TRiaDS
Translation Research in a Dental Setting

Scottish Dental Clinical Effectiveness Programme
SDCEP

SDCEP Oral Health Assessment and Review (OHAR)

In-Practice Implementation Study: June 2011

Executive Summary

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Executive Summary

Background and Aims: In March 2011, the Scottish Dental Clinical Effectiveness Programme (SDCEP) published the Oral Health Assessment and Review (OHAR), Guidance in Brief (http://www.sdcep.org.uk). During the SDCEP guidance development process a diagnostic analysis of current practice and dentists' attitudes towards conducting an oral health assessment (OHA) in primary care practice was undertaken by the Translation Research in a Dental Setting (TRiaDS) Programme. A number of perceived barriers to conducting an OHA in practice were identified.

This report summarises the findings from a TRiaDS in-practice implementation study that aimed to further explore these barriers in order to help understand how they might be addressed.

Methods: The study was conducted in General Dental Practices and Salaried Dental Practices in Scotland. A purposive sample of dentists representing the broad range of practice and practitioner types in Scotland was invited to take part. The study design comprised the following stages.

- *Retrospective data collection*

  To investigate which elements of an OHA are currently included in a routine check-up, the dentist reviewed and graded the records of the first ten patients who received a routine check-up during September 2010 against the OHA recommendations set out in the SDCEP OHAR guidance.

- *Action Planning*

  Dentists were asked to hold a team meeting on completion of the retrospective data collection to discuss areas for improvement and agree action plans as necessary.

- *Prospective data collection*

  All dentists conducted an OHA, as defined by the SDCEP guidance, on 10 patients who were due a routine check-up. SDCEP example recording forms were provided to record any aspect of an OHA that could not be recorded using dentists' existing

patient management systems. The time taken for patients to complete the patient history forms and the time they entered and left their dentist's surgery was recorded from the waiting room by a member of the TRiaDS team.

- *Patient Questionnaires*

  An anonymous questionnaire, completed after the OHA appointment, was used to gather feedback on patients' views about the acceptability and importance of receiving an OHA.

- *Dentist Interviews*

  Semi-structured telephone interviews were conducted with each dentist following completion of their prospective data collection. The interviews gathered in-depth information regarding: dentists' views of the recommendations contained in the SDCEP guidance; the study process; their experience of conducting an OHA; and the barriers and facilitators relating to the implementation of the guidance.

Results: Nine dentists participated in the study. Participants worked in both the General Dental Service and Salaried Dental Service and ranged in their level of experience.

- *Retrospective data collection:*

  This demonstrated that several elements of an OHA are currently included in a routine check-up. The majority of dentists do assess their patients' medical and dental histories. However, this was not always recorded in their patients' records. Patient history categories that are less frequently included are social history and dental anxiety.

  When considering clinical assessment, most dentists assessed and recorded caries and restorations, periodontal tissue and oral mucosal tissue. Tooth surface loss and occlusion were assessed but not recorded by just under half of dentists. The remaining categories within the clinical assessment element of an OHA, including head and neck examination, were not routinely included in a dental check-up.

  Other elements of an OHA that were not routinely included in a check-up by the study dentists were risk assessment and assignment, and personal care planning.

Most dentists did perceive that review intervals were risk-based; however, the majority of patients were allocated a six-month review interval.

- *Prospective data collection:*

  When conducting an OHA dentists' compliance with the guidance recommendations was high. Across all patients the average time taken to complete the patient history forms was 15 minutes. This varied between dentists from an average of 13 minutes to 18 minutes. The average time, across all patients, taken to conduct the remaining elements of an OHA (those carried out in the surgery) was 22 minutes. This also varied between individual dentists from an average of 17 minutes to 27 minutes.

- *Patient Questionnaire:*

  Patients reported that they were willing to discuss their dental, medical and social histories and indicated that they would be completely open with their dentists. Most patients believed that dental related advice should always be included in a check-up. Although fewer patients believed advice about social related factors should always be included in a check-up, the percentage that believed this type of advice should not be included was small. Most patients did prefer having an OHA in comparison to their usual type of check-up and were willing to attend their dentist at risk-based review intervals.

- *Dentist Interviews:*

  All dentists were generally supportive of the guidance recommendations and agreed with the concept of a "more thorough examination". They found that undertaking an OHA was reasonably straightforward with some reporting it was "not much change from normal" and "not as onerous as expected". However, one dentist reported that it was, "harder than expected" and another found it "stressful". All dentists believed that, in general, their patients had reacted positively to having an OHA.

  A number of barriers to conducting an OHA were identified. The main ones were: the need to arrange longer appointments and the potential impact this may have on the management of appointment books and waiting lists; the unavailability of a

computerised patient management system that would record all elements of an OHA; and the lack of an appropriate item-of-service fee for providing an OHA. On average, the study dentists believed that an appropriate fee value would be £31.

In addition to the development of suitable computer software and the inclusion of an OHA item-of-service fee in the Statement of Dental Remuneration (SDR), it was suggested that further training, particularly in relation to head and neck examination and risk assessment and assignment, would help dentists conduct OHAs in practice. It was also suggested that sending patient history forms to patients to be completed prior to them coming into the surgery might facilitate the conduct of an OHA in practice.

Discussion: There is support from dentists and patients for implementing OHAs in general practice. In general, dentists' perceptions of patients' views on the acceptability and importance of an OHA were not observed. Suggestions made by participants to aid implementation of the guidance include:

- suitable computer software to collect all the information required for an OHA;
- further training, particularly in relation to:
    - the extra-oral head and neck examination;
    - risk assessment and assignment;
- clarification on the recording of negative findings;
- reduce the time taken to conduct an OHA by simplifying elements of the data collection process;
- the inclusion of an appropriate fee in the SDR.

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