

‘Investing For Health’ Workstream No. 11: Dentistry**Theme: ‘Quality in Dental Practice’**

Tasks 1-3: “NICE into Practice” – recall intervals in dental practices.

ITEM No. 5 (of 5)**Reviewing examples of good practice in auditing NICE dental recall intervals**

Information consolidated from presentations and materials consulted by the IFH-11 NICE Dental Recalls Working Group

<i>Title of Document</i>	Reviewing examples of good practice in auditing NICE dental recall intervals
<i>Status</i>	Developed through process of discussion at IFH11 “NICE Recalls” Task Group
<i>Potential users</i>	NHS dental practitioners; Primary Care Trusts and successors
<i>Sources used / directly adapted</i>	<ul style="list-style-type: none"> - Presentations to IFH–11 dental recalls group - SE Essex Audit Paper and Tool - Dental Update paper [Gibson & co.]
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<i>Author/editor</i>	Alan McMichael

Review of examples of good practice of dental clinical audit re NICE recall intervals: information consolidated from material considered by IFH11 “NICE recalls” task group.

BACKGROUND

1. Among the objectives of the “IFH–11” working group on dental recall intervals, one intention was to provide guides or models which dentists could use to audit their practices’ compliance with NICE CG19.
2. On 14th June 2010 the working group benefited from presentations from two dental practices (*Acorn Dental Practice; Catshill Dental Practice*) and a third was submitted as a document (Kimpton & Dhody). In addition, following the meeting the Chair carried out internet and Medline searches for further public examples of audit methodologies being used. This was not an exhaustive search to Systematic Review standards, however, two relevant (and linked) pieces of work were found:
 - a short paper from *SE Essex NHS/University of Essex* which incorporated a simple audit tool
 - an academic paper published in *Dental Update in 2008*.¹ The SE Essex paper cites the latter publication.
3. To assist the group, the Task Group Chairman reviewed and consolidated salient points from these pieces of work. This paper synthesises the materials furnished to the Task Group to facilitate the objective of developing a proposed audit ‘tool’ which could then be provided as a resource for dental contractors.

PROPOSAL / RECOMMENDATION for consideration of the workgroup

4. Within the accompanying summaries there are selected ingredients for a standard audit tool. None of the pieces of work reviewed here have departed significantly from the original NICE guideline. However, at the time of writing, only one sample of a basic audit tool had been found easily accessible within the public domain (the SE Essex NHS one). Members of the group may wish to refine or develop it into a model or sample for the purposes of our group.

SUMMARIES OF AUDITS

Follow overleaf

¹ Selecting Appropriate Recall Intervals for Patients in General Dental Practice – An Audit Project to Categorize Patients According to Risk; *Gibson C and Moosajee A*; *Dental Update* **2008**; **35**: 188-194

REVIEWING EXAMPLES OF GOOD PRACTICE IN AUDITS – SUMMARIES

Acorn Dental Practice

The audit was based on work carried out by Manoj Parmar (trainer) and his FD dentist, Emma Pickering. The group gratefully acknowledges their sharing their work. We have respected Emma's wish that her work should not be circulated in its entirety [as it is being prepared for a Faculty exam submission].

Aim: The audit's aim was "to ensure that appropriate recall intervals [were] determined according patient disease and risk factors to comply with NICE guidelines."

Defined objectives:

- (a) Following each oral health review a record of an assessment of disease and disease risk exists for each patient.
- (b) Records should show that recall intervals have been identified.
- (c) Following each review visit/completion of treatment, each patient record records the dentist's recommendation for recall interval.
- (d) The recall interval is discussed and if there is disagreement this is also noted.

Standard set: 85% compliance at first cycle. First cycle numbers selected: 50, random, sample frame (time period) not stated.

Criteria: as per defined objectives (above)

Results: first cycle found objectives were almost entirely not met.

Problems identified: (a) IT: *Software of Excellence* [SoE] has a help screen, but even if it is used, the system defaults to 6 month recall interval. General exam screen not extensive enough. Otherwise: lack of practice clinical routines [in respect of NICE recalls] – undeveloped.

Remedial actions: Use SoE help screen or adapt exam screen. Decision was to adapt exam screen.

Summary results after remedial actions:

- Over 80% had risk factors identified and had recall intervals chosen based on this.
- Over 86% showed agreement by the patient with the recall interval notified.
- Variety in recall intervals was demonstrated whereas in first cycle, all intervals, if recorded, were the same.

REVIEWING EXAMPLES OF GOOD PRACTICE IN AUDITS – SUMMARIES

Catshill Dental Practice

The audit was work carried out by Roger Hawken (trainer) and FD dentist, Fauzania Chaudhry. The group gratefully acknowledges their sharing their work.

Aim: The audit's aim was “to ascertain if an appropriate assessment of risk had been made for each patient and recorded” and “to assess if recall intervals for adults and children are being set at the practice”.

Defined objectives:

- (a) Recall intervals should be set and documented in patients' clinical records.
- (b) An assessment should be completed relying on medical, social, dental history, diet habits, oral hygiene and gum health in the patient records.

Pilot study: 10 patients.

Standard set: 90% compliance at first cycle.

First cycle numbers selected: 20 each from five dentists. “Random” — sample frame (e.g. time period) not stated.

Criteria: measurement of six key components (partly listed under [b], above) but also Soft tissue exam. For overall success, Med History, Social History, and perio (gum) health considered indispensable.

Results: first cycle found all but one dentist had recorded the *required* parts of the assessment above. Recall interval as nearly always set and over 80% were set at six months (NB SoE sets R.I. automatically). On the other hand, recording of the assessment itself seldom reached 50%.

Remedial actions:

- Using configurable screens with text prompts [SoE] to encourage dentists to record the assessment, and to record agreement with the patient.
- Also use of configurable sub-boxes to record reason for choice of recall interval – note intervals confined to 3, 6, 12 or 24 months (24 – adults only).
- Dissemination to dentists and staff via meetings and memo.

Summary results after remedial actions: not yet available.

REVIEWING EXAMPLES OF GOOD PRACTICE IN AUDITS – SUMMARIES

Kimpton and Dhody Dental Practice

This audit was carried out at Andrew Kimpton and Brij Dhody's practice. We gratefully acknowledge their sharing their work with us. *Note: An unusual feature of this audit was the cross-checking of recall data with FPI 7DC forms – a box for recording this has been included in these forms since 2006.*

Aim: The primary aim of this audit [was] to assess if the recall intervals are being set in accordance to the NICE guidelines.

Defined objectives:

- (a) To Assess whether the interval period as recorded matches on the FPI7DC form, R4's Oral Health review the patient's notes.
- (b) To identify areas of weakness in accurately calculating and recording recall intervals.
- (c) To implement changes to improve the quality and standard of formulating and recording recall intervals and to determine whether these have been effective.

Pilot study: 10 FPI7DC forms per dentist (total 50).

Criteria: Grading system of A to D based on — recall interval coincides with an assessment made and matches in (up to) three locations where it would be recorded – the FPI7dc; the R4 system recall store, and the clinical records.

Standard set: 80% compliance in respect of interval marrying with the assessment made, and 75% in respect of proper recording over the possible locations (Grade A's).

First cycle numbers selected: 212 “at random”.

Results: first cycle found 82% interval complied with an assessment, and 67% were recorded in all three stipulated locations. Proportion of patients who were set a six-month recall was 76% with the next most frequent interval of 12 months (13%). All remaining intervals accounted for 11%.

Remedial actions:

- Practice discussion to achieve greater consensus in risk assessment, leading to production of a practice document on clinical criteria for caries, gum disease and cancer risk factors.

Summary results after remedial actions: 87% where interval recommended matched the assessment and 75% Grade A (= consistent full recording). Frequency of six-month recalls DECREASED to 64% (was 76%) with roughly equally INCREASE in nine-month recalls – other intervals did not change significantly.

REVIEWING EXAMPLES OF GOOD PRACTICE IN AUDITS – SUMMARIES

Dental Update Article — Gibson and Moosajee, 2008

This audit was carried out at a dental practice in Wolverhampton and was subsequently written up for publication in *Dental Update*. The project followed the classic pathway: *pilot project* → *setting standard* → *measuring attainment against the standard*.

Aim: The primary aim of this audit was “to see patients at recall intervals which were individually and appropriately selected. “

Defined objectives:

- (a) To categorise patients according to risk or oral and dental disease and document the risk category in the notes.
- (b) To select an appropriate recall interval and document it in the notes.
- (c) To discuss the recall interval with the patients and document this in the notes.

Pilot study: 25 patients per dentist (total 75). Across three dentists, the results for (a) above ranged from 52% to zero; the risk for (b) above ranged from 16% to zero; and for (c) above, was zero across the board (no recording of discussion).

Changes made before first full cycle: practice discussion among clinicians; self-development of some standardised guidance “aide-memoire” notes based on NICE CG19 Appendix E1.4; and construction of a custom drop-down menu-screen on practice software.

Cycle I Criteria and Standard set: 80% of patients should be categorised according to their risk, have an appropriate recall interval [set] for their risk; and have the discussion about their recall documented in the notes. Even if a recall interval was documented, if this was not shown as being undertaken in association with a clinical risk assessment, the interval could not be considered as being appropriate and so failed the criteria.

Full cycle No 1: numbers selected: 25 each “at random” (Total 75).

Results: first cycle – in respect of objectives a-c above; scores improved for each dentist 1, 2 and 3, to reach 100%, 60% and 84% respectively in each of the three objectives.

Further remedial actions:

- Standard [threshold] increased to 90%
- Appearance of custom screen had not occurred in connection with all clinical risks, so this was corrected. Design of the custom screen was also changed.

Summary results after 2nd remedial actions: All dentists scored 100% on all three categories – recording risk assessment; setting and recording appropriate interval; recording discussion.

REVIEWING EXAMPLES OF GOOD PRACTICE IN AUDITS – SUMMARIES

S.E. Essex NHS & University of Essex — planned joint audit project

Summary: a joint (University/NHS) dental audit programme planned for Spring 2010 to be undertaken in Essex

Aims: (a) Categorize patients' risk of caries, periodontal disease, oral cancer and tooth surface loss. Document the risk category in the notes.
(b) Select appropriate recall intervals for general dental practice patients, and document this in notes.
(c) Discuss the recall interval with the patient and document it in the notes

Guidance: groups patients by clinical condition, and then suggests preferred recall periods dependent on history and findings. E.g. *Denture patient where mucosa is not abnormal and with good denture hygiene – recommend 24 months*. Guidance also given on “signs to look for” – e.g. *“Past root-decay or large number of exposed roots”*.

Standard to be set: min. 80% of patients categorized according to risk, with recall interval appropriate for risk; and discussion about recall documented in the notes.

Methodology: self-recording of data by GDPs, analysis of forms by PCT. A baseline sample of 25 randomly selected *retrospective* record cards from previous year; followed by a working sample of 25 randomly selected cards *prospectively* (from month following adoption of NICE Guidelines – in this case, February 2010).

Paperwork supplied: self-recording data forms. One retrospective, one prospective.

Source URL

[http://www.see.nhs.uk/content/file/Document Library/Dental recall audit tool.doc](http://www.see.nhs.uk/content/file/Document%20Library/Dental%20recall%20audit%20tool.doc)

Full document and audit tool – see appendix I (follows)



AUDIT OF SELECTING APPROPRIATE RECALL INTERVALS FOR PATIENTS IN GENERAL DENTAL PRACTICES

(Joint audit project – NHS South East Essex/ University of Essex)

AUDIT GUIDANCE NOTES

Background information:

National Institute of health and clinical excellence (NICE) Clinical guideline CG19 (published October 2004) Dental recall recommends that the interval between oral health reviews should be determined specifically for each patient, and tailored to meet his or her needs, on the basis of an assessment of disease levels and risk of dental disease. The assessment should integrate the evidence presented in the guideline with the clinical judgement and expertise of the dental team and should be discussed with the patient. During an oral health review, the dental team should ensure that comprehensive histories are taken, examinations are conducted and initial preventive advice is given. This will allow the dental team and the patient/ parent to discuss:

- The effects of oral hygiene, diet, fluoride use, tobacco and alcohol on oral health
- The risk factors that may influence the patient's oral health and their implications for deciding the appropriate recall interval
- The outcome of previous care episodes and suitability of intervals
- The patient's ability or desire to visit the dentist at the recommended interval and
- The financial costs to the patient of having the oral health review and any subsequent treatments.

The patients can then be categorised according to their levels of risk. The factors determined are the patient's susceptibility to developing dental caries, periodontal disease, oral cancer and an assessment is made of tooth substance loss (TSL) not attributed to dental caries.

Once all the risk factors have been examined, the patient is placed in a risk category (Low/ Medium/ High). If the patient is termed 'high risk', it is appropriate for him/her to be seen more frequently than a patient who has very low risk of developing oral or dental disease. *(Reference: Gibson paper, Dental Update April 2008)*

Aims and Objectives of audit (Audit criteria):

The aims and objectives of this audit are:

- To categorize patients according to risk of caries, periodontal disease, oral cancer and TSL and document the risk category in the notes.
- To select appropriate recall intervals for patients in general dental practices and document it in the notes.
- To discuss the recall interval with the patient and document it in the notes.

Suggested guidance on selecting recall intervals:

Reference: Clive Gibson and Alif Moosajee, Dental Update 2008; 35: 188-194

Caries

- Existing patient – defective restorations or new caries – 6 months
- New patients with caries – 3 months then review
- Previously stable patients – who as a result of the life style or other change develops new lesions – 6 months (even if the previous recall was longer)

Periodontal

- New patients with plaque present – 6 months
- Stable periodontal status – 12 months but with 6 months scaling
- New patients with active disease – 3 months until stability has been maintained for 6 months
- Existing patient with plaque problem – 12 months

Oral Cancer

- Increased risk (over 3-6 cigarettes per day) – 6 months
- Previous suspicious lesion which has been biopsied and the patient returned to primary care – 6 months

General

- Dentures – mucosa NAD and good denture hygiene – 24 months
- Healthy new patients – 6 months
- New patients with any disease – 3 months

Suggested clinical signs and symptoms to look for, when assessing patients for risk of or from dental disease

(Reference: NICE Clinical Guideline CG19 'Dental recall')

Recent and previous caries experience

- New lesions since last check-up
- Anterior caries or restorations
- Premature extractions because of caries
- Past root caries or large number of exposed roots
- Heavily restored dentition

Recent and previous periodontal disease experience

- Previous history of periodontal disease
- Evidence of gingivitis
- Presence of periodontal pockets (BPE code 3 or 4) and/or bleeding on probing
- Presence of furcation involvements or advanced attachment loss

Mucosal lesions

- Mucosal lesions present

Plaque

- Poor level of oral hygiene
- Plaque-retaining factors (such as orthodontic appliances)

Saliva

- Low saliva flow rate

Erosion and tooth surface loss

- Clinical evidence of tooth wear

Audit standard:

80% of patients should be categorized according to their risk, have a recall interval appropriate for their risk and have a discussion about their recall documented in the notes.

Audit Methodology:

- All general dental practices encouraged to carry out a retrospective audit of 25 randomly selected record cards using data capture forms – checking patients' appointments records between 1 January to 31 December 2009 for evidence of presence or absence of audit criteria.
- In February 2010, undertaking examinations on NHS patients using audit guidance notes detailed in this document and clinical judgement to assess and documents patients' risk status in four areas (caries, periodontal disease, oral cancer and TSL), assigning appropriate intervals, discussing with the patient and recording all of it in the notes.
- Using prospective data capture forms to assess 25 randomly selected cards from examination appointments during February 2010.

If you have any queries regarding completing audit forms, please contact as detailed below.

Please send your completed audit forms by Friday 19 March 2010, using the contacts as below.

By Post:

Sushmita Sinha, Clinical Effectiveness Facilitator
South East Essex PCT
Harcourt House, Harcourt Avenue, Southend-on-Sea SS2 6HE
Ph. No: 01702 226551

By Fax: 01702 226660

By E-mail: Sushmita.Sinha@see-pct.nhs.uk



AUDIT OF SELECTING APPROPRIATE RECALL INTERVALS FOR PATIENTS IN GENERAL DENTAL PRACTICES

(Joint audit project – NHS South East Essex/ University of Essex)

RETROSPECTIVE DATA CAPTURE FORM

(1 January to 31 December 2009)

Dentist Name:		
Dental Practice Name & Address:		
Audit Record No:		
(Please tick as appropriate)	Yes	No
1. Has this patient been selected randomly for the sample? (patients seen in the dental practice between 1 January to 31 December 2009)		
2. Was a risk assessment done for Caries and documented in the notes?		
3. Was a risk assessment done for Periodontal disease and documented in the notes?		
4. Was a risk assessment done for Oral Cancer and documented in the notes?		
5. Was a risk assessment done for Non Carious Tooth Surface Loss and documented in the notes?		
6. Whether an appropriate recall interval was selected and recorded in the notes? (Only record 'Yes' if associated with documented risk assessment)		
4. Whether the discussion between the patient and the dentist about their recall has been documented in the notes?		



South East Essex

AUDIT OF SELECTING APPROPRIATE RECALL INTERVALS FOR PATIENTS IN GENERAL DENTAL PRACTICES (2010)

(Joint audit project – NHS South East Essex/ University of Essex)

PROSPECTIVE DATA CAPTURE FORM (February 2010)

Dentist Name:		
Dental Practice Name & Address:		
Audit Record No:		
(Please tick as appropriate)	Yes	No
1. Has this patient been selected randomly for the sample? (Patients seen in the dental practice in the month of February 2010)		
2. Was a risk assessment done for Caries and documented in the notes?		
3. Was a risk assessment done for Periodontal Disease and documented in the notes?		
4. Was a risk assessment done for Oral Cancer and documented in the notes?		
5. Was a risk assessment done for Non-Carious Tooth Surface Loss and documented in the notes?		
6. Please specify the overall risk category assigned to the patient condition (Low/ Medium/ High)?		
7. Whether the level of risk category was documented in the notes?		
8. Whether an appropriate recall interval was selected and recorded in the notes?		
9. Whether the discussion between the patient and the dentist about their recall has been documented in the notes?		
10. Does the patient agree with the recommended recall interval?		
11. If No, Please record the reasons for disagreement in the notes:		
Any other Comments:		

Appendix 2 – What the original NICE guideline said about AUDIT

<http://www.nice.org.uk/nicemedia/live/10952/29488/29488.pdf>

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6.3 Audit

Patient records should reflect that appropriate recall intervals have been identified on the basis of the assessment of risk in discussion with the patient. The following four criteria can be used to audit adherence to the guideline recommendations:

- At the end of each oral health review there is a record for each patient of an assessment of disease and disease risk.
- At the end of each oral health review, or at completion of treatment, there is a record for each patient of the recall interval recommended by the dentist for the next oral health review.
- The interval agreed each time, for each patient is: – 3, 6, 9, or 12 months for patients younger than 18 years, or – 3, 6, 9, 12, 15, 18, 21, or 24 months for patients aged 18 years or older.
- Where there is disagreement between dentist and patient over the recall interval, the reason for this is recorded.

[.....]

Audit at the Practice level – Recall intervals will make a ready and important audit topic at the practice level. Some coordinated production of audit tools may facilitate this process. The incorporation of the minimum data set into Dental IT software would help automate the data collection and reduce the administrative burden. It is important that any patient who may suffer from disease progression and is allocated a more extended recall should be monitored.

Audit at the local (PCT) level – this will become more important as PCTs develop the local arrangements and seek to understand the quality dimensions and patient acceptability of the new styles of dental care. The Strategic Health Authorities (SHAs) and Welsh Health Boards may also call for the (anonymised) results of such local audits.

Audit at National level – with the radical changes in commissioning NHS dental care, there will be a need to understand how the new arrangements are working and to evaluate the overall performance to the new systems and the quality of care being delivered. Once again, this will demand more of the new IT arrangements which hold the key to ready and efficient access to understanding change and quality.

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