Record Management & Retention Policy

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Introduction

Records management is the process by which our practice manages all the aspects of its records whether internally or externally generated and in any format or media type, from their creation, all the way through to their eventual disposal.

The practice's records are its memory, providing evidence of actions and decisions and support its daily functions and operations. The records management policy protects the interests of the practice and the rights of patients, staff and members of the public. They support consistency, continuity, efficiency and productivity and help deliver our services in consistent and equitable ways.

A code of practice has been published by the NHS as a guide to the required standards of practice in the management of records for those who work within organizations in England. It is based on current legal requirements and professional best practice. The following records management procedures are based on the code of practice and have been developed for use in our dental practice.

Scope

These procedures relate to health records held in any format by our practice. A health record is anything which contains information (in any media) which has been created or gathered for the purposes of providing commissioned services, including:

- All administrative records including personnel, estates, financial and accounting records, notes associated with complaints.
- All patient records including patient record cards, x-ray and imaging reports, registers, appointment books, orthodontic and other study models, referral letters, treatment estimates and any other records kept which fall into this category.
- Electronic records including computer databases, output, and disks etc.
- Emails

The practice has adopted a records management policy as it will gain several organizational benefits from so doing. These include:

- Better use of physical space.
- Better use of practice computer space.
- Better use of staff time.
- Improved control of information.
- Compliance with legislation and standards; and
- Reduced costs in the management, storage and ultimately in the destruction of patient records.

The key components of records management are:

- Record creation
- Record keeping
- Record maintenance
- Access and disclosure
- Closure and transfer
- Appraisal
- Archiving
- Disposal

Definitions

The term “Records Life Cycle” describes the life of a record from its creation/receipt through the period of its ‘active’ use, then into a period of ‘inactive’ retention (such as closed files which may still be referred to occasionally) and finally either confidential disposal or archival preservation.

In this policy, “Records” are defined as ‘recorded information, in any form, created or received and maintained by the practice in the transaction of its business or conduct of affairs and kept as evidence of such activity’.

“Information” is a corporate asset. The practice’s records are important sources of administrative, evidential, and historical information. They are vital to the practice to support its current and future operations (including meeting the requirements of Freedom of Information legislation), for the purpose of accountability, and for an awareness and understanding of its history and procedures.

Aims of our Records Management System

The aims of our records management system are to ensure that:

- Records are available when needed - from which the practice can form a reconstruction of activities or events that have taken place,
- Records can be accessed - records and the information within them can be located and displayed in a way consistent with its initial use, and that the current version is identified

where multiple versions exist,
- Records can be interpreted - the context of the record can be interpreted: who created or added to the record and when, during which process, and how the record is related to other records;
- Records can be trusted – the record reliably represents the information that was used in, or created by, the business process, and its integrity and authenticity can be demonstrated,
- Records can be maintained through time – the qualities of availability, accessibility, interpretation and trustworthiness can be maintained for as long as the record is needed, perhaps permanently, despite changes of format,
- Records are secure - from unauthorised or inadvertent alteration or erasure, that access and disclosure are properly controlled, and audit trails will track all use and changes.

To ensure that records are held in a robust format which remains readable for as long as records are required;

- Records are retained and disposed of appropriately - using consistent and documented retention and disposal procedures, which include provision for appraisal and the permanent preservation of records with archival value; and
- Practice staff are trained - so that all staff are made aware of their responsibilities for record-keeping and record management.

The guidelines that govern patient record keeping

There are two main sources of guidelines governing patient record keeping, namely the Faculty of General Dental Practice (FGDP UK) (Now known as The College of General dentistry (CGDent)) and the General Dental Council (GDC).

Faculty of General Dental Practice (UK) (FGDP (UK)) – now known as CGDent

The FGDP (UK) published Clinical Examination and Record Keeping – Good Practice Guidelines in 2001 and updated these guidelines in 2009, then again in 2016.

The General Dental Council (GDC)

In 2013 the GDC published the first in their series of standards documents governing the practice and conduct of dentists registered in the UK. All registered dentists are required to abide by the GDC's published guidance and a failure to do so can bring a dentist's registration into question.

'Standards for Dental Team', the document lays out the principles of practice in dentistry and provides guidance on applying these 9 standards.

Standard 4.1 of the guidance states that a practice must " *make and keep contemporaneous, complete and accurate patient records"*

Roles and Responsibilities

Mohamed Elbadri has overall responsibility for records management in the practice and they are responsible for the management of the organisation and for ensuring appropriate mechanisms are in place to support service delivery and continuity. Records management is key to this as it will ensure appropriate, accurate information is available as required.

The practice has a responsibility for ensuring that it meets its legal responsibilities, and for the adoption of internal and external governance requirements.

The Caldicott Guardian

Mohamed Elbadri, the practice's Caldicott guardian, has particular responsibility for reflecting patients interests regarding the use of patient identifiable information. They are responsible for ensuring patient identifiable information is shared in an appropriate and secure manner.

Mohamed Elbadri is responsible for ensuring that this policy is implemented and that the records management system and processes are developed, co-ordinated and monitored.

Practice Team

The practice team, as part of its operational responsibility, is responsible for the overall development and maintenance of health records management.

All staff, whether clinical or administrative, who create, receive and use records have records management responsibilities. All staff must ensure that they keep appropriate records of their work in the practice and manage those records in keeping with this policy and with any guidance subsequently produced.

All practice staff will be made aware of their responsibilities for record-keeping and record management through training and guidance.

Legal and Professional Obligations

- The UK GDPR
- The Data Protection Act 2018.
- The Freedom of Information Act 2000.
- The Common Law Duty of Confidentiality,
- Any new legislation affecting records management as it arises

Clinical Audit and Peer Review

Clinicians need to participate in a form of audit and peer review that is relevant to their sphere of practice. This must be carried out at a frequency pertinent to the degree of risk and the findings of earlier audits. Audits and reports might be expected when regulatory inspection/investigation takes place or as part of a complaint investigation.

Private practice should audit their procedures. Generally, audit is a systematic method for evaluating anything you do with the aim of improving whatever you are auditing.

The profession and the public expect health care professionals to participate in peer review as an essential tool in maintaining and improving standards of clinical care.

Peer review processes will be determined by local circumstances and the clinical interests of individual clinicians. A formal peer review process might be convened in a practice because of a local clinical need. This might be a matter of clinician discussion. Irrespective of how informal these discussions might be, they should be recorded with a note made of any outcomes and actions subsequently implemented.

Maintenance of records

The quality and the condition of the health record are vital to the service user and the organisation. Therefore, the organisation ensures that equipment used to store records on all types of media (paper, memory stick, x-ray, etc) provides storage that is clean, safe and secure from unauthorised access or environmental damage and which meets health and safety and fire regulations, but which also allows maximum accessibility of the information proportionate to the frequency of use.

Use of records

Accurate recording and knowledge of the whereabouts of all records is crucial if the information they contain is to be located quickly and efficiently. One of the main reasons why records are misplaced or lost is because their next destination is not recorded anywhere.

The practice complies with the common law duty of confidence and ensures that staff members are provided with guidance on disclosures of service user information in its staff confidentiality code of

conduct.

Terri-Gail Phillips-Hale will ensure that when records are transferred via email it is in accordance with good information security practice to ensure records are protected from unauthorised access.

Record Keeping

Records at the practice are kept safely and confidentially, in accordance with the Information Governance policy.

Comprehensive, clear, accurate, legible, contemporaneous patient records are vital to both good patient care and risk management. While this is widely known, many clinicians continue to keep records that expose them medico-legally.

All entries should be dated, with the following minimum information always recorded:

- All personal details (name, date of birth, address, contact telephone numbers, doctor"s address, special preferences)
- Medical history proforma every 12 months (or with each new course of treatment) with updates at every exam
- What the patient is complaining of (c/o), including no complaints
- Social history including smoking and alcohol
- Extra-oral examination/TMJ / Nodes (including all negative findings)
- Soft tissue exams (S/T) (including all negative findings)
- BPE – at every examination visit and periodontal pocket charts when appropriate, i.e., when BPE codes of 3 and 4
- Chart of existing and required restorations, including ‘watches’
- Caries and wear and tear
- Radiographs taken at appropriate intervals according to patient risk status/clinical need and written reports for all radiographs
- Caries and periodontal disease risk assessments
- Diagnosis (if appropriate)
- Discussions of all treatment alternatives and options, with reasons behind any treatment decisions
- Treatment plans and valid consent (including treatment declined)
- Prescription to hygienist/referral to any specialist
- Any correspondence from specialists
- LA, any drugs prescribed, all treatment details and all materials used.
- Warnings given of any potential adverse consequences of treatment.
- Any complications arising during treatment.
- All advice given.

Clinicians should audit their patient records to ensure they are following these good practice guidelines. A patient record audit proforma is available in the audit’s folder on the portal. When the CQC or any other regulator inspect practices, they will expect to see evidence that clinicians have audited their patient records on a frequent and regular basis.

Personal information

The following minimum personal information should be recorded for all patients:

- Full name (including if relevant, a note of how the patient wishes to be addressed e.g. first name, nickname, title)
- The name of the parent or guardian if the patient is a child
- Address
- Date of birth
- Preferred contact telephone numbers in order of preference
- Email address if applicable
- Name and address of the patient’s general medical practitioner

- Name of any relevant specialist practitioner
- Any other relevant patient identifier e.g., computer reference number
- Occupation
- The name of the person to be contacted in an emergency.
- If a purely private patient, the preferred usual payment method e.g., fee per item, payment plan, insurance etc.

This information should be recorded by administrative team members and updated at every examination appointment to ensure the information remains current.

Medical history

The medical history proforma should be signed by the patient and then checked with the patient, either by the dentist or by an appropriately trained dental nurse prior to the dentist signing it to confirm its accuracy.

The medical history should be updated for each new 'course' of treatment or when the patient re-attends after the agreed recall interval. It should also be updated if the practice is advised of a change to the medical history in the intervening period.

A new medical history proforma should be completed by the patient every 12 months with written updates recorded in the notes at each update.

It should be noted that the absence of an up to date medical history means that you do not have valid consent to treat the patient as you are not in possession of all the relevant information that would enable you to explain the pros and cons of all treatment options to the patient.

Relevant previous dental history

Previous dental history that may impact on the patient's current treatment needs should be recorded. This includes such things as:

- Date of last visit to a dentist
- Whether they are regular or irregular attenders
- Details of any problems or complex treatments e.g., periodontal treatments (including treatment with a hygienist), complex restorative treatments e.g. crowns, bridges, implants, orthodontic treatment, oral surgery treatment, any adverse reactions to previous analgesia/anaesthesia
- The patient's perception of their anxiety level
- Attitude to dental care e.g. pain relief only (otherwise do not perceive a need to attend), their views on the aesthetics of their teeth, commitment to a preventive approach etc.

Relevant social, behavioural or family history

Relevant social and behavioural history includes potential risk behaviour such as smoking, excessive use of alcohol, high sugar consumption, fizzy drink consumption and other potentially erosive behaviours, betel nut or tobacco chewing.

Relevant family history includes a family history of periodontal disease or siblings of children with a known high decay rate.

Reason(s) for attendance

Details of the reason or reasons the patient is attending should be recorded and it is very helpful to record this largely in the patient's own words. If the patient has no presenting complaint this should also be recorded.

Below are several examples of clinical recordings. Dentists who choose to put an added dental interpretation on what the patient has said should ensure they do not change the meaning or

emphasis of what the patient has said.

Extra-oral clinical examination

Details of the following should be recorded:

- E/O appearance including facial asymmetry or abnormal coloration
- Facial swellings
- Lymph nodes
- TMJ

Both positive and negative findings should be recorded. If there are no abnormalities an entry that states E/O – NAD is acceptable.

Intra-oral clinical examination

Details of the following should be recorded:

- Soft tissue examination – record positive and negative findings.
- Examination of the teeth to include:
- A full dental charting of the teeth present.
- Restorations (including material used)
- Caries (presence and location)
- Missing teeth
- Prostheses (including veneers or inlays, crowns, bridges, dentures and implants)
- Endodontically treated teeth.
- Teeth that should be 'watched' but do not currently require restorative intervention.
- Tooth wear
- Mobility
- Significant malocclusions and
- Treatment required.
- Examination of the periodontal tissues to include:
    - A Basic Periodontal Examination (BPE)
    - More detailed records dependent on the BPE scores

Radiographic findings

The following must be recorded:

- Justification for the exposure
- All radiographic findings (caries, bone levels, widening of periodontal membrane space, radio-opacities, endodontic treatments, unerupted teeth if needed for orthodontic assessment or if past their normal eruption date)
- No abnormal findings (can be recorded as NAD)
- A quality assurance rating denoting diagnostic value

Note – It is a legal requirement to record these radiographic findings.

Special tests

The following should be recorded if relevant:

- Vitality tests
- Percussion tests
- Pathology tests

Differential diagnosis

A differential diagnosis should be recorded for all presenting complaints and for any clinical findings such as periodontal disease, malocclusion, adverse radiographic findings etc.

Discussions and advice given.

The following should be discussed with the patient and a record of both the discussion and the outcome should be recorded:

- Diagnosis
- All alternative treatment options for a given problem
- Any risks associated with the options discussed.
- The likely longevity of a restoration or procedure (care should be taken that this is not stated as nor could it be interpreted as, a guarantee)
- Any potential consequences of choosing to do nothing.
- What the patient must do and agrees to do themselves to care for their oral health and/or any proposed restoration or procedure
- Any treatment declined.

Treatment plan

A treatment plan has several functions.

It should:

- Be a record of what treatment has been agreed with the patient and any associated risks
- Detail the costs of the treatment agreed upon.
- Lay out in chronological order what treatment is required according to the treatment cascade.
- Be signed by the dentist and the patient to demonstrate valid consent.

NICE guidance and the recall examination

A great deal of information is required at the new patient examination and if properly recorded at this stage the recall examination is an update of previously recorded information.

The recall interval should be determined using a balanced approach that follows NICE guidance and considers the risk factors and the patient's preference.

BPE

All patients should have a BPE score at every examination appointment. The BPE score will act as a guide as to what treatment is required. Records of the periodontal therapy undertaken should reflect the treatment relevant to the patient's BPE score. Hygienists and therapists are registered dental care professionals and as such have the same record keeping responsibilities as a dentist. Dentists have a shared responsibility for the patient's periodontal therapy if the treatment is undertaken by a hygienist or therapist and as such should ensure that the hygienist or therapist also keeps good patient records.

Periodontal therapy

A treatment plan for periodontal therapy should be agreed from records made at the examination stage. Depending on the diagnosis, the patient may require various types of treatment, either from a hygienist, a therapist or the dentist. Depending on their response to initial therapy they may also require referral to a periodontal specialist

Fillings

The following should be recorded:

- Details of the local anaesthetic used, including amount administered, site and type of LA used
- The tooth notation
- The filling notation e.g. MOD, MO, DO etc.
- The amount of caries present (if relevant) and whether the finished preparation is caries-free or not
- The amount of remaining tooth tissue
- The depth of the cavity (if relevant)
- The filling material used together with any special techniques such as bonding.
- Any adverse occurrences that happened during tooth preparation or filling
- Any advice or warnings given to the patient.

Crown or bridge

The following should be recorded:

- Details of the local anaesthetic used, including amount administered, site and type of LA used
- The tooth notation
- The type of restoration (crown or bridge)
- The impression material used.
- How the occlusion was recorded
- Details of temporization
- Any adverse occurrences that happened during the procedure
- Any advice or warnings given to the patient.
- Details of laboratory used.
- The date for the appointment to fit the restoration.

Root filling

The following should be recorded:

(Note for the purposes of this module it is assumed that a one visit endodontic treatment has taken place. In many instances the treatment will be divided into two or more visits).

- Details of the local anaesthetic used, including amount administered, site and type of LA used
- The tooth notation
- The reason the tooth is being endodontically treated
- Placement of rubber dam (or not if RD is not used)
- The method of gaining access
- Whether the pulp is necrotic or hyperaemic
- The method used for cleaning the canals.
- Any medicaments used.
- The method and agent used for irrigating the canals.
- The method and materials used for obturation.
- Details of temporization
- Any adverse occurrences that happened during the procedure
- Any advice or warnings given to the patient.

Denture

The following should be recorded for an existing denture:

- Type of denture (full or partial and if partial, which teeth it replaces)
- The material the denture is constructed from (acrylic, chrome/cobalt or other)
- An assessment of the retention (e.g. good, satisfactory, adequate or inadequate)
- An assessment of the stability
- An assessment of the occlusion

- An assessment of the freeway space
- If a partial denture, any periodontal or caries consequences

The following should be recorded if a new denture is being constructed:

- The reason a new denture is desirable.
- The patient's expectations together with any discussion about whether or not these are realistic.
- Details of the primary impressions
- Details of secondary impressions and type of special tray
- Details of the bite registration (and facebow if used)
- Details of the prosthetic teeth selected (make, size, shape, colour)
- Details of the try-in appointment together with a note on whether or not the patient is satisfied at this stage and any adjustments need for a retry (if relevant)
- Details of the retry appointment (if relevant)
- Details of the fit appointment and whether or nor any adjustments are made in the chair

Extraction

- The reason for the extraction and evidence of valid consent
- Details of the local anaesthetic used, including amount administered, site and type of LA used.
- The tooth notation
- A note that haemostasis has been achieved prior to discharging the patient.
- Post-operative instructions given.
- Any adverse occurrences that happened during the procedure
- Any other advice or warnings given to the patient

Surgical procedure

- The reason for the surgical procedure and evidence of valid consent
- Details of the local anaesthetic used, including amount administered, site and type of LA used.
- A detailed description of the procedure
- Type and number of sutures
- A note that haemostasis has been achieved prior to discharging the patient.
- Post-operative instructions given.
- Any adverse occurrences that happened during the procedure
- Any other advice or warnings given to the patient.

Radiographs

The taking, storage and retention of radiographs is governed by different pieces of legislation and there is some overlap.

The Ionising Radiation Regulations 2017 and the Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER) control the use of radiographs in dentistry. These regulations stipulate several requirements that impact on clinical record keeping.

Radiographs are a vital adjunct to good patient care and are used to aid diagnosis and during some treatments such as endodontic treatment. They should also be taken prior to undertaking certain restorative treatments such as crowns, bridges or veneers and prior to undertaking extractions or surgical treatments, orthodontic treatment and prior to periodontal therapy.

The Faculty of General Dental Practice (FGDP) (now known as CGDent) publishes criteria for prescribing radiographs entitled 'Selection Criteria for Dental Radiography' and these guidelines should form the basis for all radiographic prescribing in dentistry. Practitioners who fail to follow the FGDP's guidance and continue to prescribe 'routine' bitewing radiographs every 2 years risk having their decision challenged during audit visits.

Dentists have a responsibility to ensure they understand and comply with all the legislation governing radiography in dentistry.

The regulations require:

- Justification of all radiographs
- Optimisation – does not need to be recorded.
- A written clinical evaluation
- Quality assessment

How should these things be recorded?

Justification

There must be a valid reason for all radiographic exposures. Often this will be obvious and no specific comment in the notes is required e.g. working length radiographs for endodontic treatment or prior to an extraction etc. If, however, the reason for taking the radiograph(s) is not obvious then the justification should be recorded. For example, if it is only 18 months since the last bitewings were taken and the patient has few restorations and no pocketing over 3mm then a written justification would be required because this would appear to be going against the FGDP guidelines. E.g. 2 Bitewings required as patient reports recent excessive consumption of fizzy drinks. In this situation the prescribed radiographs are justified but this is not obvious until the new clinical information is known.

A written clinical evaluation

Clinical findings should be recorded for all radiographs.

Examples:

Caries LL6, UR7. Bone loss as charted.

Short root filling UR5 canals appear sclerosed, no apical pathology.

UR1 radiolucent area 3mm diameter

Also, negative findings should be recorded e.g. bitewings – NAD

Quality assessment

A principal objective of the employer's QA programme is to ensure the consistent

production of radiographs of adequate quality for diagnostic purposes, while minimising patient doses so far as possible. It is therefore important to monitor image quality performance on a regular basis and a simple subjective image quality rating system is proposed for this.

The *Guidance Notes for Dental Practitioners on the Safe Use of X-ray Equipment* recommends a two-point scale for the subjective quality rating of dental radiographs known as A or N.

Quality rating	**Basis**	**Target (percentage of radiographs or CBCT images in sample)**	
		Digital imaging	**Film imaging**
Diagnostically acceptable ("A")	No errors or minimal errors in either patient preparation, exposure, positioning, image (receptor) processing or image reconstruction and of sufficient image quality to answer the clinical question	Not less than 95%	Not less than 90%

Diagnostically not acceptable ("N")	Errors in either patient preparation, exposure, positioning, image (receptor) processing or image reconstruction which render the image diagnostically unacceptable	Not greater than 5%	Not greater than 10%

All new patients should be asked when they last had radiographs taken and every effort should be made to retrieve these from the patient's previous dentist.

Radiographs must be stored safely and retained for the same time as all other parts of the patient record. In paper-based practices or practices that retain paper records for storing artefacts such as referral letters and other correspondence analogue radiographs should be mounted and stored within the record. Digital radiographs should be stored electronically.

Photographs

Clinical photographs have an increasingly important part to play in patient record keeping. They are useful for the following:

- Before and after images for aesthetic or cosmetic cases
- For patient education especially in the case of periodontal patients where it is important to demonstrate the problem and its' cause to the patient
- A record of the patient's presenting clinical status – this is especially useful if there is likely to be a difference of clinical opinion in an alleged supervised neglect case.

Photographs should be stored and retained for the same time as all other parts of the patient record. They should either be stored electronically or as part of the paper record.

Study models

Study models are essential for planning and analysis in a number of clinical situations. These include:

- Orthodontics
- Restorative cases
- Aesthetic cases
- Implant cases
- Record of tooth wear
- Occlusal assessments

Study models form part of the patient's record and therefore should be retained for the same time as other parts of the record. Storage of study models and diagnostic wax-ups can be problematic as both are bulky items. It is however essential that provision is made for the safe long-term storage of these items. Orthodontic practices and practices that undertake a high volume of complex restorative cases are those with the greatest need for storage space.

Diagnostic wax-ups

Diagnostic wax-ups show the patient what can be achieved and should be retained with the study models for the case and for the same time period as other parts of the record.

Correspondence relating to the patient

From time to time and in certain circumstances (such as in the event of a complaint) patients will correspond with their dentist and the dentist will need to reply. This will either be via email or letter. All such correspondence should be retained in line with the specific retention periods. In the event of a complaint involving litigation of any kind then all correspondence relating to this should also be kept as part of the patient's record.

Paper-free practices will need to find an appropriate method of storing written correspondence (including emails). This can either be achieved by scanning letters and other documentation and then storing this electronically or practices that still retain paper files even though patient records are kept electronically can store written correspondence (including printouts of emails).

Referral letters and replies to referral letters

A referral letter should contain all relevant details to enable the clinician to whom the patient has been referred to contact the patient and to understand what is required. A referral may be for a second opinion or it may be a request for diagnosis and treatment.

The referral letter should include:

The patient's name, address, contact telephone number, date of birth and gender.

A summary of any relevant medical or dental history (note you must have the patient's consent to disclose this information in your referral letter)

- The reason for referral including any patient-stated preference for treatment
- Whether the referral is for an opinion only or for treatment
- An indication of the level of urgency
- Whether the referral is made under the NHS or private contract (if the referral is under private contract, then whether the patient has been advised of any likely costs and what these are)
- Your name, address and contact telephone number.
- Copies of any relevant radiographs or other special tests
- Any additional needs the patient may have

The receiving clinician should send a copy of the initial assessment, report and treatment plan to the referring dentist. On occasion the receiving dentist may disagree with the request for proposed treatment if they feel it is inappropriate for any reason. In that situation they should respond to the referring dentist stating the reasons for their decision.

When treatment proceeds, upon completion the receiving clinician should send an 'end of treatment' letter.

This should contain:

- A report on the treatment undertaken
- Details of any complications that may have arisen.
- What (if any) follow-up is required
- Their assessment of the patient's view of the treatment
- Any other details relevant to the success of the patient's treatment

Letters of referral and all responses also form part of the patient record and should be kept and stored in a similar fashion to that described above.

Pitfalls of keeping poor records

Good record keeping is often not seen as being integral to good patient care, instead being seen as a time-consuming inconvenience that detracts from the important business of providing good patient care. Sadly, it is often only when a dentist encounters a problem, either with some form of complaint or where the records are so poor that he or she is unable to ascertain what treatment has previously been provided or planned for the future that the dentist comes to understand the importance of keeping full, accurate, contemporaneous records.

It is also quite widespread practice to write the notes up at the end of the session or worse still at the end of the day. Practitioners believe misguidedly that they will remember what their patient said and what they did some hours after the event. Not only is this unrealistic, it also specifically

contravenes the General Dental Council's requirement to make and keep contemporaneous records, meaning that they must be written at the time of seeing the patient.

A failure to keep good patient records not only means that it is difficult to provide a high standard of patient care, but it also leaves the dentist in a very vulnerable position should a patient have cause to seek legal advice on the appropriateness of a treatment option or the standard of care provided. Without adequate patient records the dentist places him or herself in a position that can be very difficult to defend.

Disposal of health records

As a base line process, each practice should assess their archived records. Practices should begin the assessment in alphabetical order over a period of several weeks. The practice should separate those records that will be destroyed and those that will require archiving. For practical purposes, those patients who have not attended between 5 and 10 years are those that will be archived until 11 years have elapsed when they will be destroyed by the data storage company.

If a patient has not attended the practice for 5 years, the practice will need to appraise if the records that have reached their minimum retention period of;

- For adults 11 years (11 years in Wales)
- Children"s records should be retained for 11 years or until the 25th birthday or 26th if the patient was 17 when treatment ended.

If they have, these records should be prepared to be destroyed. Records can be destroyed in-house or by using an external approved company. Destruction should be completed following ISO 15489-1:2016.

The practice will maintain a log of the disposal decisions taken; this log will show the following:

Practice Location	Patients Name	Date of Birth	Date Last Attended Practice	Date of Transfer	To be Archived	To be Destroyed	Name of Company

This is to ensure that the practice is aware of those records that have been archived or destroyed and are therefore no longer available in the practice. If a patient subsequently returns to the practice a new dental record will be made. Any clinical records as requiring permanent preservation are transferred to safe storage.

Consent

We may sometimes need to use patient confidential information. Where this is to be done, we are required to obtain the patient's consent.

Approval

These procedures have been approved by the undersigned and will be reviewed on an annual basis.

It is a fundamental requirement that all the practice's records are retained for a minimum period, for legal, operational, research and safety reasons. The length of time for retaining records will depend on the type of record and its importance to the practice's functions. The practice has adopted the retention periods set out in the records management policy.

Records Management Systems Review

The practice will regularly review its records management practices for compliance.

The review will:

- Identify areas of operation that are covered by the practice's policies and identify which procedures and/or guidance should comply to the policy,
- Follow a mechanism for adapting the policy to cover missing areas if these are critical to the creation and use of records,
- Set and maintain standards by implementing new procedures, including obtaining feedback where the procedures do not match the desired levels of performance; and
- Highlight where non-conformance to the procedures is occurring and suggest a tightening of controls and adjustment to related procedures.

Record Retention

The retention periods provided are the minimum periods for which records must be retained for health and care purposes. In most cases, it will be appropriate to dispose of records once this period has expired, unless the records have been selected for permanent preservation. Organisations must have procedures and policies for any instances where it is necessary to maintain specifically identified individual records, or group of records (clinical or otherwise) for longer than the stated minimum, including:

- temporary retention
- public inquiries
- ongoing access request, for example, where the ongoing processing of an access request cuts over the minimum retention period. It would not be acceptable to dispose of a record that is part way through being processed for an access request because the minimum retention period has been reached.
- where there is a continued business need beyond the minimum retention period, and this is documented in local policy

There will be occasions where care specialties will create digital records that have different retention periods. Where records contain personal data, the decision to retain must comply with UK GDPR. Generally, where there is justification, records may be retained locally from the minimum period set in this Code, for up to 20 years from the last date at which content was added.

Moving from paper to digital

Wherever possible, organisations should be moving to digital records. The original paper record guarantees the authenticity of the record. However, it can make it hard to audit access to the record, depending on where this is stored, because paper records do not have automatic audit logs. Storage of paper records also will incur costs, whether in-house or offsite. This cost will only increase as the size of the holding or length of time they are stored, increases. Where possible, paper records management processes should be as environmentally friendly as possible.

Examples include the shredding of paper records and the end product used for recycling purposes instead of burning records in industrial furnaces.

Destruction of digital records

Destruction implies a permanent action. For digital records ‘deletion’ may not meet the ISO 27001 standard as the information can or may be able to be recovered or reversed. Destruction of digital information is therefore more challenging. If an offsite company is used, the health and care organisation as the controller should check with the ISO whether the provider meets the necessary requirements, similar to the process for the destruction of paper records. One element of records management is accounting for information, so any destruction of hardware, hard drives or storage media must be auditable in respect of the information they hold.

Destruction of paper records

Paper records selected for destruction can be destroyed, subject to following ISO 15489-1:2016. Destruction can be conducted in-house or under contract with an approved offsite company. If an offsite company is used, the practice organisation, as the controller, is responsible for ensuring the provider chosen to carry out offsite destruction meets the necessary requirements and can evidence this. This evidence should be checked as part of due diligence (for example, if the provider says they have the ISO accreditation, then check with the ISO). Other diligence activities, such as a site visit to the contractor, should also be carried out. Destruction provider companies must provide a certification of destruction for the bulk destruction of records. This certification must be linked to a list of records, so organisations have clear evidence that records have been destroyed. Records that do not contain personal data or confidential material can be destroyed in a less secure manner (such as confidential waste bins that do not provide certificates of destruction). If in doubt, material should be treated as confidential and evidentially destroyed. Do not use the domestic waste or put records on a rubbish tip to destroy identifiable, confidential material, because they remain accessible to anyone who finds them. The British Security Industry Association (BSIA) has provided a guide on information destruction.

When personnel files are held in paper or computerised format, they are subject to data protection legislation. You must be aware of the restrictions on the disclosure of and access to such data. Employees have the right to access their records and it is your responsibility to ensure that the data is accurate. Before you release their data to a third party you must seek permission from that individual, a consent form can be obtained for this from the DCME compliance portal.

Personnel files and training records, including disciplinary and working time records should be kept for 6 years after the employment ceases.

It is recommend retaining clinical records for 11 years (11 years in Wales) unless the treatment was complex or particularly difficult patients in which case for up 30 years. Any other records related to patients’ clinical records, including information about drugs supplied to them, laboratories used for prosthetic work and patient complaints details should be kept for a minimum of 11 years.

Business records as well as VAT records should be kept for a minimum of 6 years.

PAYE, NI and payroll records, SSP and SMP must be kept for at least three years according to HMRC although the general recommendation is 6 years.

Employers’ liability insurance certificates should be kept for 40 years. Health and Safety risk assessments should be retained permanently. COSHH risk assessments should be kept for at least 5 years.

We also recommend keeping certain training records such as Continuing Professional Development and Clinical Governance records for 5 years after you retire to ensure that you have them handy should the need arise.

With digital storage, it is possible to scan and store documents indefinitely, consider this as an option for all documents.

Terms of use is written in general terms and is believed to be based on the relevant legislation, regulations and good practice guidance. This information is indicative only and is intended as a guide for you to review and take professional advice to suit your circumstances.

Working casts and models

Working casts and study models can be problematic to store. In an ideal world, they would all be kept indefinitely or scanned with a 3D scanner before recycling. If you do not have a scanner, you could consider storage or scanning with a third-party company. If there is litigation, the possession of a model may help you to defend a case. You may decide to give working casts and models from crown and bridgework to the patient for safekeeping. If you do so, provide a protective model box and record what has been done on the clinical records.

It is advisable to keep implant casts until the treatment has been completed and the patient is satisfied. Although this does not mean that a patient won't subsequently complain if they have a problem later on. Giving the models to your patients can relieve a storage problem, but you will lose control over what could be an important piece of evidence in the future. For this reason, the general advice is to keep as many of the models as you can for as long as you can.

Retention Periods

Patients

Record	Retention period	Reference	Info source
Accidental exposure to radiation report Exposure dosimetry records	30 years (or until the person has reached the age of 75 if longer) 60 Years (or until the person has reached the age of 75 if longer)	The Ionising Radiations Regulations 2017	HSE
Appointment books	2 years after the year to which they relate. Diaries of clinical activity and visits must be written up and transferred to the main patient record. If the information is not transferred from the diary, so the only record of the event is in the diary, then this must be retained for 8 years and reviewed. Some staff keep hardback diaries of their appointments or business meetings. If	Records Management NHS Code of Practice 2021	Legal

	these contain no personal data, they can be disposed of after two years		
Clinical records including working casts and models	11 Years for adults – England 11 Years for adults – Scotland and Wales Children"s records should be retained until the 25th birthday or 26th if the patient was 17 when treatment ended.	NHS Record Management Code of Practice 2021	DoH, NHS, SDcep, Northern Ireland DH, HIW
FP 17s	11 Years	NHS Record Management Code of Practice 2021	NHS Record Management Code of Practice 2021
Complaints records (patients)	NHS England – 10 years NHS Scotland, Wales and NI – 6 years	NHS Record Management Code of Practice 2021	
Dental Lab Statement of Manufacture of Dental Appliance	10 years	The Medical Device Regulation	GDC
Friends and Family Test Response Cards/digital responses	2 years		
Subject access requests	3 years	NHS Record Management Code of Practice 2021	
Subject access requests where there has been an appeal	6 years	NHS Record Management Code of Practice 2021	

Service, maintenance and practice logs

Record	Retention period	Reference	Info source

Clinical Audit Records	5 years	NHS Record Management Code of Practice 2021	NHS
Autoclave Records (Note: photocopy steriliser print outs)	A minimum of 2 years	Pressure Systems Safety Regulations 2000	CQC, HTM 01-05
Compressors, fire equipment inspection	2-3 years	Provision and Use of Work Equipment Regulations (PUWER) 1998	HSE
Controlled drugs invoices (Schedules 2-5)	2 years	Misuse of Drugs Regulations 2001	
COSHH risk assessments	5 years from the date of the assessment	The Control of Substances Hazardous to Health Regulations 2002 (COSHH)	CIPD, HSE
Fridge temperature records	Min 1 year (For the life of any products stored within)	Recommendations for the retention of pharmacy records	NHS
Health and safety risk assessment	Indefinitely, updated regularly	Management of Health and Safety Work Regulations 1999	HSE
Employers' liability insurance certificate	40 years	The Employers' Liability (Compulsory Insurance) Regulations 1998	Department of Work and Pensions
Portable appliance inspection and testing	3 years		Care Quality Commission (England)
Infection Prevention Audits	Minimum of 2 years, kept on the premises.	HTM 01-05	
Washer-disinfector logbooks and records	A minimum of 2 years	HTM 01–05	

Waste records (hazardous): consignment notes and consignee returns.	3 Years	HTM 07-01	
Waste records (Non-hazardous): Waste Transfer Notes	2 Years	HTM 07-01	
Water safety records related to legionella risk management	Min 5 Years	HTM 04-01, the Approved Code of Practice L8, HTM 01-05	
Daily infection prevention checklists	2 years		
Emergency Drugs and Equipment Record	2 years		
X-ray equipment test results	The life of the equipment		

Financial

Record	Retention period	Reference	Info source
Accounting records	6 years		CIPD, HMRC
Dental laboratory invoices	6 years are recommended		
VAT records	6 Years	VAT notice 700/21	HMRC

Staff records

Record	Retention period	Reference	Info source
DBS/CRB Criminal records check certificates copy.	**NEVER HOLD ORIGINAL ON SITE-TAKE PHOTOCOPY OF TOP AND GIVE**		DBS, ICO

	BACK TO THE INDIVUAL		
Occupational health records	Keep until 75th birthday or 6 years after the staff member leaves whichever is sooner	NHS Record Management Code of Practice 202	
Pre-employment health screening questionnaire	Keep until 75th birthday or 6 years after the staff member leaves whichever is sooner	NHS Record Management Code of Practice 2021	
Income tax and NI returns, income tax records and correspondence with the HMRC	Not less than 3 years after the end of the financial year to which they relate. 6 years are recommended.	The Income Tax (Employments) Regulations 1993 (SI 1993/744)	CIPD
Statutory Maternity Pay records, calculations, certificates (Mat B1s) or other medical evidence	3 Years after the end of the tax year in which the maternity period ends.	The Statutory Maternity Pay (General) Regulations 1986 (SI 1986/1960)	CIPD, HMRC
Statutory Sick Pay records, calculations, certificates, self-certificates	The Statutory Sick Pay (Maintenance of Records) (Revocation) Regulations 2014 (SI 2014/55) abolished the former obligation to keep these records. Although there is no longer a specific statutory retention period, employers must keep sickness records to best suit their business needs. Six months after the end of the period of sick leave is sensible in case of a disability discrimination claim. For personal injury claims, the limitation is 3 years. If there"s a contractual claim for breach of an employment contract then keep records for 6 years after the	The Statutory Sick Pay (Maintenance of Records) (Revocation) Regulations 2014 (SI 2014/55)	CIPD, HMRC

	employment ceases. Employers should keep a record of SSP paid due to COVID-19 as HMRC may request records.		
Health surveillance records If you cease to trade, notify HSE in writing and make the records available to them.	40 Years	The Control of Substances Hazardous to Health Regulations 2002 (COSHH)	CIPD, HSE
Wage/salary records, overtime, bonuses, expenses	6 Years		CIPD
Application forms and interview notes (for unsuccessful candidates)	6-12 months	CIPD	
Parental leave	18 years from the birth of the child	CIPD	
Personnel files and training records (including disciplinary records and working time records)	6 years after employment ceases	CIPD	
Redundancy details, calculations of payments, refunds, notification to the Secretary of State	6 years from the date of redundancy	CIPD	
CPD records	5 years after the end of your CPD cycle	GDC – CPD for dental professionals	
Whistleblowing records	6 years post investigation	Public Interest Disclosure Act 1998	CIPD

Other

Record	Retention period	Reference	Info source
Accident books Accident records/reports RIDDOR reports	3 Years after the date of the last entry 3 Years for each report 5-6 years to allow for litigation	The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)	CIPD, HSE

Document Control

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0.1	Draft	29.3.22	P. Grieve	Original Document Created

0.2	Final	04/12/22	P. Grieve	Formatting
0.3	Final	7/2/23	P. Grieve	Additional guidance on children's records added
0.4	Final	20.03.23	H. Davis	Organised the retention schedule into staff/patients etc and combined records managment, record keeping and record retention policies together.

The latest approved version of this document supersedes all other versions, upon receipt of the latest approved version all other versions should be destroyed, unless specifically stated that previous version(s) are to remain extant. If any doubt, please contact the document author.

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