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Annals and Essences of Dentistry

Mini Review

Audit on Recall Intervals of High Risk Children at Billings Hurst Dental Practice

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ABSTRACT

Caries is an established, chronic disease present in childhood in both deciduous and permeant dentition. Recently released statistics from Public Health England, noted one in four five years old now has dental decay. This is a pressing concern, as no progress has been made since the previous survey who noted a similar figure. The responsibility of dental decay not only lies on the patients or parents, but also their dental practitioner to monitor and review the child to ensure prevention or early detection of such lesions. Thus, there is an increased importance placed on the recall intervals of high-risk children. These reviews assess the children on the dental caries factors such as, a high cariogenic diet, poor plaque control, their fluoride intake as well as any medical history changes.

Keywords: Caries; Oral mucosa; Dental health; Fissure sealants

INTRODUCTION

The system of recall is a notion that has been commonly used, with the most common system of adults visiting the dentist twice a year [1,2]. The recall appointment is imperative to review the oral health which not only includes the assessment of caries but also an examination to review the periodontal health of the patient and to review any changes in oral mucosa which could possibly allude to oral cancer. This is important in pediatric patients whom need to be assessed during their developing dentition, as early diagnosis can save a child or adult a lengthy treatment [3].

As noted, the worldly acceptance of a bi-annual review has since been challenged as we must view each patient individually. Thus, the basis of a risk assessment was formed, encouraging patient involvement in understanding why they may be a higher risk and how to change habits to become low risk. A study by Wang, studied the recall time alongside the patient's dental health [4]. It was concluded, those with a longer recall interval, tended to have a higher DMFS (decayed, missing and filled teeth). This again reinforced the importance of periodically monitoring the child's dental health for prevention [5].

Risk assessment is fundamental in the preventative care of patients and is now routinely assessed during dental checkups. This should be carried out from the first eruption of primary dentition and reviewed at each appointment. The aim of this is to develop a care plan based on the Childs susceptibility. Fontana, noted a patient placed on high risk, must have the appropriate treatment and advice to manage his and prevent or slow down further spread [6]. The risk assessment will inform the practitioner, not only of the frequency of recall but radiographs and the provision of preventative measures. This will help to formulate the appropriate treatment plan of the child.

LITERATURE REVIEW

Caries is multifactorial and in the majority, can be prevented. The main evidence based interventions most commonly provided by the child's dental practitioner include, using fluoridated toothpaste, diet advice, fluoride varnish and fissure sealants. Further advice on this can be provided by the Delivering Better Oral Health toolkit. The caries risk assessment of a child must include an evaluation of the child's previous caries history, diet, fluoride use and the host susceptibility. There should also be an analysis of the behavioral and social factors of the child, gaining the healthcare worker's opinion can also further our understanding of provide a sound assessment. It is also important at this stage, to not only assess the child's dental motivation but also the parents'. The preventive approach at this point may be to incite good oral hygiene habits for the

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Received : 01-Apr-2022, Manuscript No. AEDJ-22-15468; **Editor assigned:** 04-Apr-2022, Pre QC No. AEDJ-22-15468 (PQ); **Reviewed:** 18-Apr-2022, QC No. AEDJ-22-15468; **Revised:** 25-Apr-2022, Manuscript No. AEDJ-22-15468 (R); **Published:** 05-May-2022, DOI: 10.35248/ 0975-8798.22.14.223

Citation: Singh S (2022) Audit on Recall Intervals of High Risk Children at Billings Hurst Dental Practice. Ann Essence Dent.14:223.

parents to model on to their children as well as them having ultimate control of their diet [7]. The recall interval of children is seemingly more pressing, as evidence proves the spread of caries to be faster in newly erupted secondary dentition. The stage of the mixed dentition is imperative to assess regularly as it is noted, children may not be brushing as effectively and it is also the time where malocclusions may also be detected [8]. We must encourage good oral habits at an early stage and reiterate this regularly to children, to ensure the improvement or maintenance of good oral hygiene.

A staff meeting was put in place discussing why this may be occurring and how as a practice we would put in further changes to improve adherence. It was noted in the meeting, placing the risk level as part of their oral health assessment templates would be a useful reminder to place this on all notes. Practitioners noted, due to the template used for their new patients not having a risk assessment prompt, they often forgot to place it for their patients. This was commonly agreed upon within the practice, and thus a template formulated with a prompt was encouraged for the practitioners to use. This has further been proved who encouraged the use of templates [9]. This allows for more reliable clinical information as the clinician is reminded to place a risk assessment. This is also important when reviewing the audit annually as we can easily assess this during collection. However, templates do also have its own limitations as we must not keep generalized clinical information for our patients. Although practitioners were treating the children for the diagnosed disease, the children were not appropriately reviewed thereafter to ensure prevention of further carious lesions.

It was also found placing information in common sites around the practice may be a useful reminder to the clinical staff. Thus, posters were placed in the staff room and leaflets were given to the practitioners with the written guidance. This discussed the importance of risk assessments and how this might impact the recall appointment. The NICE guidelines were summarized with the findings as well as the aim of the second cycle. Discussing my findings, the practice in whole agreed the importance of regularly reviewed higher risk children at a shorter recall time.

As well as educating the clinicians of the importance of recall, it would also be beneficial to inform the parents of the patients to the recall system. The created awareness may encourage parents to be more motivated with their child's dental health, as changing oral habits will mean the parents do not need to bring their children in at shorter intervals. We must motivate and encourage interest in their children's oral health as well as the significance of their individual recall.

Sufficient time was given for the changes to be implemented in the practice and this was assessed with the use of a prospective audit cycle, consisting of another sample size of 20 patients. The second cycle showed a huge improvement, with 100% of the high risk children having the accurate risk level written in the notes, as part of their template. As well as, 85% of patients had the appropriate recall interval of 3 months. This proved a positive result of the interventions placed and will be continually reviewed annually in the practice to maintain this standard.

DISCUSSION

This audit consists of two cycles, a retrospective and a prospective audit. Both audits involved analyzing a random selection of 20 high risk patients under the age of 18, attending for an oral health assessment. The results of the first cycle were collected and compared to the set standard placed by the National Institute of Clinical Excellence (NICE). Analysis of the data noted if the children had been given a risk level as well a recall interval.

The results of the first audit cycle showed that only 65% of the high risk children had the accurate risk level write in their notes. Of this, only 40% of the high risk children seen were placed on the appropriate recall interval of 3 months. Therefore, further teaching and interventions needed to be put in place to ensure the dentists in the practice were aware of the current guidance and the current findings of the audit.

Findings from the second cycle, was again discussed with the clinicians. It was noted, the templates brought the most change as the risk assessment box prompted and reminded them to do this for every child patient. It was also found, being reminded of the recall intervals was useful in placing them on the right pathway and in ensuring their appointment time was booked in appropriately with reception. The non-clinical team also found, understanding the recall times useful if ever booking appointments, ensuring the patient were on the right pathway.

CONCLUSION

The study proved that the practice needed to attain the accepted recall standards as per the NICE guidelines to improve patient care and management. It was important for the practitioners to understand how not following these guidelines could be detrimental for patients as we are not assessing and treating them on an individual basis. The second cycle proved the practitioners were able to take on board the advice and findings given. The changes implemented have brought the results expected and it is now the aim of the study to continue and maintain this.

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