Oral Health Assessment Audit

Executive Summary: February 2013

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EXECUTIVE SUMMARY

Introduction and Aims

All dentists working in the General Dental Service in Scotland are required to undertake 15 hours of clinical audit every three years under regulation 31E of the amended National Health Service (General Dental Services) (Scotland) Regulations 1996.

In June 2011, NHS Education for Scotland's (NES's) Scottish Dental Clinical Effectiveness Programme (SDCEP) led the development of a national, pre-approved, online audit on oral health assessment (OHA) to support dentists meet their audit requirements before 31 August 2011.

In addition to providing support for dentists to meet their audit requirements, the audit aimed to support dentists introduce OHAs into their routine practice and inform the future implementation of SDCEP's Oral Health Assessment and Review (OHAR) guidance.

This report summarises the findings from the audit.

Methods

The audit design and data collection comprised the following stages:

1. Retrospective Data Collection

   The dentist reviewed and graded the records of their last 10 adult patients who received a routine examination against the OHA categories detailed in the audit's Retrospective Data Collection Form. The dentist then summarised the data and identified if they had met the recommended standards for each OHA category.

2. Prospective Data Collection

   Dentists conducted an OHA, as described in the SDCEP guidance, on five adult patients attending for a routine examination or a first visit. A Retrospective Data Collection Form was completed for each patient. The dentist then summarised the data across all five patients.

3. Identification of Barriers

Dentists identified and listed the barriers to achieving the recommended standard for completing an OHA in their practice.

4. Action Planning

Dentists selected three barriers and developed action plans to address these. An example action plan was provided as a guide.

5. Reflective Reports

Dentists wrote a report reflecting on their experience of conducting OHAs and of conducting the audit.

Results

Nine hundred and thirty-five dentists from 525 practices across Scotland completed and submitted the audit before the deadline of 31 August 2011. This represents approximately one third of all dentists and half of general dental practices in Scotland.

Retrospective Data Collection

The retrospective data revealed that, in general, most dentists did not meet the recommended 'recording' and 'risk' standards in the majority of the OHA categories.

In the OHA categories related to their patients' histories, the majority of dentists did assess and record their patients' medical history. However, the percentages assessing and recording their patients' social and dental histories and level of anxiety were low. In the OHA categories related to clinical assessment, again the percentages of dentists meeting the 'recording' standard were low. Similarly, most dentists did not assess and assign patients' overall risk of developing future oral disease or provide written care plans.

In all OHA categories the percentage of dentists meeting the 'risk' standard was considerably higher than the corresponding percentage meeting the 'recording' standard.

Within some of the OHA categories, the majority of dentists did assess and record at least one element. Examples include; smoking within the social history category, lesions in the caries category, BPE in the periodontal tissue category and intra-oral soft tissue examination

in the oral mucosal category. OHA categories where no element was assessed and recorded by the majority of dentists were dental anxiety, extra-oral head and neck examination, tooth surface loss and tooth abnormalities. The data also demonstrates that dentists often assess elements of an OHA but do not record that assessment has been carried out.

Prospective Data Collection

In general, dentists' compliance with the guidance recommendations was high when conducting the audit OHAs. Compliance remained relatively low in the tooth surface loss, caries, dental trauma, tooth abnormalities and patient care plan OHA categories.

Barriers to Conducting an OHA

Several barriers to implementing OHAs into routine practice were identified. A key barrier was the time taken to conduct an OHA and the potential impact on management of the appointment book and the length of waiting lists. Linked to time was the level of the fees paid for conducting a dental examination with many dentists reporting that they considered current fees to be inadequate.

Other barriers related to the unsuitability of practice management systems for recording all the information necessary to conduct an OHA and the costs associated with additional paperwork.

A number of barriers concerned the potential educational needs of patients, dentists and other members of the dental team. These included: dentists' beliefs that patients do not have sufficient knowledge and understanding of the importance and relevance of an OHA; dentists' lack of knowledge and skills in aspects on the OHA for example, extra-oral head and neck examination and discussing alcohol consumption; and the need for dental nurse training in recording some components of an OHA.

Barriers relating to dentists' beliefs about their patients included the belief that patients would find an OHA too time consuming and would be concerned about the depth of the assessment and the additional assessments being conducted. There was also a belief that patients might not provide accurate information in their patient histories.

Action Plans and Reflective Reports

Initial analysis of the action plans and reflective reports suggests many dentists did consider and reflect on the OHA process and how it might be implemented in practice.

Most action plans addressed barriers that the dentist or other members of the dental team could take steps to overcome. However, some plans focused on barriers that could only be addressed at a higher policy-level, in particular around remuneration and funding.

The reflective reports reiterate many of the findings from the synthesis of the barriers. However, several potential benefits of conducting an OHA were identified. These included the benefits of having more detailed, relevant information and a method to record changes over time enabling more effective risk assessment and treatment planning.

A number of dentists noted that they had already taken steps to introduce aspects of the OHA related to risk assessment and record keeping into practice.

Discussion

There are several differences between current practice and the OHAR guidance recommendations. However, current practice does include many aspects of the OHA, although patient records often do not record that assessment has been carried out.

A number of strategies to support implementation of the OHAR guidance were identified. Strategies that dentists and dental teams intended to implement were outlined in the action plans. Other strategies included: introduction of a fee for the OHA; communication with software companies regarding the requirements of an OHA; clarification of how negative findings should be recorded; population-level educational initiatives for patients; and the provision of dentist and dental team education and training.

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