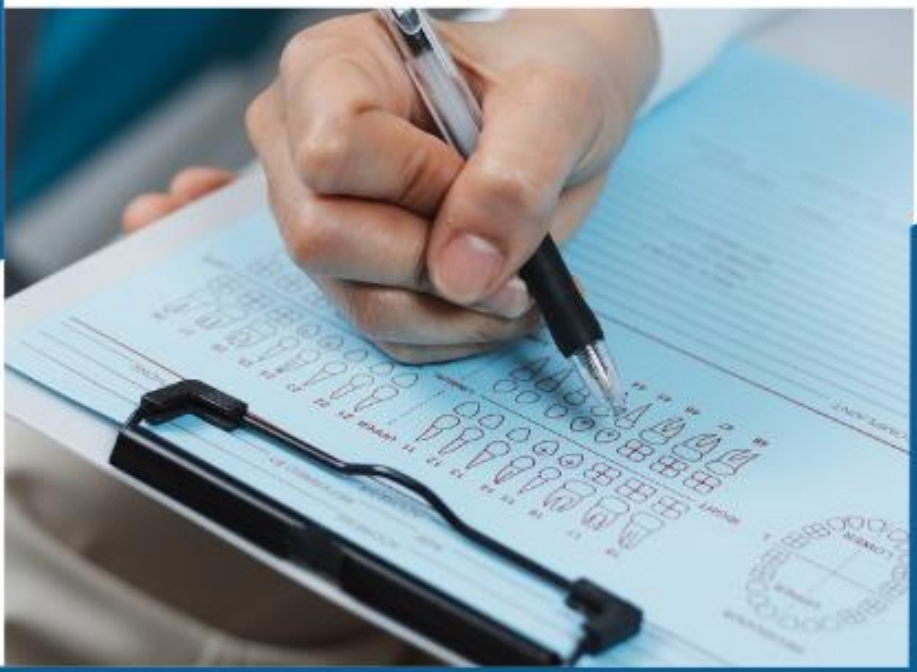

GUIDELINES FOR DENTAL RECORD KEEPING AND DENTAL CHARTING

MALAYSIAN DENTAL COUNCIL
MALAYSIAN DENTAL THERAPISTS BOARD

GUIDELINES FOR DENTAL RECORD KEEPING AND DENTAL CHARTING

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and
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TABLE OF CONTENTS

1. Introduction 1

2. Purpose of this Document 1

3. Related Documents 2

4. Definition of Dental Record 3

5. Principles of Good Dental Record Keeping 3

6. Key Components of Dental Record 5

7. Practice of Additional Record 11

8. Patient Record Transfer 12

9. Retention and Disposal 12

10. Conclusion 14

Appendix 1: Dental Charting 16

- A. Principles of Dental Charting 16
- B. Considerations 17
- C. Odontogram 18

Appendix 2: Basic Periodontal Examination (BPE) 21

Appendix 3: Sample of Good Dental Record 22

Members of The Working Committee 24

Acknowledgement 25

1. Introduction

Good dental record documentation is a hallmark of quality dentistry and a standard of care that patients have come to expect from practitioners. At the clinical level, a good dental record reflects the degree of care a practitioner observes as well as the institution they represent. A comprehensive dental record will provide the clinicians with the information needed to prepare a suitable treatment plan for the patient, which will benefit both parties. It could also help the practitioner in a medico legal situation if it arises.

2. Purpose of this Document

2.1. This guideline serves as a reference for the standard of dental recordkeeping expected from practitioners.

2.2. This guideline presents the **minimum standards and quality of dental record-**

keeping that practitioners should consider as part of the care for their patients.

2.3. This guideline is applicable to both manual and electronic dental records, whichever is available for the practitioners.

3. Related Documents

This guideline should be read together with the following documents:

3.1. Code of Professional Conduct Malaysian Dental Council 2022
3.2. Dental Act 2018 [Act 804]
3.3. Guidelines On Radiation Safety in Dentistry 2010
3.4. Code of Criminal Procedure 2012 [Act 593]
3.5. Private Healthcare Facilities and Services Act 1998 [Act 586]
3.6. Akta Arkib Negara 2003 [Akta 629]
3.7. Personal Data Protection Act 2010 [Act 709]
3.8. Akta Fi 1951 (Act 209)

3.9. Garis Panduan Pengurusan Penyakit dan Kondisi Periodontium Serta Peri-Implan Pergigian KKM 2022

4. Definition of Dental Record

A record is any item of information specifically related to a patient, regardless in any form or medium, created or received from a practitioner, dental office, or any health-related institutions, and they are maintained as part of providing care and conducting dental service. Examples of dental records include dental charts, radiographs/digital images, casts, photographs, etc.

5. Principles of Good Dental Record Keeping

5.1 Each patient shall have an individual dental record to avoid mix-ups.

5.2 All entries into dental records shall be:

5.2.1 Clear, factual, contemporaneous, concise, accurate, and legible.

5.2.2 Done immediately on the same day and in chronological order after treatment is completed to reduce error.

5.2.3 Recorded permanently using ink or in any acceptable electronic format.

5.2.4 Properly dated and labelled.

5.2.5 Manually or digitally signed or initialled at the end of each entry by the treating practitioner for traceability and accountability.

5.3 The same tooth notation system, symbols, abbreviations, colour coding, or characters should be used in every dental chart and should be stated in the record.

5.4 In case of any corrections need to be done on any entry:

5.4.1 For physical dental record (e.g.card), the error must be struck through, dated, initialled or signed in a manner that does not obscure the error, and the corrected entry should follow as above.

5.4.2 For electronic dental record, enter new date, refer to the error in the previous entries, state the reason, and enter the corrections as mentioned above.

5.5 Dental records of a patient are confidential and shall be securely kept on the premises and should only be accessible and/or reviewed by authorised personnel.

5.6 Dental records shall be retained until the specified duration before they can be properly disposed of following legal requirements.

6. Key Components of Dental Record

This section is the crux of dental records. All the information should be written down for future reference in any circumstances. There are **10 key components** that all dental records should have, as listed in Table 1.

Table 1: Ten key components of clinical dental record

No.	Components	Description
1.	**Personal information**	i) Name, identification/passport number, date of birth, gender ii) Address and contact number iii) Name and contact details of next of kin or legal guardian (for the underage patient) iv) Emergency contact
2.	**Purpose of visit/ Presenting chief complaint**	Document the chief complaint in verbatim by the patient and the complaint history, including the severity of the pain, if any.
3.	**History (medical, dental, social)**	i) Evaluation of the patient's general health (present medical condition, medications taken, allergies, etc.)

No.	Components	Description
		ii) Past dental treatments and complications, if any iii) Oral-related habits (bruxism, smoking, vaping, alcohol intake, etc.)
4.	**Clinical examination**	i) Extra-oral ii) Intra-oral: dental charting, the complaint tooth/site iii) Vital signs (for the high-risk patient)
5.	**Investigations carried out and relevant results**	Any investigation performed onto the patient, (e.g. pulp test, radiograph(s), laboratory test. etc.) and the results, if applicable
6.	**Diagnosis**	If a patient comes with a complaint, the practitioner should write a diagnosis of the condition if possible. If no definite diagnosis can be given, a list of possible diagnoses should be written down.

No.	Components	Description
7.	**Treatment plan**	A practitioner should have a proposed treatment plan for the patient after executing all the above components. This is to ensure comprehensive follow-up and easy referral by a future professional colleague if the patient is to be seen by others besides the current practitioner. In addition, any discussion on the cost or risk of the treatment should be written down so patient can make informed decision and consent.
8.	**Consent**	Consent should be obtained from the patient before treatment is carried out. Additional consent should be taken for photography, audio or video of the patient. Comprehensive explanation on informed consent can be found in Section 1.4 and Section 1.5

No.	Components	Description
		of the Code of Professional Conduct (2022)
9.	**Progress notes**	This component is the most comprehensive section of the dental record. Notes on the particular visit: i) Date and time of visit ii) Procedures undertaken iii) Type(s) of material used iv) If anaesthetic is used, record the type and quantity used v) A detailed description of any complication encountered during the procedure and its management vi) List of medications dispensed, administered, or prescribed vii) Post-operative instructions

No.	Components	Description
		viii) Medical certificate issued, if any ix) Relevant follow-up appointments and/or referrals with a copy of the referral letter kept in the patient's record x) If any untoward incident occurs, it should be written down in detail complete with the actions taken by the practitioner to handle the situation xi) Any changes to the original treatment plan or revisions to the original diagnosis need to be written down clearly with the reasons clearly stated xii) Any missed appointment should be recorded accordingly
10.	**Exit notes**	If the patient informs the practitioner of their intention to quit the visit to the current clinic, the

No.	Components	Description
		practitioner should write down the reasons for their decision and any final advice given to them.

* Adapted from American Dental Association (ADA)

- Dental charting is explained in detail in **Appendix 1.**
- Basic Periodontal Examination (BPE) as in **Appendix 2** is optional and encouraged to do together with dental charting.
- Two examples of good dental record or notes are included in **Appendix 3.**

7. Practice of Additional Record

7.1 For any record besides the written notes (e.g. radiographs, photographs, video, study model, etc.), proper labelling and storage are warranted. The labelling should have at least the following:

7.1.1 Patient's name and identification/ registration number.

7.1.2 Date of the recording.

7.2 If any of these records are to be handed over to the patient, an appropriate note should be written down for the record. In addition, digital copies are encouraged to be made before the handover and kept in the clinic for future reference.

8. Patient Record Transfer

8.1 Should there be an authorized patient record transfer, the method of transfer shall maintain the confidentiality and privacy of the patient, and a copy should be made and kept in the facilities.

8.2 The clinic shall record the transfer with a clear handover transaction written down and signed by receiving party for future reference.

9. Retention and Disposal

9.1 Dental records shall only be disposed of after the period specified under any written laws pertaining to the limitation period.

However, indefinite keeping of the patient record is recommended.

9.2 The general retention period for dental records is seven (7) years after the last patient visit to the dental facility. The retention period for children's dental records is seven (7) years after reaching the birth age of 18 years old.

9.3 Dental records with ongoing medico-legal or court cases should be retained indefinitely for future reference.

9.4 The disposal of dental records should be done in a secure manner without compromising patient confidentiality, and digitisation of records before disposal is recommended.

9.5 The clinic should document the disposal with the date and method of disposal.

10. Conclusion

This guideline presented the minimum standard of proper dental record keeping, which is part of the high standard quality of dental care as expected of patients from practitioners. A properly kept and comprehensive dental record would and could be the best defence to the practitioners in case of complaints or litigation issues with the patient, as well as raising the standard of dental record keeping in Malaysia at par internationally. Practitioners should aim to have a comprehensive dental record for their patients because failing to prepare is preparing to fail.

APPENDICES

Dental Charting

A. Principles of Dental Charting

- Practitioners shall thoroughly chart all new patients during their first visit and date the chart accordingly.
- Practitioners shall re-chart every returning patient if the dental charting exceeds the period of 12 months from the last dental charting, or whenever earlier, based on the dental practitioner's professional judgement.
- Practitioners shall use an odontogram or its equivalent to represent the patient's dental health status by illustrating the dental conditions.
- Practitioners shall not alter the completed and dated odontogram or its equivalent from the previous visit(s). Instead, a new odontogram or its equivalent must be filled if needed, e.g. annual check-up.

- Every tooth shall be given status and clearly documented in the dental chart.
- If radiographic investigations are carried out, any findings from the radiographs shall be included in the dental chart.
- In an emergency situation, such as non-stop bleeding from the oral area, or if the patient has disabilities or difficulties in mouth opening, dental charting may be deferred to subsequent follow-up visit(s).

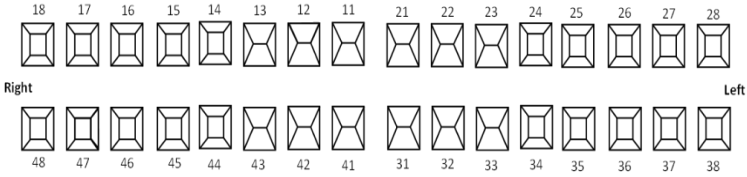
B. Considerations

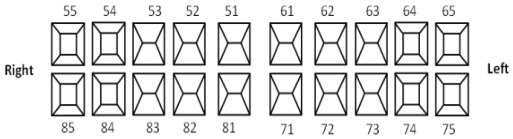
- With the current upward trend of diabetes among Malaysians and the established link between diabetes and periodontal problem, practitioners are encouraged to perform basic periodontal examination (BPE) and charting for initial detection and subsequent referral (refer to **Appendix 2**).

C. Odontogram

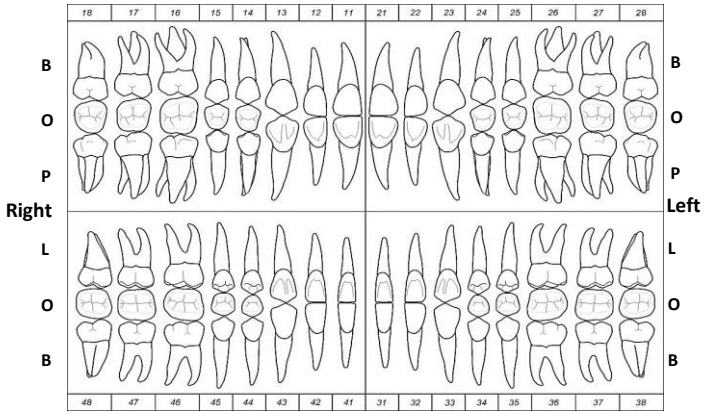
- There are two types of odontograms:

a) Geometrical odontogram

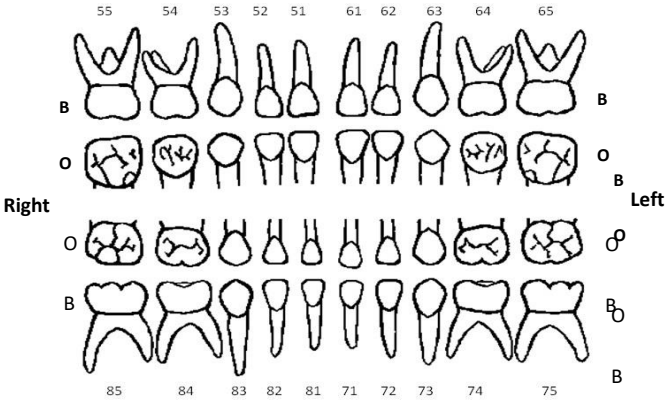




b) Anatomical odontogram



Permanent Dentition



Deciduous Dentition

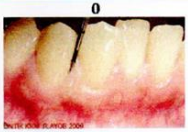
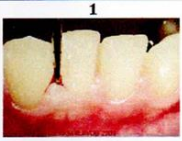
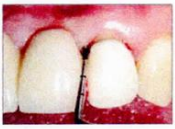
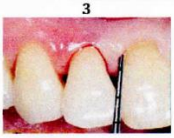
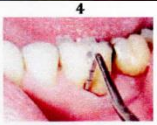
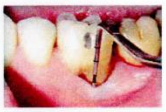
* Federation Dentàire Internationale (FDI) notation is used throughout

- Practitioners are at liberty to adopt either type of odontogram or its equivalent. However, the geometrical odontogram is sufficient to record dental status.
- Practitioners may choose either combined or separate odontogram or its equivalent for deciduous and permanent dentition.
- The odontogram or its equivalent used by practitioners should allow for the recording of tooth notation and symbols, abbreviations, or characters.

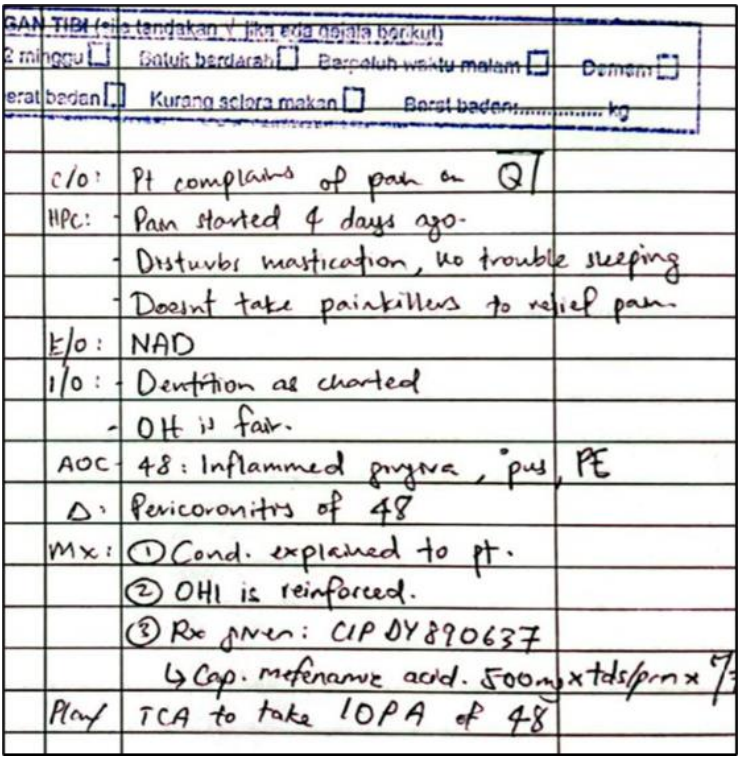
- Odontogram or its equivalent should have appropriate labels to indicate the orientation of the tooth.
- A loose odontogram or its equivalent shall be kept within the same dental record of the patient.
- As treatment progresses, it is unnecessary to update or modify the filled odontogram or its equivalent. It is sufficient for practitioners to document the treatment details in the treatment progress notes.

Basic Periodontal Examination (BPE)

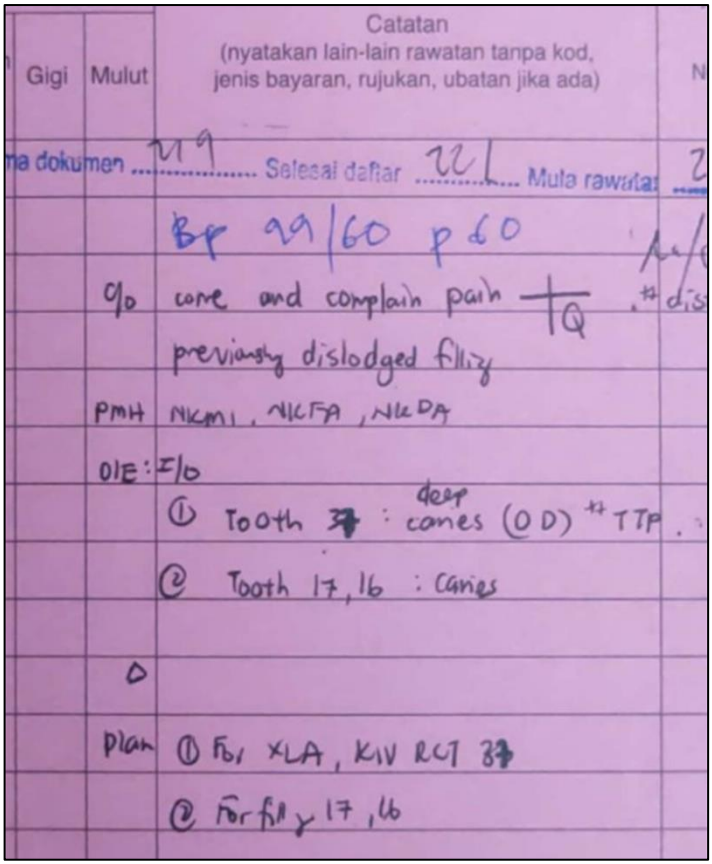
Gambarajah 1: Panduan Ciri Klinikal dan Senarai Pengurusan Pesakit Mengikut Skor BPE (*Basic Periodontal Examination*)[24] bagi Periodontitis

KOD	CIRI KLINIKAL	KEPERLUAN RAWATAN
0 	• Gingiva sihat • Tiada perdarahan semasa pemproban • Jalur hitam prob CPITN kelihatan sepenuhnya • PPD<3.5 mm	• Tidak perlu rawatan
1 	• Perdarahan semasa pemproban • Jalur hitam prob CPITN kelihatan sepenuhnya • PPD<3.5mm	• Motivasi dan pendidikan higin mulut
2 	• Perdarahan semasa pemproban • Faktor retentif plak (contoh: kalkulus, tampalan rungkup) • Jalur hitam prob CPITN kelihatan sepenuhnya • PPD<3.5mm	• Motivasi dan pendidikan higin mulut • Pembuangan faktor retentif plak termasuk kalkulus supra dan subgingiva
3 	• Perdarahan semasa pemproban • Jalur hitam prob CPITN kelihatan separa • PPD ≥3.5 - ≤5.5mm	(Pesakit sihat dan/atau penyakit sistemik yang boleh diurus –Jadual 2) • Motivasi dan pengajaran higin mulut • Pembuangan faktor retentif plak termasuk kalkulus supra dan subgingiva • Penskaleran dan debridmen akar (Pesakit dengan penyakit sistemik yang kompleks dan tidak dapat diurus – Jadual 2) • Motivasi dan pengajaran higin mulut • Rujukan* kepada Pakar Pergigian Penjagaan Khas *Jika tidak terdapat Pakar Pergigian Penjagaan Khas di negeri, boleh rujuk ke Pakar Periodontik
4 	• Perdarahan semasa pemproban • Jalur hitam prob CPITN TIDAK KELIHATAN • PPD>5.5mm	• Motivasi dan pengajaran higin mulut • Perlu rujukan kepada Pakar Periodontik
* 	• Penglibatan cabang akar • Jika ada boleh digabung dengan kod lain • Contoh dalam gambar: kod 2*	• Rawatan mengikut skor (0-4) • Rujukan berdasarkan kompleksiti rawatan

Sample of Good Dental Record



GAN TIDI (cth tandakan √ jika ada gejala berikut)		
2 minggu ☐	Batuk berdarah ☐ Berpeluh waktu malam ☐	Demam ☐
erat badan ☐	Kurang selera makan ☐ Berat badan: ..... kg	
C/O:	Pt complains of pain on $\overline{Q7}$	
HPC:	- Pain started 4 days ago.	
	- Disturbs mastication, no trouble sleeping	
	- Doesnt take painkillers to relief pain.	
E/O:	NAD	
I/O:	- Dentition as charted	
	- OH is fair.	
AOC	- 48: Inflammed gingiva, pus, PE	
Δ:	Pericoronitis of 48	
Mx:	① Cond. explained to pt.	
	② OHI is reinforced.	
	③ Rx given: CIP DY890637	
	↳ Cap. mefenamic acid. 500mg x tds/prn x 7/7	
Plan	TCA to take IOPA of 48	



Gigi	Mulut	Catatan (nyatakan lain-lain rawatan tanpa kod, jenis bayaran, rujukan, ubatan jika ada)	N
na dokumen		Selesai daftar ..... Mula rawatan	
		Bp 99/60 p 60	
	C/O	core and complain pain ~~TQ~~ ++ dis	
		previously dislodged filly	
	PMH	NKMI, NKFA, NKDA	
	OIE:	F/O	
		① Tooth 37 : deep caries (OD) ++ TTP	
		② Tooth 17, 16 : Caries	
	D		
	Plan	① Fb, XLA, KIV RCT 37	
		② For fill 17, 16	

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