TRiaDS

Translation Research in a Dental Setting

SDCEP Comprehensive Oral Health Assessment Consultation Interviews

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INTRODUCTION

During the period between November 2008 and February 2009 the consultation draft of the Scottish Dental Clinical Effectiveness Programme (SDCEP) *Guidance on Comprehensive Oral Health Assessment* was made available for review and comment. The guidance aims to facilitate individualised, long-term, preventive-orientated care to improve and maintain the oral health and general health of each patient by providing advice on how to conduct a comprehensive oral health assessment[1].

Copies of the consultation draft and feedback form were sent to 115 individuals, organisations and associations. This included a random sample of 50 General Dental Practitioners (GDPs).

In partnership with SDCEP the Translation Research in a Dental Setting (TRiaDS) Programme aims to improve the quality of the dental health care of patients in Scotland by conducting and evaluating a programme of integrated, multi-disciplinary translation research. As part of this, one priority is to gather information about current primary dental care practice and how this relates to key recommendations of SDCEP guidance. One stage in the guidance development process where this information can be gathered is consultation.

Therefore, the 50 randomly sampled GDPs who were sent the COHA consultation draft guidance were invited to take part in a telephone interview to explore, in greater depth, their views of the guidance. This report provides a summary of the interview findings.

AIMS

The aims of the consultation interviews were to:

- identify current practice when conducting an oral health assessment;
- identify the main barriers and facilitators to implementing the guidance;
- inform the future development of the guidance and its translation into practice.

METHODS

Letters were sent to all 50 GDPs asking if they would be willing to take part in a short telephone interview that would give them an opportunity to discuss their views of the guidance and its potential impact on their practice in more depth. Only three practices said that they would be unwilling to take part. More than one attempt was made to contact the remaining 47 practices to arrange a suitable time for an interview. Of these 47, 12 GDPs took part in the interviews along with one dental nurse and one hygienist-therapist. For the 35 who did not take part the main reasons were they were too busy, we were unable to contact the GDP by telephone or they no longer worked at that practice.

The interview schedule followed a standardised structure to identify salient beliefs regarding barriers and facilitators and

advantages and disadvantages that relate to implementation of the guidance[2].

The questions focused on the following eight expected behaviour changes all of which were considered to be important elements of a COHA and some of which are behaviours that are likely to be new to the majority of dentists and so will constitute a change in practice if the guidance is followed:

1. Conducting and recording a head and neck assessment for all patients;
2. Conducting and recording a basic periodontal examination for all patients;
3. Taking and reporting bitewing radiographs to assess caries at intervals that are appropriate to the risk level of the patient;
4. Keeping comprehensive records;
5. Identifying and recording a risk level for each patient;
6. Writing a long-term personal care plan for each patient;
7. Identifying and recording a risk-based recall interval for each patient;
8. Assessing and recording caries and restorations using the International Caries Detection and Assessment System (ICDAS)[3] for all patients.

A copy of the interview schedule can be found in *Appendix 1.*

RESULTS

Demographics:

Twelve GDPs, one dental nurse and one hygienist-therapist took part in the interviews. Of the twelve GDPs, the majority has been practising for over 10 years (7/12) and works in multi-handed practices. Nine of the 14 participants interviewed advised that their practice employs a hygienist or a hygienist-therapist and there was an almost equal split between fully NHS (6/14) and part NHS practices (8/14). The majority use a computer-based recording system, some use both a computer-based and a paper-based system and three said they use a paper-based system only. The most commonly used computer software was R4; however, other packages mentioned included Software of Excellence, Merlin and Wisdom.

General Impressions:

Half of those spoken to felt that the aim of the COHA guidance is to produce a systematic framework that will result in more consistent and standardised treatment for patients. Two participants felt that the guidance is trying to promote best practice and one felt it is aiming to encourage a more preventive approach. The vast majority (12/14) agreed with the general principles of the guidance and were generally very positive about what it is trying to achieve. They all, however, had concerns about its implications in practice. The majority felt that they were carrying out most of the recommendations to some extent, but not to the level stated in the guidance. In particular, some behaviours (e.g. taking and recording a social and dental history and identifying and recording a risk level) are being carried out in a more informal manner than that recommended and recording is being done in a more "*haphazard*" way.

Carrying out a head and neck assessment and using ICDAS were stated as the most challenging sections to implement, mainly due to time and a lack of training. Taking a medical, social and dental history of a patient, assessing anxiety, using and reporting radiographs and conducting a basic periodontal examination (BPE) were a few of the areas that participants thought would be less challenging for their practice to implement. This was generally because they are already being done to some extent.

One participant commented:

"We are doing a lot of this already but maybe over the course of a few appointments, not all in one."

Specific Behaviours:

During the interviews participants were asked about eight specific behaviours contained in the SDCEP guidance.

Recording a social and dental history for each patient

Of the fourteen participants two said they currently record a social and dental history for each patient in line with the guidance recommendations. Eleven said that they do ask some of the questions but not to the extent that the guidance recommends. One reason highlighted for this was time. However, participants also reported feeling awkward asking some of the questions, in particular around alcohol intake, and it was perceived that patients might not be happy providing this information or may not provide honest answers. The majority agreed that recording a social and dental history for each patient is something that needs to be done but only two participants said that they plan to change their practice in line with the guidance recommendations. Three participants said they plan to change their practice to some extent but not to the full extent of the guidance; one said that they would follow the recommendations if they were paid and another said they would do it if they had an electronic system.

One participant commented:

"We should ask questions about smoking, drinking, diet etc. but I wouldn't like to be asked them. Maybe this is something for the younger dentists."

Conducting a head and neck assessment for all patients

Two participants said they currently conduct and record a head and neck assessment for each patient in line with the guidance recommendations and two said that they conduct a less in-depth assessment. Reasons for not conducting a head and neck assessment included time, lack of confidence, dentists' expectations about patients' attitudes and worrying the patient unnecessarily. Some participants reported that they would only do an assessment if the patient presented with a related complaint and felt that it is not something that needs to be undertaken for every patient. Four participants said they plan to change their practice in line with the guidance.

Conducting and recording a basic periodontal examination (BPE) for all patients

Eleven participants reported conducting and recording a BPE for all patients. Of the three who did not, one reported conducting BPEs for over 18s only and the other two cited a lack of time and habit, claiming it was a generational issue:

"I don't record a BPE for all patients, there is a page on the software programme to allow you to record it but I don't always record it as routine."

The majority (11/14) agreed it was something that needs to be done and highlighted no real difficulties associated with doing it. Two of the three participants currently not conducting a BPE plan to change their practice and the other said they would if they were paid.

Conducting and recording caries and restorations for all patients

Twelve participants currently conduct and record caries and restorations for all patients; however, none use ICDAS as recommended in the SDCEP guidance. The vast majority also record early signs of enamel lesions that don't require restorations. There were no major difficulties highlighted in doing this. Of the 14 interviewed, only two were aware of ICDAS before reading the guidance; however, the majority agreed with the system in principle. There were mixed feelings about implementing ICDAS in practice, and some felt it would be very difficult to use:

"I agree with the principles of ICADS but think it will be difficult to use in practice."

"I suppose I agree with ICDAS in principle, if [there were] no time or financial constraints."

Others, however, felt it would just take time to get used to using a new system and would require some training.

"The notation would be hard to start with but you would get used to it eventually."

One participant reported that they plan to change their practice in line with the guidance recommendations, three said they would consider it, one said they would if they were paid and two said they would but did not plan to use ICDAS.

Taking and reporting bitewing radiographs to assess caries at intervals appropriate to the risk level of the patient

The vast majority of interviewees reported that they take and report bitewing radiographs to assess caries at intervals appropriate to the risk level of the patient and think that it is something that needs to be done. No major reasons for not doing it were highlighted although two participants stated it was unethical to take unnecessary radiographs.

Identifying and recording a risk level for all patients

Three participants reported identifying and recording a risk level for each patient, three reported doing it for children only and three reported doing it in a more informal manner than the guidance recommends. Reasons for not doing this included "*just never having done it before*", not being sure how to do it, not being sure of the reasons for doing it and time constraints. Nearly half of those interviewed reported that this is something that needs to be done but others felt it would depend on the individual patient. Three participants plan to change their practice, three were unsure and two thought they would but not to the full extent of the guidance recommendations.

Identifying and recording a risk-based recall interval for each patient

Three of those interviewed said that they currently identify and record a risk-based recall interval for all patients, as opposed to the standard six month recall interval. Six participants said that they do it but not to the extent of the guidance recommendations. The only reason provided for not identifying a risk-based recall interval was the ease of sticking to the standard six month recall period. The vast majority agreed that identifying and recording a risk-based recall interval is something that needs to be done; however, patient expectations and funding for a three month recall interval were considered the biggest barriers. Four participants reported that they plan to change their practice, one said they would consider it, two reported that they would do it if they were computerised and another said they would if appropriate funding was provided.

Writing a long-term personal care plan for each patient

No participant currently writes a long-term personal care plan for each patient. The main reason highlighted for this was that they had "*just never thought about doing it before*". However, time, difficulties in predicting and a fear that patients would "*hold*" dentists' to what is written in the plan were also cited. The majority think that it is something that needs to be done but have concerns over the length of time it will take:

"Writing a long-term personal care plan for each patient is a good idea and it helps you to get to know your patient better"

"Writing a long-term personal care plan is a good thing as it shares the problems and hence the ownership."

One participant raised concerns that the plan could act as a legally binding document and patients may expect dentists to follow it rigidly. Four of those interviewed reported that they plan to change their practice, one said they would consider it and another reported they would change their practice but not to the full extent of the guidance recommendations.

Barriers:

The main barriers to following the recommendations in the guidance can be categorised under the following three headings:

Time

Participants reported that longer appointments would be required to follow the SDCEP guidance, resulting in dentists seeing fewer patients per day and hence reducing patient access and creating longer waiting lists. The additional time that would be required for both dentists and patients to complete the patient forms, not to mention the storage of this paperwork, was also considered to be a significant barrier. Participants also raised concerns about the amount of time that would be required for additional training and to get used to using new systems such as ICDAS.

Financial Remuneration

Appropriate funding was also highlighted as a barrier and, in particular, funding to allow for longer appointments and a three month recall interval if appropriate.

GDPs' Perceptions

GDPs perceive that patients may be unwilling to and may not understand why it is necessary to complete the forms, to provide social and dental history information and to have a risk-based recall interval. It was also suggested that for some patients poor literacy skills may act as a barrier to following the guidance recommendations. In addition, GDPs expressed a reluctance to ask certain questions, for example, in relation to patients' alcohol intake, and a fear of writing down a personal care plan in case they are held to it, and suggested changing their own habits might be challenging.

Other barriers identified included the expense to patients of following a long-term personal care plan, identifying a confidential area for patients to complete the forms, the possibility that patients' poor oral hygiene may mean that a visit to the hygienist is required before certain conditions can be seen or determined and ensuring that the forms are ratified by their local NHS board.

Suggestions for Implementation:

Introducing appropriate funding and increasing the workforce were highlighted as the main facilitators that could assist in the implementation of the guidance. In particular, it was suggested that more hygienists were required and they could assist in the use of ICDAS. Other suggestions included: (1) introducing the guidance in stages, although it was considered important to ensure the final agenda is made clear; (2) piloting in, for example, other settings such as community, hospital or private practice; (3) training in the form of section 63 courses or in-practice visits as has been done for decontamination; and (4) developing computer software that could be used in line with the guidance. Another suggestion was to have a local representative who could be called upon for advice on any new systems or procedures.

SUMMARY

Based on the sample interviewed, the findings were mixed. Some feedback was positive in terms of the content and format with one participant making the following comment about the patient forms:

"I am thinking of adopting these straight away as they are much better than what we use at present."

However, others felt that the guidance contained a bit too much information:

"This is a good comprehensive plan and is nicely formatted but it is a bit too detailed, a bit too much information."

There were conflicting views about what format the published guidance should take. Some participants liked the quick reference guide, suggesting it would be useful to laminate it and stick it on the wall but others felt the full guidance document was necessary.

In terms of implementation, participants' views were also mixed. Some participants were optimistic that implementation is achievable but that it may take time or require to be introduced in stages:

"I don't see introducing this guidance as a problem as it is very easy to follow. I think the guidance is good and we need to be looking at the longer term and patients expect a higher standard of care."

If it were to be introduced in stages; however, it was felt important not to *"try and pull the wool over the dental professions eyes"*. It was felt that honesty about the overall agenda should be maintained.

One participant's closing remarks were:

"The guidance has acted as a good motivator. It helps to concentrate the mind and is a good way of reinvigorating practices."

[1] Scottish Dental Clinical Effectiveness Programme. *Guidance on Comprehensive Oral Health Assessment- Consultation Draft. November 2008*

[2] Michie S, Johnston M, Abraham C, Lawton R, Parker D, Walker A on behalf of the "Psychological Theory" Group. **Making psychological theory useful for implementing evidence based practice: a consensus approach**. Qual. Saf. Health Care, Feb 2005; **14**: 26-33.

[3] Ismail, A. I., Sohn, W., Tellez, M., et al., 2007. The International Caries Detection and Assessment System (ICDAS): An Integrated System for Measuring Dental Caries. *Community Dent Oral Epidemiol*, 35, 170-178.

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Appendix 1

Consultation Interview Schedule – Comprehensive Oral Health Assessment

Interviewer:

Name of Dental Practice:

Name of participant:

Job title:

Length of time in post

Date of interview:

Discussion checklist:

- researcher introduction – advise not a clinician!
- purpose of the study: to inform the future development of this guidance
- aim of the interview: to get more in depth feedback of dentist's thoughts on the guidance.
- practicalities / timescales:
    - brief list of questions by telephone ~ approx 20 minutes
    - interviewer taking written notes
- assurance of confidentiality

Questions:

1) Before we discuss the guidance it would be helpful if you could tell me:

    a) how many dentists work in your practice?

    b) if your practice employs a hygienist or a hygienist therapist?

    c) is your practice fully NHS?

    d) Do you use a paper or computer based recording system in your practice?

    e) if so, is there any particular software package you use? (e.g. R4, Software of Excellence, other?)

Thank You. As you will be aware this guidance document is at the consultation stage and still under development. I will pass on the feedback you provide today to the Guidance

Development Group, who will use your feedback to inform the future development of the guidance.

What I'm going to do now is ask you some general questions about the guidance document and so it may be helpful to have the document to hand. I will then touch on a few aspects in more detail.

2) To start off, from looking at the guidance what is your take on what the guidance is trying to achieve?

3) Barriers aside, (e.g. time, money) do you agree with the principals of the guidance?

   Why?

4) a) Which sections covered in the guidance do you think will be particularly challenging for your practice to implement?

   b) Why?

   c) What might help your practice implement this/these section(s)?

5) a) Which sections do you think will be less challenging for your practice to implement?

   b) Why?

There is a lot of information in this guidance so what I'd like to do now is ask for your views on a number of specific aspects.

6) Do you currently record a social and dental history for each patient? (e.g. details of their diet, smoking and drinking habits, oral hygiene routine, previous treatment)

   a) Yes – please provide some more details/how do you do this?

   b) No – why not?

   c) Do you think it is something that needs to be done? Why?

   d) What might be the difficulties in doing this?

   e) If not currently following guidance recommendations, do you plan to change your practice?

7) Do you currently conduct and record a head and neck assessment for all patients?

a) Yes – please provide some more details/how do you do this?

b) No – why not?

c) Do you think it is something that needs to be done? Why?

d) What might be the difficulties in doing this?

e) If not currently following guidance recommendations, do you plan to change your practice?

8) Do you currently conduct and record a basic periodontal examination for all patients?

a) Yes – please provide some more details/how do you do this?

b) No – why not?

c) Do you think it is something that needs to be done? Why?

d) What might be the difficulties in doing this?

e) If not currently following guidance recommendations, do you plan to change your practice?

9) Do you currently assess and record caries and restorations for all patients?

a) Yes – please provide some more details/how do you do this?

b) No – why not?

c) Do you record early signs of enamel lesions (that don't require a restoration)?

d) Do you think it is something that needs to be done? Why?

e) What might be the difficulties in doing this?

f) Are you aware of the ICDAS method for recording caries and restorations?

If yes, do you agree with the principles of ICDAS / Do you agree with the principles of identifying early lesions before they require restoration i.e. a preventive approach?

g) If not currently following guidance recommendations, do you plan to change your practice?

10) Do you currently take and report bitewing radiographs to assess caries at intervals that are appropriate to the risk level of the patient?

a) Yes – please provide some more details/how do you do this?

b) No – why not?

c) Do you think it is something that needs to be done? Why?

d) What might be the difficulties in doing this?

e) If not currently following guidance recommendations, do you plan to change your practice?

11) Do you currently record details of examinations when there is nothing significant found?

If no, why not?

12) Do you currently identify and record a risk level for each patient?

a) Yes – please provide some more details/how do you do this?

b) No – why not?

Do you think it is a good idea to divide risk factors into 3 categories (as done in the guidance)? If not, what would help?

c) Do you think it is something that needs to be done? Why?

d) What might be the difficulties in doing this?

e) If not currently following guidance recommendations, do you plan to change your practice?

13) Do you currently identify and record a risk-based recall interval for each patient (as opposed to the standard 6 month recall interval)?

a) Yes – please provide some more details/how do you do this?

b) No – why not?

c) Do you think it is something that needs to be done? Why?

d) What might be the difficulties in doing this?

e) If not currently following guidance recommendations, do you plan to change your practice?

14) Do you currently write a long-term personal care plan for each patient?

a) Yes – please provide some more details/how do you do this?

b) No – why not?

c) Do you think it is something that needs to be done? Why?

d) What might be the difficulties in doing this?

e) If not currently following guidance recommendations, do you plan to change your practice?

15) What do you think are the main advantages of following the recommendations in this guidance:

a) to you personally

b) to your practice

c) to your patients

16) What do you think are the main disadvantages of following the recommendations in this guidance:

a) to you personally

b) to your practice

c) to your patients

17) What did you think of the quick reference guide?

18) Is the current guidance useful as a reference guide or as an every day tool?

19) Were elements of the guidance to be introduced in stages, do you think this would make it easier to adopt?

If no, do you have any other ideas?

20) Do you have any other comments about the draft guidance you would like to add?

Thank you very much for participating.

Is there a DCP in your practice you could suggest that may be willing to take part in this interview?

Would you be happy to be contacted again in the future?