ADVICE

AUDIT FOR DCPs

If you can't measure it, you can't manage it, says **Kathryn Marshall.**¹

Making a start

Clinical audit and peer review became a terms of service requirement in April 2001. All dental practitioners with a GDS contract have an obligation to participate in 15 hours of clinical audit and peer review activity in any three year period.

This just concerns dentists then right? In most dental practices what is good for the dentist is good for the DCPs too. In other words at some stage the dentists will look to you to get involved. Audit is here to stay. Providing evidence of participation in clinical audit will be one of the requirements for meeting the standards set by the GDC for revalidation for all dental professionals.¹ How then to make a start?

Your practice situation

When deciding on an audit topic to choose you should ask yourself the following question: **'How can we improve the quality of what happens at the practice in every aspect of the delivery of care?'**

You might want to find something that would involve everyone; a process that would bring about improvements and changes. Audit encourages the dental team to look objectively at different aspects of the practice. It enables individuals to recognise where improvements need to be made, and how to make those changes. It also encourages re-examination from time to time of those areas which have been audited to ensure that a high quality of service is being maintained or further improved.

Record-keeping

Why not consider record-keeping? In particular the recording of data collected the first time a patient visits your practice. Good record-keeping is vital to dental practice. If records are accurate care will be effective and efficient.²

It is not just the individuals in a particular dental practice that need to be clear about

what treatment the patient is receiving and why. Other dentists and colleagues working in the wider healthcare environment may be involved in the delivery of care. It could also be that the records will be needed to defend a decision at some point if a patient makes a complaint.³

'Audit encourages the dental team to look objectively at different aspects of the practice.'

Sometimes dental professionals do not always record essential information on every new patient record. Medical histories are not signed by patient and clinician, treatment options are not recorded and sometimes full patient contact details are not noted in enough detail. The latter is the role of the dental nurse and receptionist. Clearly it is the responsibility of everyone in the team to maintain up-to-date clinical records.⁴ **Start with the end in mind. Consider what you want to achieve. Keep it simple.**

A suitable aim

To establish if new patient clinical records contain all the necessary information for the record to be considered factual, consistent and accurate.

¹ RDN, Dip DHE, Clinical Dental Lead (DCPs) Kent, Surrey & Sussex Deanery; Practice Development Tutor, Wales Deanery

Setting a standard

You will need to carry out some research on what will give you a set of reasonable evidence based standards that you can all agree on. The Clinical Examination and Record Keeping Good Practice Guidelines published by Faculty of General Dental Practice⁴ are suitable in this case. Using these nationally agreed standards you will then need to agree on some reasonable local 'good practice' guidelines for recording data on new patients.

Designing your data capture form

You will need a simple form to record your findings, one that will enable you to show the aspects of the data you are going to measure. Agree on the accepted percentage for each criterion. There will be some areas where the standard needs to be at 100% as these areas are vital to safe practice.

Description of the audit process

After the data capture form has been designed and approved, and before the audit takes place, it is a good idea to hold a briefing and training session. This is to make sure that those gathering the data fully understand the criteria and how it is to be recorded.

It is important that those taking part in the audit fully buy in to the reasons for undertaking it. Maybe produce some 'frequently asked questions' for the team to share (Table 1).

Making it happen – a possible plan

Identify the last 20 new patients to the practice from the appointment book. The receptionists select the record cards.

The data can be recorded on the form by anyone in the team who has attended the audit training and understands the project. This is not usually the same team whose patient record is being examined. Assess the figures to match them against the criteria agreed on the data capture form. The discussion that will take place after the audit is complete will involve the whole team.

Analysis of the data

Depending on what the audit shows there will be a need for some changes and/or improvements to the process of gathering patient information data in the practice.

For example if the standard set and agreed by the team at the start of the audit was 100% for having the medical history form signed and dated and this was achieved only 80% of the time

then this means that the practice has fallen below the agreed standard.

Action plan and evaluation of changes

This will be achievable because the team will now have a full understanding of the process and the advantages of audit as a tool for change. Organising communication and dissemination of information among the team will be vital to an action plan.⁵

To maintain momentum and keep the audit alive you can use the data capture form as a checklist to be completed at the end of every new patient appointment by the dentist and nurse. It can be signed by the dentist. It can be completed in the surgery and handed to the receptionist. S/he will also check that every box

'It is important that every member of the team feels part of the decision making process.'

has been ticked. She will then file it with the patient record card.

This should show an improved efficiency and demonstrate best practice in this area.

Post audit discussion

Audit is an essential pillar of clinical governance. When choosing an audit in the practice it is important that every member of the team feels part of the decision making process. Collaborative working gets the best results.

The use of the frequently asked questions helps to dispel any concerns over audit for the team. A good data capture sheet is essential to determine that what is recorded is accurate. A successful audit should highlight any problems that exist and the action/s taken in response to these.

The primary function of recording accurate data (including medical histories) is to ensure that the dental team has all the essential information to treat the patient in a manner that is compatible with their general health.

A measure of success in audit will depend on what is subsequently done with the data. In looking at the outcomes of any audit it is important to understand what the results are

telling us. If data are not recorded properly at source, and omissions are made, then there is every chance that opportunities will be lost in making improvements to service and the delivery of care to patients.

Without all the evidence verified on a patient's record card it is impossible to determine what the patient requires for whole patient care. An example of this would be if we do not determine the smoking habits of a patient we are unable to offer assistance in smoking cessation.

If we consider whether everything in a dental practice is worth counting and indeed can be counted⁶ we understand that audit can help to highlight where we are failing to count (deficiencies) and close the loop. **Audit is a continuous journey, not a destination. Outcomes are the ultimate indicators of quality.**⁷

Providing the subject is selected around an area that needs to be improved, the team are fully involved with the process, and there is an action plan to make changes as a result, then **there is no better way to instigate change within primary dental care than audit.**

1. General Dental Council. *Developing revalidation*. London: General Dental Council, 2008.
2. Morgan R. Quality evaluation of clinical records of a group of general dental practitioners entering a quality assurance programme. *Br Dent J* 2003; **191**: 436-441.
3. Dental Protection Society. Risk Management Module 20, Record Keeping (CD-ROM). London, 2004.
4. Faculty of General Dental Practice. Examination and Record Keeping Good Practice Guidelines. London: St Paul, 2001.
5. Marshall K F. Evaluating the quality of care. Bournemouth: BUPA Annual Conference, 2002.
6. Rattan R *et al*. *Clinical governance in general dental practice*. Oxon: Radcliffe Medical Press Ltd, 2002.
7. Donabedian A. *The definition of quality and approaches to its assessment*. Ann Arbor, MI: Health Administration Press, 1980.

Further reading

Clinical audit made simple II. www.smile-on.com. 2005.

Table 1 Frequently asked questions (FAQs) on AUDIT for dental teams**1. Why are we doing this particular audit?**

At this practice we want to provide our patients with the care they need with the confidence of knowing that we have all the details we need to make the right treatment decisions based on facts.

Our records need to be an accurate reflection of what we do for a patient and why.

When choosing what to audit we all agreed that sometimes there is information missing from records and this causes problems in the future care of our patients.

We often go through the process of checking various checks and examinations with patients, and we do not always write these down.

As we are keen to get it 'right first time, every time, for every patient' it makes sense to start with new patients. Then we may cascade the audit to look at all our records. This is called a Retrospective Audit. It is on the process aspect of the delivery of care to our patients.

2. Who needs to be involved with the audit?

We all do. This is because we are all part of the system for gathering data to make our patient records accurate. The receptionists take all the patient's biographical details, the dentists record details such as the condition of the teeth and gums, the dental nurses check that the patient's medical history is up-to-date, and the practice manager checks the notes to look at whether the patient has paid for their treatment.

3. So what will we actually be doing?

We will need to pull the records of the last 20 new patients that attended the practice: ten who saw dentist A and ten who saw dentist B. Then using the data capture form that has been designed we can record whether the information required is stated on the record card. We can do this over one day in the practice with the receptionists pulling the records and dentist A and his or her nurse looking at dentist B's records and dentist B and his or her nurse looking at dentist A's records.

The data will then be analysed and matched against the standards we all agreed to use to measure our performance.

4. What if we find that we have scored badly - won't that be embarrassing for the dentists?

The purpose of this audit is for us all to see where our record-keeping strengths and weaknesses lie. It will give us a chance to all take part in a system of continuous quality improvement. We will probably find that it is our system for recording patient details that needed updating. It is not the individual's fault.

5. What happens after we get the results?

These will be fed back in a de-briefing meeting. Probably the score will not be equal on all aspects. If we can see where problems lie we can concentrate and put a special effort in to ways of improving the score. We will all be involved in the process of suggesting new ways of working with regard to record-keeping. It may be that we score 100% in some areas. This will give us an opportunity to celebrate our good practice. Perhaps sharing it with other teams, or letting patients know via our new newsletter.

6. Is that the end of the project?

Audit is an ongoing cycle. After we have agreed on methods to improve the systems we will take another look in three months and re-audit new patient records to see if there have been any improvements.

Remember: if we can't measure it - we can't manage it. Below is a diagram to help you understand the audit cycle.

7. What are the benefits for the patients?

If we show areas that need improvement patients will get a higher level of service and care. For example, if we record a patient's up-to-date mobile telephone number they can be called and be given the opportunity to attend for a last minute appointment when the dental hygienist has a cancellation. If we make sure that our record entries are legible it will be easier to answer questions a patient may have with regard to their treatment as everyone in the team will be able to read the notes and offer advice as appropriate.

8. Are there any benefits to us?

Confidence that you are adopting best practice and following nationally agreed standards for record-keeping. You will also get five hours of verifiable CPD for taking part.