be forwarded to the new orthodontist to enable treatment to continue with the minimum of disruption. A suggested minimum data set is outlined on the BOS Case Transfer Form (See Appendix 1) and should include a set of duplicate records where appropriate. You should keep the original records until the transfer has been completed.

11.2 Prior to the transfer

Try to ensure all the appliances are in good order and that the oral hygiene is as satisfactory as possible. It is advisable to take up to date records, such as study models and photographs, just prior to transfer to the new orthodontist.

Both the patient and parents should be advised that the accepting orthodontist will have full authority to treat the case in a manner that they feel is best for the patient. They should also be reminded that orthodontic treatment normally involves appliance change throughout treatment and the new orthodontist may therefore make further changes.

The patient/guardian should also be made aware that private fee schedules vary and that it is reasonable to expect a change in the fee arrangements.

Try to avoid making statements as to the period of time the new orthodontist will require to complete the treatment.

The patient/guardian should be advised that all the pertinent records will be forwarded to the new orthodontist, but that the referring orthodontist will continue to be available until the transfer is complete.
11.3 Accepting a transfer

Once you have received a referral letter and records consider the following:

- If you are unable to accept the transfer, or following examination feel unable to do so, let the referring orthodontist know as soon as possible. If possible try to secure the services of another competent orthodontist in your area.
- Following a review of the diagnostic data, inform the patient and/or parents of the procedures necessary to achieve a successful treatment outcome and particularly any fee schedule where relevant.
- If all parties are in agreement regarding the transfer of treatment to the new orthodontist, then the patient should be welcomed into the practice as quickly as possible.

Occasionally patients are transferred who are ready for treatment but have not yet started. In such cases consideration should be given to crediting the time the patient may have spent on the previous orthodontist’s waiting list.

Sometimes patients under treatment arrive without being referred. In such cases it is prudent to write to the original orthodontist to request the necessary transfer information, as outlined in the BOS Case Transfer Form (Appendix 1), along with a set of duplicate records, in order to avoid unnecessary confusion. It is advisable to get up to date records, such as study models and photographs, before continuing the orthodontic treatment.

12 How long should records be kept for?

The Data Protection Act (1998) states that personal data should not be retained for longer than is necessary. Defence unions, however, recommend that ideally all records should be retained indefinitely. There is a conflicting demand between the destruction of records, which is irreversible, and the continued storage of records, which is expensive.

Every organisation should have a retention/disposal policy in place that is based on the retention schedules contained in the Records Management: NHS Code of Practice (Department of Health, 2006 - applies in England and Wales). This code of practice includes guidance relating to minimum retention periods for clinical records. The code of practice should be followed in England and Wales but, before destroying any records, you should also ensure that you are following and complying with any local guidance. The guidance differs in different jurisdictions of the UK.
Records of private patients:
Advice regarding minimum retention periods for NHS dental records also applies to private records.

More details on the retention of patient records can be found in Appendix 2.

12.1 Study models and 3D digital study models

As study models form part of the clinical records, once they are no longer required for part of the clinical treatment, consideration may be made regarding placing these in long-term secure storage. It is advisable to keep a log of study models sent to a secure storage facility and have in place a protocol for retrieving/reviewing and destroying study models (see below).

12.2 The benefits of 3D digital study model archiving

3D digital images of models, both separately and in occlusion, may be suitable for retaining the information provided by the models. It would, however, be important to ensure no loss of information occurs if models are to be scanned in this way for the purpose of retention.

To-date there are no clear medico-legal guidelines regarding the substitution of 3D digital images for plaster study models and the subsequent destruction of the original plaster study models. There has not been a medico-legal test case to establish if, following construction of 3D digital images, the original study models, which are part of the patient’s medical records, once produced, can legally be destroyed before the time limit for the disposal of medical records as set out in the retention regimes for each jurisdiction within the UK.

It is argued that, if necessary, the plaster models could be reconstructed and there is evidence that 3D digital models provide the same clinically valid information as the plaster models they are produced from.

The NHSBSA require contract holders to keep the original plaster models until the reporting process has been completed. However the advice must be to exercise caution. If the case was difficult or there was any hint of a dispute or dissatisfaction by the patient, then it would be better to err on the side of caution and retain the study models under the current legislation. This is a fast evolving area and you are urged to check on the current legislation/guidance before disposing of plaster study models early.
The Dental Protection Society advice is that original study models should be retained during both the active treatment and retention period. This is the minimum time for which they would advise retaining original models before relying on scanned images alone.

13 Destruction of clinical records

13.1 Study models

Once a decision is made to dispose of study models, it is important these are disposed of in a confidential and secure way. Study models can no longer be disposed of in normal commercial waste (or clinical waste) as they contain gypsum, which must not be land-filled with biodegradable waste due to the risk of production of hydrogen sulphide. Local Authority waste departments should be contacted for advice regarding the disposal of this kind of waste. It is necessary to remove patient identifying information written or stamped on the study models, subject to the mode of disposal. It is also prudent to seek advice from your Trust’s or Local Authority waste coordinator. It is advisable to keep a log of any clinical records that have been destroyed so it is possible to demonstrate records have been destroyed rather than lost.

13.2 Written and digital records

All orthodontic records should be reviewed before destruction. You should have a written policy on the destruction of records, and follow that policy. A complaint or claim for clinical negligence is more likely if treatment has been less than satisfactory, especially if it involved an adverse incident or complication. Ideally you should retain any records which might involve any patient dissatisfaction or for particularly complex cases.

Destruction of records should be carried out in a way that protects patient confidentiality e.g. paper records should be shredded or incinerated with the documents being retained in a locked bin and collected upon consignment.

Computer-held records may be difficult to delete entirely from a hard drive and appropriate IT advice should be sought. You may want a specialist security firm to dispose of records for you, but make sure that they sign a confidentiality agreement and obtain written certification as proof of destruction.
14 Relevant law, regulations and guidance

Access to Health Records Act (1990) - Governs access to the health records of a deceased person.


Confidentiality: NHS Code of Practice. Department of Health (2003) - The NHS and all persons working within the NHS have a common law duty of confidence to patients. The duty of confidence extends after the patient’s death or an employee has left.


Data Protection Act (1998) Crown Copyright - Implemented on 1st March 2000, covers personal records, determining the principles that safeguard the data subjects rights. Access to the health records of living patients is governed by the act.


Freedom of Information Act (2000) - Gives extended rights of access in certain circumstances, to information which is not held on computer or a relevant filing system.

GDC Standards for the Dental Team (2013) - Sets out the standards of conduct, performance and ethics that govern dental professionals. It specifies the principles, standards and guidance which apply to all members of the dental team. It also sets out what patients can expect from dental professionals.


IRMER – Ionising Radiation (Medical Exposures) Amendment Regulations (2006).

NHS Dental Services Business Services Authority: Production of 3D digital study models from plaster originals (2014) (V1.0).

Public Records Act (1958) - Under the terms of the Public Records Act 1958 sections 1-3 all NHS records are public records. The Secretary of State for Health and all NHS bodies have a statutory duty to make arrangements for the safekeeping and eventual disposal of records.

A guide to the required standards of practice in the management of records for
those who work within or under contract to the NHS organisations in England.
It is based on current legal practice.

Setting and Achieving the NHS Standard for Records management: A roadmap

Welsh Assembly Government guidance on managing records in NHS Trusts and
Health Authorities (2012).

**Scotland:**
National Standards for Dental Services, NHS Quality Improvement Scotland (Scottish

*Scottish Executive Health Department records retention schedule (see Annex B).*

**Northern Ireland:**
The delivery of dentistry in Northern Ireland is monitored against these standards
by the Regulation and Quality Improvement Authority (RQIA) and the Health and
Social Care Board.

Code of Practice on Protecting the Confidentiality of Service User Information,
DHSSPS (2009). Department of Health, Social Services and Public Safety (Northern
Ireland): Good management, good records-acute and community.
References


Useful websites

British Medical Association www.bma.org.uk
Dental Protection Society www.dentalprotection.org
Department of Health www.dh.gov.uk/PolicyAndGuidance
Information Commissioner’s Office www.ico.gov.uk
National Archives (body responsible for advising on the management of NHS records) www.nationalarchives.gov.uk/recordsmanagement/advice/standards.htm
NHS Dental Services Business Services Authority http://www.nhsbsa.nhs.uk/DentalServices
Medical Defence Union www.the-mdu.com
Medical Protection Society www.mps.org.uk
Medical and Dental Defence Union of Scotland www.mddus.com
Northern Ireland: Regulation and Quality Improvement Authority (RQIA) www.rqia.org.uk
Appendix 1

BOS ORTHODONTIC TRANSFER CASE FORM

Date: ____________________________

To: ____________________________

From: ____________________________

Patient’s name: ____________________________

D.O.B. ____________________________ Gender: ____________________________

Old Address: ____________________________

Postcode: ____________________________ Tel No: ____________________________

New Address: ____________________________

Postcode: ____________________________ Tel No: ____________________________

Date of Move: ____________________________

Relevant Medical/Dental/Social History: ____________________________

Aims of treatment: ____________________________

Treatment plan: ____________________________

Appliance system: ____________________________

Progress: ____________________________

Records: Study models, Radiographs, photographs ____________________________

Contract: Specialist practice, Hospital, Community, GDP ____________________________

Contract: NHS, Private ____________________________ Fees due: ____________________________
Appendix 2
Guidance on retention of patient records:

England and Wales
Minimum retention periods:

Adult:
Patient health records unless otherwise specified:
• 10 years after conclusion of treatment, the patient’s death or after the patient has permanently left the country.

Child:
Records relating to children and young people (including paediatric, vaccination and community child health service records):
• Until the patient’s 25th birthday or 26th if an entry was made when the young person was 17 at the conclusion of treatment, or 8 years after death.

Dental screening records:
• Adults: 11 years after conclusion of treatment.
• Children: 11 years after conclusion of treatment, or up to their 25th birthday, whichever is the longer.
• Patients receiving treatment for a mental disorder within the meaning of the Mental Health Act 1983: 20 years after no further treatment considered necessary; or 10 years after patient’s death, if sooner.
• Patients serving in HM Armed Forces. Not to be destroyed.
• Patients serving a prison sentence. Not to be destroyed.

Photographs, X-Ray films (includes all digital images and scans) and X-Ray reports:
• Treat as a permanent part of the patient health record.

Clinical audit records:
• 5 years.

Dental Epidemiological Surveys:
• 30 years.

Scotland
The best resource, giving an up to date and comprehensive view of the various statutory and practical requirements, is the Scottish Government document - Scottish Government Records Management: NHS Code of Practice (Scotland) (available for download http://www.scotland.gov.uk).
The current guidance was published in 2012 and sets out the required standards of practice for the management of records for those who work within or under contract to NHS organisations in Scotland. It is based upon current legal requirements and professional best practice and as such can be considered as the benchmark guidance for the appropriate handling of private treatment records as well. The relevant retention periods are set out in Annexe B which details the minimum retention period for each type of health record.

Advice on minimum retention period for personal health records:
The recommended minimum retention periods should be calculated from the end of the calendar year following the last entry on the document.

Adult:
• 6 years after the last entry (see above), or 3 years after the patient’s death.

Child (16 years and under):
• Until the patient’s 25th birthday, or 26th if an entry was made when the young person was 17; or 3 years after death of the patient, if sooner.

Patient receiving treatment for a mental disorder:
• 20 years after date of last contact between the patient or client or service user and any health or care professional employed by the mental health provider, or 3 years after the death of the patient or client or service user if sooner and the patient died while in the care of the organisation.

**Northern Ireland**
In Northern Ireland the Regulation and Quality Improvement Authority (RQIA) state records should be retained for 10 years.
The Department of Health, Social Services and Public Safety – Northern Ireland http://www.dhsspsni.gov.uk gives the following advice:

Adult:
• 8 years.

General Dental Services Patient records:
• 6 years.

Orthodontic records:
• 6 years.

Dental records of a serving prisoner:
• 11 years after release from prison.
Persons lacking capacity:
- When the records come to the end of their retention period, they must be reviewed and not automatically destroyed. Such a review should take into account any genetic implications of the patient’s illness. If it is decided to retain the records, they should be subject to regular review, commencing 15 years after the conclusion of treatment.

Patients involved in clinical trials:
- 15 years after conclusion of treatment.

Child:
- Health records of a child whether in a hospital setting or a community setting should be retained until the person’s 25th birthday or 26 if the young person was 17 at conclusion of treatment, or 8 years after last entry if longer, or 8 years after death if death occurred before the 18th birthday. Where the young person is 19 then the records should be kept for 8 years after last entry. In such cases where the child grows into adulthood and maintains a need for treatment without a break of 8 years, then the record continues into adulthood and should be kept until 8 years after the last treatment or 8 years after death.

Dental and Epidemiological surveys:
- Review after 30 years.