

PART III.1 RECORDS

8. In this Part,

"communal screening program" means a program designed to detect gross oral abnormalities or disease in identified population groups, through dental hygiene assessments in which no instrument other than mirrors, explorers, probes and lights are used intra-orally, and where instruments are not used for periodontal examination, and where no payment is made from or on behalf of a client to the member. O. Reg. 9/08, s. 1.

9. (1) A member shall, in relation to his or her practice, take all reasonable steps to ensure that records are made, used, maintained, retained and disclosed in accordance with this Regulation. O. Reg. 9/08, s. 1.

(2) A member shall ensure that his or her records are up to date and made, used, maintained, retained and disclosed in accordance with this Regulation. O. Reg. 9/08, s. 1.

10. (1) Subject to subsection (2), a member shall maintain a daily appointment record that contains the name of each client who the member examines, treats or for whom the member renders any service. O. Reg. 9/08, s. 1.

(2) Where a client is part of a communal screening program, the member shall maintain a daily appointment record that contains,

(a) the information required under subsection (1); or

(b) the name of each client participating in the program, the name of the group each client is associated with and the name of any other member working with the member. O. Reg. 9/08, s. 1.

11. (1) Each member shall maintain an equipment service record that contains servicing information for any instrument or equipment that is used by the member to examine, treat or render any dental hygiene service to a client. O. Reg. 9/08, s. 1.

(2) Each member shall maintain a record referred to in subsection (1) in relation to equipment that is used to sterilize equipment or instruments. O. Reg. 9/08, s. 1.

12. (1) Each member shall maintain a financial record for each client, unless the client is a client in a communal screening program, or any other program where there is no payment from or on behalf of a client to the member. O. Reg. 9/08, s. 1.

(2) A financial record shall contain the treatment or procedure rendered, the fee charged or received, and where available, the record of any receipt issued by or on behalf of the member. O. Reg. 9/08, s. 1.

12.1 (1) Subject to section 12.2, each member shall maintain a client health record for each client, that contains,

- (a) the client's name, address, and date of birth;
- (b) the date of each professional contact with the client, or the client's substitute decision-maker, and whether the contact was made in person, telephone or electronically;
- (c) for each intervention, the amount of time the member spent providing dental hygiene care;
- (d) the name and address of the client's primary care provider, if available;
- (e) the name and address of the client's primary care dentist, if available, unless the record is shared with that dentist;
- (f) the name and address of any referring health professional;
- (g) an appropriate medical and dental history of the client;
- (h) every written report received by the member respecting examinations, tests, consultations or treatments performed by any other person relating to the client;
- (i) a copy of every written communication sent by the member relating to the client;
- (j) each examination, clinical finding and assessment relating to the client;
- (k) any medication taken by the client as a precondition to treatment or examination by the member for each intervention, including the name of the medication, the time it was taken, and if the medication was not administered to the client by the client, the name of the person who administered it to the client;
- (l) any dental hygiene treatment plan;
- (m) each treatment or procedure performed for each intervention, and the identity of the person applying the treatment if the person applying the dental hygiene treatment was not the member;
- (n) any advice given by the member including any pre-treatment or post-treatment instruction given by the member to the client or the client's substitute decision-maker;
- (o) every controlled act, within the meaning of subsection 27 (2) of the *Regulated Health Professions Act, 1991*, performed by the member, including the source of the authority to perform the controlled act;
- (p) every referral of the client by the member to any other person;

- (q) every procedure that was commenced but not completed, including reasons for non-completion;
 - (r) a copy of every written consent provided by the client, or the client's substitute decision-maker; and
 - (s) every refusal of a treatment or procedure by the client, or the client's substitute decision-maker. O. Reg. 9/08, s. 1.
- (2) The member shall ensure that every part of a client health record has a reference identifying the client. O. Reg. 9/08, s. 1.
- (3) The member shall ensure that every entry in a client health record is dated and includes the identity of the person who made or dictated the entry. O. Reg. 9/08, s. 1.

12.2 A member shall maintain a client health record, where the client is part of a communal screening program, that contains,

- (a) the client's name, and a reference to the group with whom the client is identified;
- (b) the date and nature of the screening;
- (c) every clinical finding and assessment made by the member;
- (d) every referral of the client by the member to any other person;
- (e) a record of every refusal of a treatment or procedure by the client, or the client's substitute decision-maker. O. Reg. 9/08, s. 1.

12.3 The member shall maintain his or her records in a manner that ensures that a client or client's substitute decision-maker and an investigator, assessor or representative of the College who is authorized under the *Regulated Health Professions Act, 1991* has access to the records. O. Reg. 9/08, s. 1.

12.4 (1) Subject to subsection (2), every financial and client health record shall be retained for at least 10 years following,

- (a) the last intervention with the client or the date of the last entry in the client health record, whichever is longer; or
- (b) the day the client became or would have become 18 years old, if the client was younger than 18 at the time of the last intervention with him or her. O. Reg. 9/08, s. 1.

(2) A member shall retain a record relating to a communal screening program for at least three years following the date of the program. O. Reg. 9/08, s. 1.

(3) A member shall retain each daily appointment record respecting a client for 10 years from the date of the last client intervention and retain each equipment

service record for 10 years from the date of the last entry respecting the equipment or instrument. O. Reg. 9/08, s. 1.