



Periodontal audit .

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Auditing in periodontal treatment and disease.

Background.

Undiagnosed and untreated periodontal disease is one of the fastest growing areas of litigation and complaints in dentistry.

People are living longer, and more people are retaining their teeth into later life. Consequently, the overall potential periodontal risk is rapidly increasing. Most allegations of undiagnosed, untreated and under-treated periodontal disease arise when a patient sees a new dentist for the first time. This may result from the retirement of the patient's previous dentist, or simply because the dentist has left the practice. Sometimes the patient attends a different dentist in an emergency situation, or following the sale of the practice where they have been treated over many years.

On other occasions, of course, a patient will seek a second opinion because they already have concerns about the treatment being provided for them by their existing dentist.

Allegations

The most common allegation is that the patient was unaware of the presence of periodontal disease, or that the extent and implications of the periodontal problems had not been explained to them. Where there are significant levels of periodontal disease, and one or more teeth have a doubtful or terminal prognosis, the patient may well become very angry, blaming the previous dentist for allowing the periodontal condition to deteriorate under their care. If the condition, along with the treatment options and appropriate advice, is not explained to the patient, the individual may well feel that they have been let down by the professional person they have trusted over many years.

Two questions always arise:

- Did the dentist in question properly diagnose, treat and monitor the periodontal disease?
- Did the critical discussions and explanations occur between the dentist and the patient?

Attention often focuses upon the clinical records and what they do (or do not) contain, in order to establish which version of events is better supported by the contemporaneous notes.

Periodontal audit

Aim:

The aim of the audit is to examine the clinical records of patient who are being seen with either moderate or significant levels of periodontal disease.

The records are checked to determine whether there are dated entries confirming *each* of 16 key landmarks (Dental Protection Society 2014.)

1. A written medical history has been taken, and updated at regular intervals. This includes a review of any medication taken by the patient
2. Appropriate screening (for example, BPE score, do the patient's gums bleed on brushing?) and follow-up investigation (for example, x-rays) has been carried out.
3. A diagnosis of periodontal disease has been made.
4. The patient has been informed of the presence of the disease.
5. The patient has been given specific information regarding the site(s) and severity generally, and in respect of any specific teeth which have an unfavourable prognosis.
6. Some kind of measurement of the site(s) and severity of the disease has been made (this may range from BPE scores, to more detailed probing depth recordings and might include notes of bleeding points, mobility, and pathological changes affecting individual teeth).
7. Known risk factors for periodontal disease (especially smoking) have been checked.
8. Appropriate levels of initial treatment (for example, scaling, root planing) have been carried out, and repeated at suitable intervals.
9. The patient has received suitable advice and instruction regarding oral hygiene, risk factors (for example, on cessation of smoking), to enable the patient to become personally involved in the control of their periodontal disease.
10. The tissue response and the patient's compliance has been checked for and further measurement/monitoring of the progression of the disease has taken place.
11. The above monitoring has been repeated at appropriate intervals, with any necessary x-rays and other investigations (including questioning the patient as to any areas of bleeding, discomfort, etc).
12. Any failure on the patient's part in respect of compliance (oral hygiene, risk factors, attendance, for example) has been brought to the patient's attention, and the importance stressed.
13. Where the periodontal disease is particularly severe, and/or has not responded to the advice and treatment provided, the possibility of a referral for specialist advice, or treatment has been considered and discussed with the patient.
14. If the patient has declined such a referral for any reason, has this been made clear?
15. Any occasion when the patient has failed to attend appointments, or has cancelled appointments at short notice. This includes occasions when the patient agrees to contact the practice to make further appointments, but fails to do so, or when the patient does not respond to reminders or recall letters.
16. Any occasion when the patient has declined the treatment recommended for them (for example, a referral to a dental hygienist, or the provision of treatment to address any occlusal imbalance).

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Method:

If 10 patients are selected who have been seen with moderate or significant periodontal disease.

Scoring

Score Level of detail

- 0 If the records contain no reference at all to the landmark in question.
If the records contain an entry which, while not optimal in terms of its detail, still suggests that
- 1 the landmark had been identified.
- 2 If the records contain a specific dated entry, clearly identifying the landmark in question.

Note that each record card (or record) would have a potential maximum score of 32 and therefore for 10 patients 320

It is a useful exercise to do this exercise with your teams as gaps in the record keeping can be filled by team involvement., For example:

- Reception might check whether there is a recently updated medical history
- The notation for cancelled or Failed to attend appointments must be recorded.
- The hygienist and DCP must record conversations, explanations and warnings

Explanation with patient on perio-site
severity
actions

Warnings/ risk-

Compliance

I attach an pop up aid used allowing as a reminder to add notes, however the team must be aware of its existence

Periodontal audit

Landmark number	0	1	2
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Total			

Periodontal audit

This audit will provide a useful audit showing how your clinical records are containing the relevant detail required in periodontal disease.

Please note the different colours for question 6 and 11.

6. Some kind of measurement of the site(s) and severity of the disease has been made (this may range from BPE scores, to more detailed probing depth recordings and might include notes of bleeding points, mobility, and pathological changes affecting individual teeth).

This is asking whether the BPE score relates to more detailed investigations:

I attach the BPE guidance from SCDEP

BPE Score	Guidance on Further Assessment and Treatment
0	Periodontal treatment is not required
1	Plaque and gingivitis charting and oral hygiene demonstration.
2	As for code 1 plus remove supra-gingival plaque, calculus and stain, and if necessary sub-gingival plaque and calculus, using an appropriate method.
3	As for code 2 plus full periodontal examination of all teeth and root surface instrumentation where necessary (N.B. Where code 3 is observed in only one sextant, carry out full periodontal examination and root surface instrumentation of affected teeth in that sextant only).
4	As for code 2 plus full periodontal examination of all teeth and root surface instrumentation where necessary (more time is required for root surface instrumentation than for score 3). Assess the need for more complex treatment and consider referral to a specialist.
*	Treatment need will depend on the BPE scores of 0 to 4 for that sextant. Assess the need for more complex treatment and consider referral to a specialist.

This is another audit that can be considered as is the appropriate radiographs and monitoring in periodontal disease

11. The above monitoring has been repeated at appropriate intervals, with any necessary x-rays and other investigations (including questioning the patient as to any areas of bleeding, discomfort, etc)

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Based on the 2013 FGDP(UK) guideline,¹⁴ if radiographs are indicated:

- ♥ For uniform probing depths ≥ 4 and < 6 mm and little or no recession, take horizontal bitewing radiographs. If the anterior teeth are affected, take intra-oral periapical views using the long cone paralleling technique.
- ♥ For probing depths ≥ 6 mm, take intra-oral periapical views of all affected teeth using the long cone paralleling technique.
- ♥ For irregular probing depths, take horizontal bitewing radiographs and supplement these with intra-oral periapical radiographs taken using the long cone paralleling technique.
- ♥ If a perio-endo lesion is suspected, take an intra-oral periapical radiograph using the long cone paralleling technique.
- ♥ Where large numbers of intra-oral periapical radiographs are required, consider taking a panoramic radiograph if there is access to a good quality/low dose panoramic machine.

- the degree of bone loss - if the apex is visible this should be recorded as a percentage;
- the type of bone loss - horizontal or angular infrabony defects;
- the presence of any furcation defects;
- the presence of sub-gingival calculus;
- other features including perio-endo lesions, widened periodontal ligament spaces, abnormal root length or morphology, overhanging restorations, caries.

A key to any dental treatment is to review that you have consent from the patient and it is worth noting that many practices ask patients to complete a patient experience survey after certain dental treatments such as Endodontics, complex restorative treatment and periodontal therapy...think of the value of this in the patient record!!!

Periodontal audit

WE VALUE YOUR OPINION.

We would like your opinion on our consent process.

The consent process is what we do to help you make a decision about whether to have treatment and which option to choose.

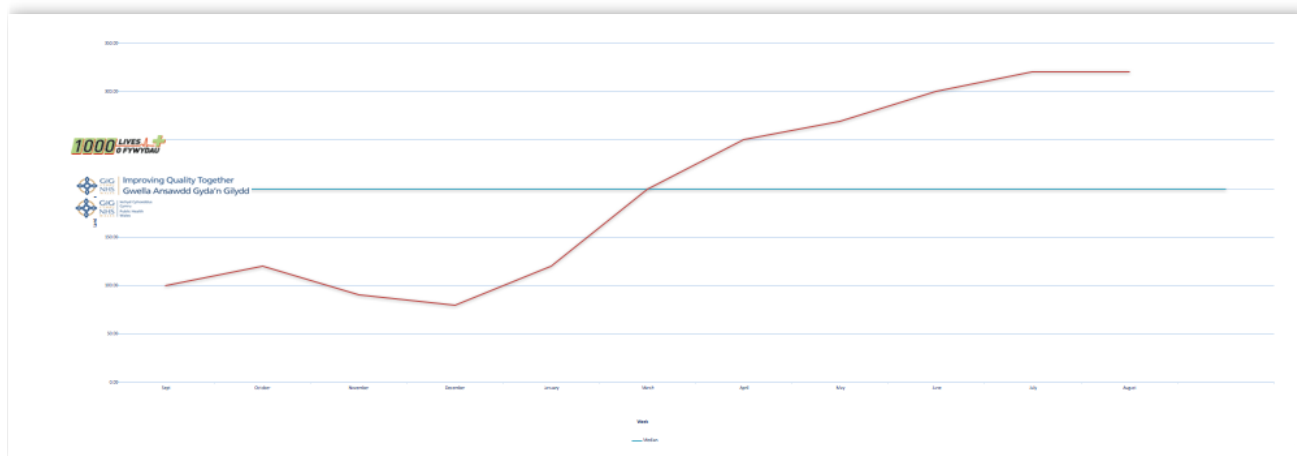
Now that you have completed your treatment with us, we would like you reflect upon your time when we discussed your treatment and answer the following questions.

	Yes	No			Comments	
1. Did you have enough time to make a decision on your treatment options?						
2. Did we provide you with enough information on your treatment?						
3. Was the information easy to understand?						
	Very Good	Good	Fair	Poor		
4. How would you rate the end result of your treatment?						
	Yes exactly	Mostly	Only a little	Not at all		
5 Are you aware of your long term commitment to maintenance						

Periodontal audit

IQT Improving Quality Together

Using the methodologies for IQT it can be seen that if this audit is undertaken as a monthly exercise using a smaller number of patients then a run chart can be produced recording changes in the total landmark number score.



This will allow determination of shifts in improvement

Please note that the opportunity to audit, question reflect and improve in this subject are endless especially with periodontal treatment. We have shown how one audit can become three, if we consider whether our radiographs are appropriate as well and whether our BPE link to further tests. The key is involve the team and maybe add elements which the team feel are important.

With the DCPs , therapist and hygienist they might want to consider whether they are working under Direct access or not. If they are not:

1. Do they have a dentist providing a written treatment plan?
2. Do they have a dentist prescription or group directive?
3. The radiography issues -

Registered dental hygienists and therapists are able to take on the roles of 'operator', 'practitioner' and 'referrer' under IR(ME)R

However, dentists remain the only member of the team who can 'report' on all aspects of a radiograph.

References:

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Selection criteria for Dental Radiography revised Feb 2018

Online via open standards <https://www.fgdp.org.uk/publication/selection-criteria-dental-radiography>

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