**Devon LDC CLINICAL AUDIT AND PEER REVIEW**

**Dental Clinical Audit**

**11. Delivering Better Oral Health**

 **for**

**Children and Young Adults**

**Audit start date:**

**Completion date:**

|  |
| --- |
| **Dental Clinical Audit report (tick) check list****All sections need to be completed and included when returning your report:** |
| **1.** Include your **Protocol** for treating different types of patients  | [ ]  |
| **2.** Completed **data capture sheets**  pages: 6 - 7  | [ ]  |
| **3.** Suggested Mandatory **Aims & Objectives** page: 8 | [ ]  |
| **3.1** Suggested **Action Plan**  page: 8  Action Plan to include changes made after producing  the protocol and before audit cycle | [ ]  |
|  **Reflection** | [ ]  |
|  | [ ]  |

**2015 Structured Dental Clinical Audit**

**11. Delivering Better Oral Health for Children and Young Adults**

 **Originally Prepared by: South West Clinical Audit & Peer Review Assessment Panel,**

**South West Clinical Audit and Peer Review Assessment Panel**

**11. Clinical Audit of Delivering Better Oral Health**

**THIS IS NOT STRICTLY SPEAKING A CLINICAL AUDIT. IT IS AN EXERCISE IN HELPING PRACTITIONERS IDENTIFY THE CARIES RISK STATUS OF YOUNG PATIENTS AND IN DEVELOPING PROTOCOLS TO DELIVER APPROPRIATE CARE AND DECIDE ON NICE RECALL INTERVALS**

**THERE IS AN AUDIT ELEMENT BUILT IN TO IDENTIFY WHETHER YOUNG PATIENTS ARE RECEIVING APPROPRIATE CARE FOR THEIR CARIES RISK STATUS**

The audit aims to help introduce a Caries Risk assessment Programme for children and young adults in order to achieve the objective of “Supporting dentists and their teams to develop and use health promotion skills”

This will also help practitioners identify the risk status of individual patients and develop a treatment plan to suit their needs

The idea is the patient, guardian or carer of all children of 16 and under, to complete a short questionnaire about the patient on the form supplied. (Usually in the waiting room before the appointment) The answers that they provide, coupled with an assessment of risk factors by yourself at the clinical examination should help you classify the patient as high, medium or low risk of dental caries. The questionnaire will be returned to the parent with the risk status clearly marked and with recommendations about frequency of check ups and diet and fluoride. These can be used in conjunction with advice sheets on healthy eating and fluoride toothpaste based on the recommendations in “Delivering Better Oral Health”.

It also promotes the ideas of OHI and healthy eating to the patient and their parents or guardians. It highlights the need to reduce the intake of added sugar food and drinks and for regular brushing with high fluoride toothpaste. There is also the possibility of patients moving to a lower risk category if the correct preventive measures are taken and we hope this will act as an incentive for parents.

It will also make it possible to audit the caries risk status of patients aged 16 and under over a period of time and to evaluate whether there is an oral health gain.

**Aims and objectives**

* **To assess the Caries Risk for Children and Young adults**
* **To develop a protocol for delivering care appropriate to the individual patient**
* **Audit how often the appropriate care is provided**
* **You may wish to carry out a second cycle to assess any changes in practice you have made**

**Source material**

The programme is based on the evidence based recommendations in “Delivering Better Oral Health” second edition published in July 2009.

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**Method**

**This audit is useful to include the whole Dental team and could be started at a Practice meeting.**

1. Use the Patient questionnaire and the Dentist Appraisal recording sheet provided to assess the caries risk status of 30 patients aged 16 and under. I would suggest using a fairly straight forward classification of high, medium or low risk. This will familiarise you with the process and help to formulate a protocol for treatment.
2. Develop a **protocol** for treating young patients with different caries risk status. The different factors to consider may include **recall intervals, oral health education, fissure sealing, fluoride varnish, rinses and high fluoride toothpastes.** The patient questionnaire contains some suggestions about treatment options but you are free to use these, or change them to your own preferences.
3. Using the patient questionnaire and Dentist appraisal recording sheet undertake a

prospective audit of 30 patients and compare the treatment actually provided with the protocol and make any changes to the protocol or treatment that you think necessary.

Keep the appraisal form with your patients’ notes or in their computer record. Please send back the audit recording sheet (6) with pages 7, 8 and 9.

**If more than one dentist in the same practice completes the same audit, each dentist must complete their individual audit, data and feedback sheets.**

**Timetable of activity:**

**Month one:**

Assess the caries risk status of 30 or more patients and then produce the protocol for treating the different types of patient

**Month two and three**

Complete a prospective audit, assessing the caries risk status of 30 patients and comparing the treatment provided to each individual patient with the treatment suggested by your protocol.

**NB**

The caries risk factor recording sheet can be embedded into your computer records. In our practice we use Exact and save the recording sheet in the patient letters section. If you wish to receive the form on page 5 electronically to copy and paste into your computer system please contact Jackie and she will e-mail it to you. Otherwise keep the paper appraisal sheet in the patients record card.

**DENTAL CARE PLAN FOR CHILDREN AND YOUNG ADULTS**

PATIENT NAME:............................................................ Date of Birth ..................................

DEAR PARENT OR CARER,

WE WOULD LIKE TO FIND OUT IF YOUR CHILD IS AT RISK OF TOOTH DECAY AND WHETHER WE CAN REDUCE THAT RISK WITH YOUR HELP

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE: (*Please circle the most appropriate answer*)

YOUR DENTIST WILL USE THIS INFORMATION ALONG WITH THE USUAL CHECK UP TO ASSESS THE RISK AND EXPLAIN HOW IT CAN BE REDUCED.

|  |  |  |  |
| --- | --- | --- | --- |
| 1. How often does your child brush their teeth?
 | Oncedaily | Twicedaily | Occasionally |
| 1. Do you supervise/assist with tooth brushing?
 | Yes | No | Occasionally |
| 1. Does your child use adult fluoridated toothpaste?
 | Adult paste | Child paste | None |
| 1. Does your child have sugary snacks, sweets or drinks in-between meals most days
 | Yes | No | Occasionally |
| 1. Are fizzy drinks consumed most days?
 | Most days | Occasionally | Never |

TO BE COMPLETED BY YOUR DENTIST AFTER THE CLINICAL EXAMINATION

Tooth decay Risk Assessment: Low Risk □ Medium Risk □ High Risk □

ADVICE TO PARENT OR GUARDIAN:

Low Risk: 6 or 12 month check up: Continue with current regime of regular brushing and good diet.

Medium risk: 6 month check up: Monitor eating and drinking (Ask for healthy eating advice sheet) and try to reduce frequency of sugar intake and supervise twice daily tooth brushing with adult fluoride toothpaste.

High Risk: 6 month check up. Consider 3 month appointment for fluoride application. Monitor eating and drinking (Ask for healthy eating advice sheet) and try to reduce frequency of sugar intake and supervise twice daily tooth brushing with adult fluoride toothpaste. Consult your dentist about using a high fluoride toothpaste or mouthwash.

**Cut down on how often you have sugary snacks and drinks**

**Brush your teeth twice a day with fluoride toothpaste**

**If you need a snack choose foods that do not contain sugar like cheese, raw vegetables and breadsticks**

**Water and milk are the kindest drinks to teeth**

**Visit your dentist as often as they recommend**

**Caries Risk Assessment Programme**

**DENTIST APPRAISAL:**

**Factors increasing risk of dental caries**

|  |  |
| --- | --- |
| **Name** |       |
| **Postcode** |       |
| **Date of Birth** |       |
| **Date of caries assessment** | **Date** | **Date** | **Date** | **Date** | **Date** | **Date** |
|  |       |       |       |       |       |       |
| **Age at time of caries assessment** |       |       |       |       |       |       |
| 1. Poor oral hygiene at

 examination –inefficient, infrequent brushing | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Evidence of early or cavitated carious lesions within last three years
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Evidence of early or cavitated carious lesions within last year
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Poor oral health of siblings
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Medically compromised,

Physical disability, mental health issues | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Developmental or enamel

defects | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
|  7. Orthodontic appliance worn | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
|  8. Risk factors identified in Patient questionnaire | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Brushing frequency ½ | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Low fluoride toothpaste ½ | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Sugary snacks ½  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Fizzy drinks ½ | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **CARIES RISK ASSESSMENT (High, Medium, Low)** | **Tick one**[ ] **High**[ ] **Medium**[ ] **Low** | **Tick one**[ ] **High**[ ] **Medium**[ ] **Low** | **Tick one**[ ] **High**[ ] **Medium**[ ] **Low** | **Tick one**[ ] **High**[ ] **Medium**[ ] **Low** | **Tick one**[ ] **High**[ ] **Medium**[ ] **Low** | **Tick one**[ ] **High**[ ] **Medium**[ ] **Low** |

**Suggested scoring**

**0-½ RISK FACTORS: LOW 1-2 RISK FACTORS: MEDIUM 3 OR MORE RISK FACTORS: HIGH**

**South West Clinical Audit and Peer Review Assessment Panel *CAP Ref:***

**11. Clinical Audit of Delivering Better Oral Health**

**AUDIT RECORDING SHEET (data capture sheet)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **PAT****NO.** | **AGE** | **CARIES RISK ASSESSMENT****High, Medium or Low** |  **RECAL INTERVAL** **Months** | **FLUORIDE****APPLICATION****Yes/No** | **FISSURE SEALANTS****Yes/No** | **OHI AND DIET ADVICE****Yes/No** | **MET PROTOCOL****Yes/No** |
| **1** |  | [ ]  **H** | [ ]  **M** | [ ]  **L** |  | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** |
| **2** |  | [ ]  **H** | [ ]  **M** | [ ]  **L** |  | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** |
| **3** |  | [ ]  **H** | [ ]  **M** | [ ]  **L** |  | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** |
| **4** |  | [ ]  **H** | [ ]  **M** | [ ]  **L** |  | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** |
| **5** |  | [ ]  **H** | [ ]  **M** | [ ]  **L** |  | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** |
| **6** |  | [ ]  **H** | [ ]  **M** | [ ]  **L** |  | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** |
| **7** |  | [ ]  **H** | [ ]  **M** | [ ]  **L** |  | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** |
| **8** |  | [ ]  **H** | [ ]  **M** | [ ]  **L** |  | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** |
| **9** |  | [ ]  **H** | [ ]  **M** | [ ]  **L** |  | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** |
| **10** |  | [ ]  **H** | [ ]  **M** | [ ]  **L** |  | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** |
| **11** |  | [ ]  **H** | [ ]  **M** | [ ]  **L** |  | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** |
| **12** |  | [ ]  **H** | [ ]  **M** | [ ]  **L** |  | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** |
| **13** |  | [ ]  **H** | [ ]  **M** | [ ]  **L** |  | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** |
| **14** |  | [ ]  **H** | [ ]  **M** | [ ]  **L** |  | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** |
| **15** |  | [ ]  **H** | [ ]  **M** | [ ]  **L** |  | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** |
| **16** |  | [ ]  **H** | [ ]  **M** | [ ]  **L** |  | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** |
| **17** |  | [ ]  **H** | [ ]  **M** | [ ]  **L** |  | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** |
| **18** |  | [ ]  **H** | [ ]  **M** | [ ]  **L** |  | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** |
| **19** |  | [ ]  **H** | [ ]  **M** | [ ]  **L** |  | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** |
| **20** |  | [ ]  **H** | [ ]  **M** | [ ]  **L** |  | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** |
| **21** |  | [ ]  **H** | [ ]  **M** | [ ]  **L** |  | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** |
| **22** |  | [ ]  **H** | [ ]  **M** | [ ]  **L** |  | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** |
| **23** |  | [ ]  **H** | [ ]  **M** | [ ]  **L** |  | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** |
| **24** |  | [ ]  **H** | [ ]  **M** | [ ]  **L** |  | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** |
| **25** |  | [ ]  **H** | [ ]  **M** | [ ]  **L** |  | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** |
| **26** |  | [ ]  **H** | [ ]  **M** | [ ]  **L** |  | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** |
| **27** |  | [ ]  **H** | [ ]  **M** | [ ]  **L** |  | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** |
| **28** |  | [ ]  **H** | [ ]  **M** | [ ]  **L** |  | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** |
| **29** |  | [ ]  **H** | [ ]  **M** | [ ]  **L** |  | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** |
| **30** |  | [ ]  **H** | [ ]  **M** | [ ]  **L** |  | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** | [ ]  **Y** | [ ]  **N** |

**South West Clinical Audit and Peer Review Assessment Panel *CAP Ref:***

**South West Clinical Audit and Peer Review Assessment Panel**

**11. Delivering Better Oral Health for Children and Young Adults Audit**

**Please complete this mandatory page as part of your Clinical Audit activity, which will be sent anonymously to your NHS England Area Team.**

|  |
| --- |
| **11.Delivering Better Oral Health - Clinical Audit feedback:** |
| **Were the following AIMS & OBJECTIVES ACHIEVED** | **Yes** | **No** |
| **1. To assess the Caries Risk for Children and Young adults** | [ ]  | [ ]  |
| **2. To develop a protocol for delivering care appropriate to the**  **individual patient** | [ ]  | [ ]  |
| **3. Audit how often the appropriate care is provided** | [ ]  | [ ]  |

|  |
| --- |
| **Action Plan as a result of your Clinical Audit to include any changes made after producing your protocol:**      |

|  |
| --- |
| **How useful did you find this** **Dental Clinical Audit?****Please tick one of the following: *No use*** [ ]  ***Useful*** [ ]  ***Very Useful*** [ ]  |

|  |
| --- |
| **Any comments on this Structured Dental Clinical Audit especially if you ticked no use:**      |

***For Panel use only:***

|  |  |
| --- | --- |
| ***Approved*** [ ]       | ***Not Approved*** [ ]       |

**South West Clinical Audit and Peer Review Assessment Panel *CAP Ref:***

**Clinical Audit of Delivering Better Oral Health for Children and Young Adults**

|  |
| --- |
| **Dental Clinical Audit report check list****All sections need to be completed when conducting this audit:** |
| **1.** Have you established your **Protocol** for treating different types of patients ? |
| **2.** Completed **data capture sheets** (page 6 - 7)  |
| **3.** **Aims & Objectives** |
| **3.1**  **Action Plan** Action Plan to include changes made after producing the protocol and  before audit cycle |
| **3.2** **Reflection** |
|  **Implementation of changes and second audit cycle performed ?** |

***Please note:*** *a copy of your completed Dental Clinical Audit should be retained by the practice as part of your practice clinical governance portfolio.*

**I confirm that I have completed the Dental Clinical Audit activity** [ ]

**Date:**