



BRAD WRIGHT

BARRISTER

MEDIATOR | ARBITRATOR

Dental Records in the Digital Age

Digital Dentistry & Dental Technology Conference

Brad Wright - Health Law Barrister - 3 June 2022



SCAN ME



Why are records such a big deal ?

Legislation

Dental Board / AHPRA / Dental Council

Academic

Australian Dental Association

Case Law

Other Considerations

National Law 2010

**Practitioner Centred to Patient Centred
(addressing power and knowledge imbalance)**

Legislation

Health Records and Information Privacy Act 2002 (HRIP Act) (NSW)

Health Records (Privacy and Access) Act 1997 (ACT)

The *Health Records Act 2001* (Victoria) created a framework to protect the privacy of individuals' health information. It regulates the collection and handling of health information.

The Act gives individuals a legally enforceable right of access to health information about them that is contained in records held in Victoria by the private sector; and establishes Health Privacy Principles (HPPs) that will apply to health information collected and handled in Victoria by the Victorian public sector and the private sector.

The access regime and the HPPs are designed to protect privacy and promote patient autonomy, whilst also ensuring safe and effective service delivery, and the continued improvement of health services. The HPPs generally apply to: all personal information collected in providing a health, mental health, disability, aged care or palliative care service; and all health information held by other organisations.

Complaints about interferences with privacy (breaches of Part 5 of the Act or an HPP) are handled by the Health Services Commissioner.

Privacy Act (1988) Cth

The Privacy Act includes 13 [Australian Privacy Principles](#) (APPs), which apply to some private sector organisations, as well as most Australian Government agencies. These are collectively referred to as 'APP entities'.

Regulators

DENTAL BOARD CODE OF CONDUCT

Section 8.4 – Health records

Section 8.4 of the *Code of conduct* specifically refers to health records and provides you with guidance on the Board's expectations on how to manage them. It states:

Maintaining clear and accurate health records is essential for the continuing good care of patients or clients. Practitioners should be aware that some National Boards have specific guidelines in relation to records

Good practice involves:

1. keeping accurate, up-to-date, factual, objective and legible records that report relevant details of clinical history, clinical findings, investigations, information given to patients or clients, medication and other management in a form that can be understood by other health practitioners
2. ensuring that records are held securely and are not subject to unauthorised access, regardless of whether they are held electronically and/or in hard copy
3. ensuring that records show respect for patients or clients and do not include demeaning or derogatory remarks
4. ensuring that records are sufficient to facilitate continuity of care
5. making records at the time of events or as soon as possible afterwards
6. recognising the right of patients or clients to access information contained in their health records and facilitating that access, and
7. promptly facilitating the transfer of health information when requested by patients or clients.

Academic

Attributes of the complete dental record: a Delphi approach to standards

KJ Amos,*  DJ Cockrell,† C Palermo,* S Rosehill,‡ M Bearman§

*Health Professional Education and Research, Monash University, Melbourne, Victoria, Australia.

†Oral Health, School of Health Sciences, Faculty of Health, The University of Newcastle, Newcastle, New South Wales, Australia.

‡Faculty of Business and Law, University of Newcastle, Newcastle, New South Wales, Australia.

§Centre for Research in Assessment and Digital Learning, Deakin University, Melbourne, Victoria, Australia.

ABSTRACT

Background: Adherence to the Dental Board of Australia Guidelines on dental records is not universal and remediation of deficient practise requires clarity in the practical application of standards. The aim of this research is to clarify practical requirements of dental record keeping in New South Wales.

Methods: Seventeen experts were invited to participate in an electronically administered series of Delphi questionnaires. Concepts were refined until consensus was reached.

Results: Two rounds were required to achieve a satisfactory level of consensus (>80%). A high level of consensus was obtained across the two rounds, with 72% and 86% agreement on propositions in the first and second rounds, respectively. Consensus criteria were established in 14 domains to establish attributes of the complete dental record (ACDR).

Conclusions: The ACDR may supplement existing national guidelines and are likely to be useful in a remediation context in which clear, unambiguous expectations for conduct are paramount.

Keywords: Compliance, dental, documentation, record keeping, records.

Abbreviations and acronyms: ADA = Australian Dental Association; AHPRA = Australian Health Practitioner Regulation Agency; APMO = average percentage of majority opinions; DBA = Dental Board of Australia; DCNSW = Dental Council of New South Wales; NSW = New South Wales.

(Accepted for publication 11 April 2017.)

ADA Guidelines and Policy

Records consist of a variety of material generated and stored in handwritten and electronic format and include but are not limited to:

- Notes made by clinicians and staff.
- Completed written medical history.
- Consent documents.
- Copies of correspondence about and with the patient.
- Notes of telephone calls with the patient.
- Radiographs, tracings, measurements.
- Digital records including CAD/CAM records.
- Diagnostic images, reports and casts.
- Special test findings.
- Photographs, digital images and videos.
- Records of financial transactions
- Appointment books

Case Law

Dental Board of Australia v Hussain (Review and Regulation) [2022] VCAT 467

The practitioner had sent records to the Board stating that they were contemporaneous. The Board found that they had been modified materially after the notification was brought to the attention of the practitioner.

“The sixth allegation was that (he) gave false and/or misleading information to the Board, in that he indicated that a patient’s clinical records were contemporaneous when they had been edited subsequent to the date of treatment.”

“But we are unable to conclude that Dr Hussain acted altogether innocently. We consider that Dr Hussain failed to take proper care to ensure that the information he provided was true and correct. To that extent, Dr Hussain’s conduct was inconsistent with him being a fit and proper person to hold registration in the profession, in the sense that the conduct was inconsistent with him being a person with the necessary rectitude of character.”

Ownership
Assignment
Access
Possession
Control
Storage

Provision of Records

1. Other Practitioners
2. Patients
3. Regulators

Questions ?