Prevention and Treatment of Periodontal Diseases in Primary Care: Post Consultation Interviews with Practitioners

Introduction

Embedded within the SDCEP guidance development process is the TRiaDS programme of research which applies an evaluative framework (Appendix A) to support the translation of guidance into practice (Clarkson et al, 2010). To date this research has included informing the scope, gaining a patient's perspective on dental care and defining professional behaviourial outcomes.

This summary reports the next step which was to obtain the views of practitioners about implementing the recommendations in the draft guidance. Ten semi-structured interviews were conducted using a topic guide underpinned by the COM-B system - a framework for understanding behaviour (See Figure 1), (Michie et al, 2011). In this behaviourial system, 'capability, opportunity and motivation' interact to influence behaviour. Use of the COM-B system helps to understand the barriers and facilitators to implementing recommendations by making a behaviourial analysis. At the outset of the interview the practitioners were asked to identify which of the 8 key recommendations prioritised by the GDG would be the most challenging to implement.

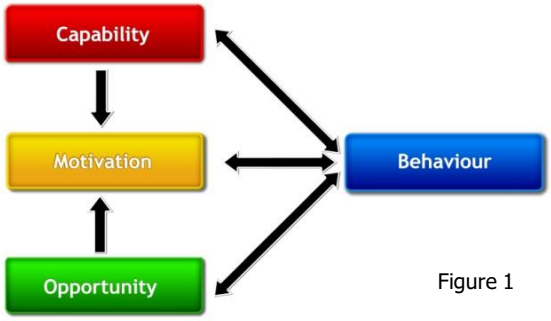

Figure 1

Findings

1. Oral Hygiene Advice

All interviewees mentioned giving oral hygiene advice as the most challenging recommendation to implement either for the individual or as a profession. Different levels of capabilities as a skill and knowledge were discussed. Some comments given about skills were:-

> *'I found very, very difficult because you know I have patients with, they are very open to discussion and to understand and still they don't do what they should do and I find quite difficult to explain'*

'I don't find it challenging because I just... it's part and parcel of what I do'

An intention to routinely offer oral health advice was a goal as part of their daily routine; however, it was often fitted into the appointment around other treatments.

> *'I think it all comes down to management and juggling and even with a short appointment, you know I will still point out where there is a deep pocket and encourage interproximal cleaning'*

Some reported lower motivation to giving oral hygiene advice with one dentist saying:-

> *'Sometimes it can be quite stressful and frustrating because you try and motivate the patient and you tell them what to do when you first see them and they say yes then you start the treatment and then you recall'*

The opportunity to give oral hygiene advice being constrained by the Statement of Dental Remuneration (SDR) was mentioned by a few who felt that the remunerations for periodontal treatments are not sufficient as they are not paid for the time needed to give oral hygiene advice.

> *'I do find more difficult to be able to provide for people due to the constraints of the NHS is that kind of more intensive kind of initial phase of treatment where you're trying to get things under control and there seems to be a bit of contradiction between the advice which is in this document and then what is in the SDR in terms of what we're getting paid for on the NHS and then the remuneration as well* '

The complexity of the SDR was confusing for some, especially a younger dentist who felt that 10c[1] treatments were being done but not always claimed for as a 10c. It was noted by one that the terminology in the SDR is not always compatible to the language in the guidance document i.e. root planning.

All interviewees mentioned patients as the factor which most influences them to give oral hygiene. Repetition of the same message was futile as it had all been said before with no effect.

> *'Well patient compliance is a part of it as well. I mean if you've got somebody that's plainly not interested and they have got poor to very poor periodontal condition but then aren't interested in what you're saying about trying to improve their oral hygiene or anything like that'*

[1] Non-surgical treatment of chronic periodontal disease, including oral hygiene instruction, over a minimum of three visits, with not less than one month between the first and third visit, and with re-evaluation of the patient's condition (to include full periodontal charting) at a further visit not less than two complete calendar months after active treatment is complete. Treatment to include root-planning, deep scaling and, where required, marginal correction of restorations, irrigation of periodontal pockets, sub-gingival curettage and/or gingival packing of affected teeth, and all necessary scaling and polishing:

2. Other Recommendations

The barriers to implementing the other recommendations were discussed. For example characteristics of the patient may prevent a BPE being carried out and having the appropriate skills to successfully explain it is a lifelong commitment.

3. TIPPS

The development of TIPPS was well received with one dentist stating the view of many, '*I guess that kind of following that without really being aware of TIPPS*'

4. Content of Guidance

Overall the guidance received positive comments:

> *'I thought I was all quite comprehensive actually. I was quite impressed with it all'*
>
> *I liked the way it was quite easy, it was straightforward, it was easy just to look at'*

Conclusions

The work here has informed the basis of a diagnostic behaviourial survey of the wider population which will collect baseline data prior to publication of the guidance.

Use of the COM-B has facilitated the factors associated with adherence to the recommendations in the guidance.

References

Clarkson et al (2010) The translation research in a dental setting (TRiaDS) programme protocol *Implementation Science*; 5:57

Michie et al (2011) The behaviour change wheel: A new method for characterising and designing behaviour change interventions *Implementation Science*; 6: 42

Appendix A: TRiaDS - The Evaluative Framework