SADA
The South African Dental Association (SADA) NPC

ADVISORY
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Informing Oral Healthcare Professionals
Bulletin

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Dear SADArite

Welcome to our Advisory Bulletin containing all the information which is important in one communication.

CLINICAL SUPPORT SERVICES

Dentists and Clear aligner therapy

Clear aligner therapy (CAT) as a treatment modality for certain malocclusions has gained immense popularity in recent years as patients become more conscious of aesthetics and as a greater number of adults in the working environment choose to pursue orthodontic treatment. Whilst CAT may present as a more convenient and comfortable treatment option in terms of better facilitation of oral hygiene, causing less discomfort as compared to fixed orthodontic appliances, reducing the number and duration of appointments and requiring fewer emergency visits, it is important to note that CAT is also accompanied by certain limitations as well as potential risks that practitioners must take into account when deciding on which treatment modality is most appropriate.

Scope and Limitations of treatment with CAT

Practitioners carrying out CAT must be mindful of:

- practical and predictable alternative for mild and moderate malocclusions or tooth movements in non-extraction, non-growing patients;
- effective at aligning and levelling arches
- effective in treating anterior crowding
- more complex movements such as extrusion, correction of severe rotations, molar uprighting, closure of extraction spaces, anterior-buccal tipping and the correction of an overjet, overbite and open bite are known to be more challenging to accomplish with aligners.
- Less likely to produce adequate occlusal contacts and achieve stable results.

Important issues for consideration

1. Irrespective of which aligner system is being used, it is the responsibility of the treating practitioner to formulate the initial treatment plan based on the detailed examination and diagnosis of that patient.
2. Once the treatment plan is submitted to the aligner company for review and is subsequently returned to the practitioner with possible suggested amendments, it is the practitioner's duty to approve or disapprove the changes made in light of the overall treatment expectations of the patient.
3. Case selection is a vital part of the ultimate success or failure of CAT. Whether the patient is a candidate for aligner therapy must be determined by the practitioner based on his/her examination of the patient, photographs, scans, radiographs and the ultimate diagnosis reached, and cannot be assigned to non-clinical persons or an application or software of aligner companies.
4. If the aligner company is situated in South Africa, it is essential in terms of the Dental Technician's Act, 1979 that the lab fabricating aligners is registered with the South African Dental Technician's Council.
5. If an international aligner company is used for the fabrication and supply of aligners, the ultimate responsibility rests with the treating practitioner. It is therefore imperative that practitioners discuss possible limitations of CAT with patients prior to commencing treatment in order to manage patient expectations.
6. Practitioners offering CAT as a treatment modality must ensure that they possess the necessary and appropriate training to ensure that case selection is carried out correctly and therefore the complexity of certain cases is not being underestimated.
7. It is also essential that in complex cases, patients are made aware at the outset that certain refinements, retreatment or referral may be required with the patient being financially liable for the cost.

References

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2. Hartshorne J, Wertheimer M. Clear Aligner Therapy (CAT) – Ethical and dento-legal risk considerations. https://www.moderndentistrymedia.com/jun_jul2022/ID-AE_12-3-Hartshorne.pdf

LEGAL & CORPORATE SERVICES

Everything you need to know about dental records

The most often asked question we receive from members, or their practice managers and employees is “how long must we keep our patient records”, “Are study models part of the dental records, and do need to keep these as we are running out of space in our practice”, “we are running out of space?”, “Does POPI Act, mean we need to destroy our records”.

All practitioners must appreciate the value of keeping accurate, detailed dental records for each patient. However, many dentists, staff, and practice managers are still unaware of how to manage dental records and do not know when it is permissible to dispose of them.

What is a dental record?

A dental record is a detailed document of the history of the illness, physical examination, diagnosis, treatment, and management of a patient.

The main purpose of a dental record is to provide a complete and accurate account of the patient's oral health and ongoing treatment, to support continuity of care, and minimise the risk of an adverse incident. Records are an essential resource for the treating dental professional - no one's memory is infallible - and for others who might be involved in the care of the patient.

Records have a valuable dento-legal purpose if a dental professional's standard of care is called into question. A contemporaneous record of a thorough examination or consent discussion can provide valuable evidence when defending yourself against allegations of clinical negligence. Conversely, if you are accused of negligence, inadequate records may make it difficult to successfully defend yourself.

The record comprises several elements including written notes, radiographs, study models, referral letters, consultants’ reports, clinical photographs, results of special investigations, drug prescriptions, laboratory prescriptions, patient identification information, and comprehensive medical history.

No financial information should be kept in the dental record. Ledger cards, insurance benefit breakdowns, insurance claims, and payment vouchers are not part of the patient’s clinical record.

Some practitioners’ dental records only contain a list of procedure codes used for billing purposes and sometimes consist of unsatisfactory abbreviated notes on the treatment provided. This does not constitute a dental record.

Some dentists still maintain dental records on paper while others maintain digital records.

It must also be remembered that the dental record may be used in a court of law to establish the diagnostic information that was obtained and the treatment that was rendered to the patient. This information helps in determining whether the diagnosis and treatment conformed to the standards of care in the profession.

What makes a good record?

To keep things simple, try thinking in terms of the 4 Cs.

Contemporaneous: make a record as soon as possible after a patient interaction.

Clear: record your findings carefully (and legibly if not using a computer) so that they can be understood by anyone who may need to read and interpret them. For example, avoid abbreviations as far as possible and use one system of dental charting. It should be clear who made an entry and when.

Complete: record as much detail as possible of all relevant aspects of a patient's appointment, including:

- medical history
- dental charting
- findings on examination including negative findings (eg no teeth tender to percussion)
- diagnosis
- discussions about treatment options and risks
- agreed treatment plan
- consent to treatment
- treatment given
- mishaps and complications.

As well as consultations, you should record telephone and email interactions with patients and any information relevant to their care, including radiographs, consent forms, photographs, models, audio or visual recordings of consultations, laboratory prescriptions, referral letters and test results. The exception is complaints correspondence, which should be kept separate because it is not directly relevant to the patient's clinical care.

Concise: records should be just long enough to convey the essential information. Avoid superfluous personal comments that could backfire if someone else needs to access the record.
What does the law say about retention periods of dental records?

Is there any law that prescribes the time that dentists need to keep their patient’s clinical records in South Africa?

No legislation presently prescribes the length of time that dentists must keep their clinical records, there are, however, ethical guidelines published by the Health Professions Council of South Africa (HPCSA) (Guidelines on the Keeping of Patient Records, Booklet 9).

The HPCSA ethical guidelines provide:

Adult Patients	At least **6 (six)** years after they become dormant.
Minor patients	Until their 21st birthday – as legally minors have up to three years after they reach the age of 18 years to bring a claim
Mentally impaired patients	until the patient's death
Occupational illness or accident	20 years after treatment has ended.
Provincial hospitals and clinics	Records to be destroyed with authorisation of the Deputy Director-General
Patients exposed to conditions that manifest in a slowly developing disease	At least 25 years
Professional indemnity provider	Minimum 11 years for adults

The cost and space implications of keeping records indefinitely must be balanced against the possibility that records will be found useful in the defence of litigation or for academic or research purposes.

A person normally has three years to initiate a claim after the relevant incident took place in terms of the Prescription Act (Act 68 of 1969).

The prescription period is delayed in some cases like in the case of minors under the age of 18 years, dental records should be kept until the minor's 21st birthday. It is important to remember that prescription may even run from when the patient has knowledge of the facts giving rise to a claim.

Therefore, not only the treatment date is crucial but also the date on which the patient has knowledge (or should, by the exercise of reasonable care have had knowledge) that harm was caused by the treatment.

Practitioners would thus have to balance the costs of indefinite retention of records and the case where the practitioner's defence of a negligence case or complaint to the regulator is handicapped by the absence of such records.

Storage of dental records

Making a record is only the start of your professional responsibilities. Whether records are held on paper or electronically, you also have an ethical obligation to uphold patients' rights by making sure records are appropriately stored, shared, and disposed of. There are few if any legal obligations, however, the ethical rules provide that all records must be kept in a safe place.

The Protection of Personal Information Act, 2013 (POPIA) (s19) provides that you must ensure the integrity and confidentiality of the personal information under your control. This means that you must take appropriate, reasonable technical, and organisational steps to prevent the loss, damage, or unauthorised destruction of personal information or the unlawful access to or processing of information. It is no longer safe to keep patient records on an open shelf in an area of the practice where it is open to everyone in the practice.

Some of the measures to be implemented include:

- keep hard copies of records under lock and key
- implement IT security measures such as firewalls, virus protection, and encryption. Seek professional advice if necessary
- arrange regular data protection training for staff. In NHS practices, staff should know the identity of their local data protection officer
- require all staff to have individual log-in profiles and strong passwords to prevent unauthorised access to patient data. Passwords should be regularly changed and password sharing should be banned
- ensure staff only have access to the information they need to do their job
- back up electronic records regularly to protect against file corruption or accidental loss. Back-ups should be held securely off-site in case of accidental loss
- have a signed written contract with all third-party suppliers, including IT contractors, which sets out your confidentiality requirements
- keep personal and professional computers and mobile devices entirely separate, to avoid confidentiality breaches.

Paper Records

Paper records can be easily damaged by moisture, water, fire, and insects. As paper records are irreplaceable, it is a good idea to identify ways in which to safeguard them.

If you keep all your dental records in paper format, you must ensure there are systems in place to protect them in case of fire, flood, or other circumstances that could damage the records.
You must ensure you install smoke and fire alarms to allow you to act quickly in the event of a fire breaking out. Water sprinkler systems can damage electronic equipment so install chemical fire extinguishers to protect your paperwork.

Basements are not recommended for storing records as they are prone to flooding, instead, store records above floor level and ideally on a high shelf.

It is also important to conduct regular inspections of your premises and have control measures carried out by experts to keep damaging insects and rodents at bay.

Electronic Records

In the case of electronic records, they should be encrypted and safeguarded by passwords so that not all personnel have access thereto and no changes can be made.

If records are saved in the cloud or on a server, it is useful to have a backup copy that is stored off-site so records can be reconstituted if the need arises.

It is no defence to argue that records or in particular x-rays were lost due to hardware or software malfunction and that all or a portion of records were permanently lost or destroyed.

What are the legal requirements for the disposal of records?

There is no legislation prescribing how records should be destroyed. The ethical rules are also silent in this regard.

Common sense would have to prevail here and one must be mindful of the provisions of the Protection of Personal Information Act, 2013, which provides that personal information of patients must be protected at all costs when destroying records.

Records should not be disposed of in the ordinary waste or given to unregistered recyclers but rather contract a professional waste disposer. It can be incinerated by a service provider or shredded in a manner that these records or personal information cannot be reconstructed.

An efficient records management system should include arrangements for archiving or destroying dormant records to make space available for new records, particularly in the case of paper records.

Records held electronically are covered by the Electronic Communications and Transactions Act, which specifies that personal information must be deleted or destroyed when it becomes obsolete.

The records should be examined first to ensure that they are suitable for disposal and an authority to dispose of them should be signed by a designated member of staff.

The records must be stored or destroyed in a safe, secure manner. If records are to be destroyed, paper records should be shredded or incinerated. CDs, DVDs, hard disks, and other forms of electronic storage should be overwritten with random data or physically destroyed.

Be wary of selling or donating second-hand computers – “deleted” information can often still be recovered from a computer’s hard drive.

If you use an outside contractor to dispose of patient-identifiable information, it is crucial that you have a confidentiality agreement in place and that the contractor provides you with certification that the files have been destroyed.

You should keep a register of all healthcare records that have been destroyed or otherwise disposed of. The register should include the reference number (if any), the patient’s name, address and date of birth, the start and end dates of the record’s contents, the date of disposal, and the name and signature of the person carrying out or arranging for the disposal.

Disclosure of patient records to patients

The second most-often question asked by members is the disclosure of records to various parties who request them and whether they can supply the same to the requesting party.

The ethical rules of the HPCSA provide that:

Person 12 years or older	The practitioner can provide the patient with a copy or abstract or access to his/her dental records should they request it.
Under the age of 12 years	Information regarding the patient may only be divulged with the written consent of the patient’s parent or guardian
The parent making a request for records in respect of a patient *under 16 years*	Disclosure can only be made subject to the consent of the patient in terms of the Promotion of Access to Information Act
Deceased patient,	May only be divulged with the written consent of the next of kin or the executor of the deceased’s estate
Third-party	No dentist shall make information available to any third party without the written authorisation of the patient or his or her legal representative.
Disclosure without consent of patient/ legal representatives	1. Court order records be handed over to the third party 2. The dentist is under a statutory obligation to disclose certain medical facts, for example, reporting a case of suspected child abuse in terms of the Children’s Act (Act 38 of 2005). 3. A patient has instituted an action in Court against a healthcare practitioner and the practitioner needs access to the records to mount a defence 4. The third party is a healthcare practitioner who has had disciplinary proceedings instituted against him/her by the Health Professions Council and the practitioner requires access to the records to defend himself/herself. 5. Where the ailment of a patient becomes known to a dentist and the nature thereof is such that the dentist concerned thinks that the information ought to be divulged in the interest of the public at large. Before the information is divulged the relevant information should be given to the patient and voluntary authorisation should be sought from the patient

Divorced or separated parents	Disclosure of their child's records maybe with the consent of the parent with full parental rights and responsibilities in respect of a child
	Where more than one parent holds the same parental rights and responsibilities in respect of a child, each of the co-holders may act without the consent of the other co-holder when exercising those rights and responsibilities, except where this Act, any other law, or a Court Order provides otherwise. One way of dealing with the troublesome issue of consent with divorced, separated, or estranged parents is to have an office policy that requires the consent of both parents, even where there is joint legal custody of the minor. Retain a copy of the custody court order in the patient file.
Provincial hospitals	The records are kept under the care and control of the clinical manager and access to such records shall be subject to compliance with the requirements of the Access to Information Act and such conditions as may be approved by the superintendent.

Right of patients to their records

The Promotion of Access to Information Act gives persons the right of access to any information required to exercise or protect their rights before the institution of court proceedings. These will have to be done in terms of the manual of the particular practice and should include:

1. sufficient particulars to enable the practitioner to identify the requester
2. sufficient particularity regarding the record being requested.
3. the form of access to the record required (copies or electronic format).
4. postal address or fax number of the requester.
5. how the requester would like to be informed of the decision on the request.
6. if the request is made on behalf of a person (if attorneys make the request, for example), proof of the capacity in which the person is making the request, e.g. a power of attorney or consent of the patient.

A reasonable fee may be requested in producing copies of records. The HPCSA has ruled that where the patient has paid for x-rays or images, they are entitled to request and obtain originals and the practitioner must keep copies in the patient file.

Standards of dental records

The guidelines state that:

1. No information or entry may be removed from a health record.
2. Be consistent.
3. Be complete and concise sometimes diagrams are useful.
4. Avoid self-serving, derogatory, insulting, or disapproving comments in patient records.
5. Contain notes about history, physical findings, investigation, diagnosis, treatment, and outcome.
6. An error or incorrect entry discovered in the record may be corrected by placing a line through it with ink and correcting it. The date of change must be entered and the correction must be signed in full. The original record must remain intact and fully legible.
7. Contain a line through the item that requires alteration so that the revision is visible under the line, dated, and signed. Under no circumstances should the note simply be deleted or torn out and thrown away.
8. Contain separate labels for diagrams, lab results, photographs, charts, and x-rays. Do not rely on sheets of paper bound or stapled together.
9. Be kept separate from financial or billing records.

For medico-legal purposes, the following are important to note:

1. Do not rewrite your notes as only notes written contemporaneously have any value in court. A practitioner may, however, make further notes at a later stage. These notes should be correctly dated and signed. The reason for recording the note should also be stated.
2. Where you are proposing treatment with inherent complications, a record that the patient proposed has been advised of the material risks and complications of the treatment in question. If possible, ask your patient to sign a confirmation that s/he has been warned of the material risks and complications of the treatment to which s/he has agreed. Such discussions regarding the material risks and complications of a procedure should take place well in advance of the date of the proposed treatment so that the patient has time to digest and consider the information conveyed
3. Practitioners should note any discussions with patients regarding fees or fee estimates.

SADA GAZETTE BULLETIN - July 2022

This bulletin overviews new relevant legislation published in the government gazette affecting the dental profession up to the end of July 2022.

To access Bulletins click here

PROFESSIONAL DEVELOPMENT SERVICES

A huge thank you to the delegates and traders who supported and joined us this past weekend at Emperors Palace Convention Centre. If you have not already done so, please complete the following survey for the lectures you attended. Please submit one response per speaker. This information is vital for SADA as it indicates where and how we can improve offerings going forward.

https://www.surveymonkey.com/r/YZDGWNF or scan the below QR code

We are pleased to announce that the 2023 SADA Dental & Oral Health Congress and Exhibition will be taking place in Cape Town at the CTICC from 25-27 August 2023. Save the dates now in your calendar.

Kind Regards

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