

The Royal College of Surgeons of England Orthodontic Audit Working Party



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Chairman's Update.

When I last wrote, I reported that our plans for a National Outcome Audit seemed to have come to nothing. Our application for funding had initially been well received by the Department, but it had soon become clear that their desire was for something which would permit the production of a national league table. I am sure that most of you would have shared my own feelings about that approach — but, without funding, our original project seemed doomed.

COG Support:

Since then, I am delighted to report that Nigel Harradine has offered the financial support of the C.O.G. — so a National Outcome Audit of Treatment within the Hospital Orthodontic Service is now on the agenda. We hope to go ahead during this year. Details will be circulated but, put briefly, the plan is that all Consultants will be invited to submit pre-treatment and post-treatment study

models for six cases (personally treated with upper and lower fixed appliances) completed after a chosen date. These will be scored using the P.A.R. index so that a national mean reduction of P.A.R. may be obtained. (There will be limited criteria for exclusion, for categories which are not appropriately reflected by the P.A.R.)

The Intention:

Our intent is to produce a picture of our current treatment standards against which individuals can compare their own performance, either within the audit or subsequently. It will be most important that participants are honest and submit a true sequence of finished treatments, including any discontinued cases.

We want our picture to include “warts and all” and any “cherry-picking” will produce a meaningless final figure which may, in the future, become a rod for our own backs.

There will, in any case, be no good reason for anyone to cheat. To encourage honesty, the project must be non-threatening and the anonymity of

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The Editors' Edge

We want our picture to include “warts and all”: any “cherry-picking” will produce a meaningless final figure which may, in the future, become a rod for our own backs.

(Continued from page 1)

participants will be closely guarded, with each one being allotted a number known only to him or her (and to the project organiser, Ros McMullan, who will not be involved in the scoring, and is sworn to silence). We need to demonstrate that we are actively looking at measures of outcome and I hope that as many people as possible will take part in the audit.

Audit Recipes:

The work of building a collection of audit recipes continues and I should like to thank all of you who have submitted projects which have proved successful locally. Bridget Doubleday has already put more than thirty into a standard format. A few will be published shortly by the faculty together with those of other disciplines and we hope to make the orthodontic recipes available, perhaps on a floppy disc, in the near future — with appropriate acknowledgements to the authors. If anyone has carried out a successful local project please let Bridget have the details.

Audit Meeting:

Once again, we held a meeting of regional audit representatives at the B.O.C. in Torquay. As usual, it was a stimulating and worthwhile session (**report on page 8**) We hope to hold a further meeting during the conference in Glasgow, which will be announced in due course. Can I again encourage anyone who cannot make the meeting to nominate a deputy to attend.

Euroqual:

Towards the end of 1998, I represented the B.O.S. at a “Euroqual” meeting in Haarlam and I hope to be present in Amsterdam this Spring when the “European Orthodontic Quality Manual” is launched.

“Euroqual” is an orthodontic group, based in Amsterdam, drawn from many countries of Europe and financed by the E.U.. Its current objective is described as

Audit ought to identify those things which are important and try to make them measurable; too often it merely identifies those things which are measurable and tries to make them important.

“... to present a user-friendly, flexible system for quality improvement, based on the previously developed quality statements, to be used by the individual orthodontic professional in Europe”.

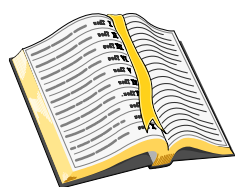
The manual, once one has penetrated its verbiage and “business-speak”, falls into two parts. First come the well-meaning

statements, flow-charts and definitions - as unexceptional as they are unexceptional. The second part deals, essentially, with audit. It is interesting, though not a little depressing, to see others facing the challenges which we in the U.K. have already faced and looking likely to make the same mistakes.

I have pointed this out, but with no real hope of achieving change. The collection of data is proposed, but with no clear purpose in prospect. (We at least have indices to help us, but the P.A.R. Index seems to be mistrusted in Europe.) Without any means of assessing the central issues of treatment, they are left to scrape around for subjects on the periphery: number of visits, number of breakages, length of treatment, white spots, non-cooperation, lost appliances, resorption, patient satisfaction etc.. Yet it is quite possible to achieve an abysmal result and still score well on all these criteria.

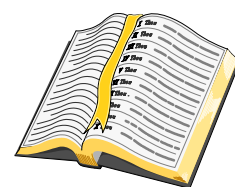
Audit ought, properly, to identify those things which are important and try to make them measurable; too often it merely identifies those things which are measurable and tries to make them important.

Good wishes to all of you,
John Muir



The Importance of Calculating the Reading Age of Orthodontic Leaflets

Keeley E O Twigg, Dental Nurse, Wrexham Maelor Hospital



AIM

To calculate the reading age of the orthodontic information leaflet circulated in the department.

STANDARD

The leaflet should have a reading age of no greater than 12 years.

PROCESS OF AUDIT

To assess reading age, the formula proposed by Reece and Walter was used. The formula is briefly known as FOG (Formula of Gobbledegook!) In

addition, a questionnaire was developed to ask all new patients their understanding of the current leaflet.

RESULTS

The FOG formula indicated that the reading age of the information leaflet was 17.8 years. Findings from the questionnaire indicated that patients found the leaflet difficult to understand.

CONCLUSION

The reading age of the current infor-

mation leaflet was too high and was not easy to understand.

IMPLEMENTATION

The leaflet was redesigned to include colourful pictures and reduce the reading age to 9 years.

Reference: Reece I and Walter S; A guide to learning independently in Further and Adult Education, Edited by Marshall and Rowland, 2nd Edition.

APPROPRIATENESS OF REFERRALS

Nikki Atack and Nigel Harradine, Bristol Dental Hospital.

INTRODUCTION:

In contrast to other authors, we have formed the view that any patient referred to the hospital between the ages of 10 and 17 years is an appropriate referral for advice or treatment. However, referrals at younger or older ages might well be inappropriate.

METHOD:

A prospective audit was carried out of 119 consecutive new patients attending the consultants clinic. Patients were grouped into three age ranges: under 10 years; 10-17 years; 18 years and over; and examined for the specific features of malocclusion listed by Fox (1993), any one of which indicated that immediate referral for an orthodontic opinion was appropriate. In the 18 years and over group, an assessment of oral hygiene was made and patients were asked whether, pre-referral, they were informed that the use of fixed appliances would be necessary, that most treatment times are between 18-24 months and that regular visits are required for appliance adjustment.

RESULTS:

Under 10 yrs (N=10 or 8% of total)

Appropriate (Fox 1993) 100%
Ready for treatment/ planning 50%
Too early for treatment/ planning 50%

10-17 years (N=91 or 76% of total)

Ready for treatment/ planning 69%
Too early for treatment 12%
Ready but no treatment appropriate 11%
Ready but declined treatment 8%

18 yrs and over (N=18, 15% of total)

Ready for treatment/ planning 67%
Declined treatment 22%
Required no treatment 11%
Knew all three pre-referral facts 67%
Excellent O.H.: all but one patient.

DISCUSSION:

Under 10 years: In this age group the criteria still seem very sensitive for most gbps if opportunities for important interceptive measures are not to be missed. The number in this group (10) was small and may reflect a "well-educated" group of referrers.

10-17 years: 12% of this group were referred too early. Greater emphasis in referral guidelines on first premolars being erupted would reduce but not eliminate this figure.

18 yrs and over: one third declined or did not need treatment. Two thirds were well informed (three basic facts).

CONCLUSIONS:

1. All patients under 10 yrs met the criteria for appropriate referral.
2. 69% patients aged 10 or older wanted, needed and were ready for treatment.

ACTION:

Guidelines for adult patient referrals will be sent to all referrers.

Reference:

Fox, N: Audit of new patient referrals. RCS Audit Newsletter Sept. 1993.

ADULT REFERRALS

Samantha Hodges and Steven Jones, Eastman Dental Hospital

AIM: To determine the nature and outcome of adult new patient referrals.

STANDARD TO BE TESTED: All adult patients referred for treatment should both need and want orthodontic treatment

PROCESS OF AUDIT TECHNIQUE

All new patients over the age of 17 years were assessed over a three month period to determine:

- the age range
- the reasons for referral as identified by the referral letter and the accuracy of this when compared to the problems identified by an orthodontist
- IOTN (Dental Health Component)
- the outcome

RESULTS AND ASSESSMENT

In only 25% of the cases was the reason for referral as stated by letter also identified as the main problem by the orthodontist. IOTN (DHC) was recorded for 90% of patients: 49% came into categories 4 & 5, 10% into category 3, 31% into categories 1 & 2.

Outcome

- 17% were thought not to require any form of treatment
- 24% had a malocclusion too mild to accept for treatment within the hospital service
- 24% declined the offer of treatment
- 27% were accepted for treatment
- 8% were required to have a further multidisciplinary assessment before reaching a definitive treatment plan.

CONCLUSION

Many adult referrals are inappropriate both due to the mild nature of the malocclusion and the reluctance of the patient to undergo lengthy and often complex treatment.



PLAN FOR IMPLEMENTING FINDINGS

All new patients are currently sent information forms which they are required to fill in and return prior to a consultation appointment being made. In future, a letter to adult patients will be included with this and will inform them that, although they will be given a consultation, treatment will not necessarily be undertaken at the hospital. An orthodontic information leaflet, including photographs, would help to inform patients of what is involved with orthodontic treatment.

This audit will be repeated in one year.

**The purpose of Audit is to identify when there is a need for the individual clinician to change clinical activity.
When did you last change your clinical activity as a result of Audit?**

CLINICAL EFFECTIVENESS - WHAT DOES IT MEAN TO YOU?

John K Williams, Wakefield.

You are bound to have come across the publicity in the media recently about patients receiving inappropriate treatment. The Bristol Paediatric Cardiology deaths brought matters to a head. We clinicians wonder about how such things can happen and what can be done about it, because it is sad and embarrassing and inevitably casts a shadow over all professions.

A fundamental issue is that there is now a widely recognised variability of clinical activity in many disciplines, and that this is associated with a variability in clinical outcomes for similar conditions. Variability in clinical approach can well be argued to be a good thing - but on the other hand providing inappropriate treatment which results in poor outcomes cannot be supported.

All this has come to light because of the increasing interest in collecting reliable data on clinical activity. The painful disclosures are welcome because they are the stimulus to achieving real improvements in clinical outcomes. The clinicians I meet are aware of these matters. The Government, the media and many patients are also worried. There is a real problem, and it is not easy to solve. There is the autonomy of the clinician - the freedom to prescribe whatever treatment seems to be right at the time. This may well be in the patient's interest, but only if the clinician is aware of the "best" approach for the condition and is capable and willing to provide it. The clinician though may not be up to date, and may be set in modes of treatment which are no longer appropriate. This is where CPE is important, and Audit, and the availability of realistic and reliable clinical Guidelines. It has to be remembered though that the purpose of CPE, Audit and Guidelines is to improve outcomes - which will sometimes mean that the clinician *needs to change clinical behaviour*. Sometimes of course the clinician is prevented from providing the best treatment because of circumstances beyond his control (e.g. funding or facilities) - but we must not allow this

to excuse inappropriate treatment caused by clinician error. In many areas of clinical practice there is just not enough reliable research data upon which to base recommendations. Most clinicians are not aware of how their clinical practice and outcomes compare with those of their colleagues. This is not because of intentional concealment, but because the structures under which such awareness can be promoted are just not used.

***THE PURPOSE OF CPE,
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What about orthodontics?

To begin with, we are less likely to be under the floodlight because our patients do not die if we make mistakes. Nevertheless, I should think that the same sort of problems that I describe above also apply to us. I go

to my Regional Audit meetings, and have access to Guidelines and CPE. Something I have certainly noticed at Audit meetings is that there is a considerable variability in clinical approach. Whether this is resulting in variability in outcomes I am not sure - because most of our Audit activity has not really addressed that question. I think it needs to do so. It has been easy for us to forget that the purpose of Audit is to identify when there is a need for the individual clinician to change clinical activity. Most of our Audit has not had the slightest hope of doing that! When did you last change your clinical activity as a result of Audit? Things would be easier if only we had more reliable data about the results of various clinical approaches - then we could write better Guidelines and apply the Audit process properly. I am not sure how my outcomes compare with those of my colleagues. I suppose that applies to most of us. I need to be prepared to change my clinical activity in the interest of improving outcomes if others are doing better. If I don't know how my colleagues are doing I have no information on which to base a different approach.

So, we are facing great changes.

IN PRAISE OF CLINICAL AUDIT

Mark Tobin , Newport Pagnell



Closer interest in what we are doing. I recommend all of you to read the NHS consultative document "A First Class Service". It is clear and readable, and sets out the Government's intentions for improving clinical quality. Some of the proposals are controversial - for instance the intention to publish what amounts to "league tables" related to clinical outcomes. We are facing "ranking" of our outcomes. In the very nature of things, we cannot all achieve the average standard of outcome for any particular activity. What is going to happen to those of us who are significantly worse than the average?

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Would "re-training" really be effective? There are major problems in this area too - but we cannot, and should not, duck the issue. It is our responsibility as professionals actively to pursue improvement in clinical outcomes, and if we don't get on with it someone else is going to do it for us. Finally, on a more hopeful note, the NHS Consultants in Orthodontics are

Excuses abound as to why one should not engage in clinical audit! These range from lack of time, funding or interest through laziness and arrogance to resistance to change. Thus I was reluctant to participate in audit until I had been qualified for six

years.

Many of us have participated in peer review schemes and, like myself, have probably enjoyed the experience but clinical audit is a more lonely experience: it lacks the social intercourse of peer review. There is much to recommend it however as I discovered in two audits carried out at my practice during 1997.

A local facilitator helped us to choose topics and provided us with much valuable advice as neither I nor my partner had any previous experience of preparing a formal audit study. We chose topics that we had both felt uneasy about for some time: "The Quality of Radiographs" and "The Treatment of Emergency Patients".

During our first meeting the objectives of the study were defined, standards set and a plan of action formulated. Broadly speaking the objectives were very simple: to improve the quality of the service provided to our patients and thus improve our practice.

What happened during the next three months annihilated any of my former excuses for not participating in clinical audit. The misguided belief that everything was going well was soon dealt a terminal blow. Clear indications of where we were failing became apparent. Clinical audit in all its glory suddenly dawned upon me, embodied

in the beautifully simple question "how can we improve upon this?" The benefits have been enormous both to our patients and to our practice. The main long term benefit, however, has been a change in our practice philosophy. We now apply the principles of clinical audit on a continuous basis to all aspects of our practice. Many different areas have

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since been reviewed and the same principles applied: a standard is set, a shortcoming identified, a way of improving current procedure sought and a change instituted. In order to complete the audit loop, a further clinical audit is undertaken to assess the benefit of these changes.

Through this process of constant and never-ending improvement I have discovered a more successful and rewarding practice and look forward to continuing the audit process.

about to run a National Audit of outcomes based on 6 consecutively treated cases. All Consultants will be invited to participate, and the PAR assessment will be used. This is a

genuine attempt to address the sort of issues the Government is interested in, and I very much hope that it will be widely supported.

QUALITY OF CLINICAL PHOTOGRAPHS

Nicola Parkin and Jonathan Sandler, Chesterfield Royal Hospital

AIM:

To assess the quality of photographs taken within the orthodontic department.

STANDARD:

Less than 10% of photographs should need to be repeated on the grounds of quality.

METHOD:

All photographs were taken with the Yashika Dental Eye II Camera. Four sets of slides (4 extra-oral, 3 intra-oral and 2 occlusal views per set) were randomly selected from each of nine photographers. Eight assessors, after verbal instruction, graded the slides as "very good", "acceptable" or "unacceptable" using seven criteria e.g. focusing and adequate depth of field, correct positioning of centre lines etc.

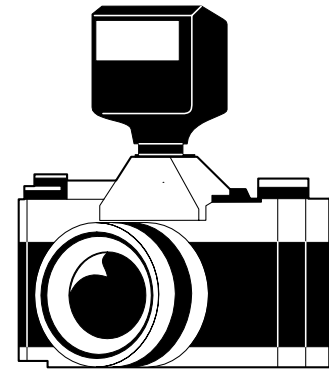
RESULTS:

36 slides were viewed per photographer. The results were analysed separately for intra-oral, extra-oral and occlusal views.

Photographers varied in their ability to take different views: two did not meet the standard for extra-oral views, four for intra-oral views and five for occlusal views. Two photographers failed to meet the standard in all three categories.

CONCLUSIONS:

1. Many slides were deemed unacceptable
2. Two photographers consistently produced films of a high standard
3. Over 35% of slides produced by three operators needed repeating.



PLAN FOR IMPLEMENTATION OF FINDINGS:

1. Emphasise basic photographic technique.
2. Repeat this audit in 6 months.

Reference:

Sandler P.J. and Murray A.M.
Clinical Photography in Orthodontics
JCO November 1997

UNERUPTED ECTOPIC MAXILLARY CANINE TEETH

Susi Caldwell, Manchester.

The unerupted ectopic maxillary canine commonly requires surgical exposure prior to orthodontic alignment.

STANDARDS:

1. 90% of patients undergoing maxillary canine exposure should be under 15 years of age at the time of operation.
2. 90% of patients should undergo only one surgical procedure per ectopic canine.

METHOD:

Patients who required surgical exposure of maxillary canines during 1997 were identified retrospectively from the theatre books of the South Manchester University Trust Hospitals.

RESULTS:

33 patients were identified and 45 op-

erations were performed. Ten patients had bilateral canines exposed on the same day. All patients had a pack placed at operation. 50% of cases were referred by specialist orthodontic practitioners, 47% by the orthodontic department and 3% directly by a GDP. The ages of the patients were: <15 years, 64%; 15 - 16 years, 24%; >16 years, 12%. Only 2 (5%) exposures required a repeat procedure.

DISCUSSION:

The standard procedure of placing a pack at the time of exposure appears very satisfactory. Only one cleat was bonded, at a repeat procedure. It was felt that the maxillofacial department's aggressive approach to exposure contributed to the success. It was disappointing to find that only 64% of patients were under 15 at the time of operation. If the age is raised to

16 years this would include 88% of patients and this may be more realistic. Of the 12% (4 cases) undergoing this operation older than 16 years, two were late referrals, one was a waiting list oversight and one was an individual with little interest in his dentition.

CONCLUSIONS:

64% of patients were under 15 years at operation - we failed to reach the standard. Only 5% of canines required a second operative procedure - we exceeded the standard.

IMPLEMENTATION OF FINDINGS:

- Highlight early detection in future section 63 courses.
- Re-audit for reduction in age at operation and to ensure that the high surgical standard is maintained.

AN AUDIT OF BRACKET FAILURES

Matthew Power and Nigel Taylor, Royal Surrey County Hospital, Guildford.

AIMS:

1. To assess the number of bracket failures
2. To reduce the incidence of breakage by identifying risk factors
3. To establish an acceptable standard for failure.

PROCESS:

A prospective study was carried out using a questionnaire to quantify all bracket failures over a three month period. Variables recorded included: patient age and gender, malocclusion and oral hygiene, appliance type and time to bracket failure.

RESULTS:

48 bracket failures were recorded. There were no gender or age differences. Increased overbite and bracket failure were strongly correlated. Most failures occurred within the first six months of

treatment and 50% within the first three months. Damon and Viazis brackets were more susceptible to breakage than standard and min-twin straight wire or TipEdge brackets.

RECOMMENDATIONS:

1. Additional counselling of patients commencing fixed appliance treatment to stress the importance of a soft diet and taking extra care with fixed appliances. Reinforce with appliance education leaflets.
2. Consider anterior bite planes if overbite is deep.
3. Avoid Viazis and Damon brackets if overbite is deep.
4. A standard was agreed that no more than two episodes of bracket failure should occur for each course of treatment.
5. Repeat audit in six months

THE EDITORS' EDGE

CLINICAL GOVERNANCE:

Clinical governance is becoming the latest "buzzword". It is one of the government's top priorities in the NHS. The DoH definition is "a framework through which the NHS organisations are accountable for continually improving the quality of services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish".

The clinical governance framework is for all clinicians and looks to:

- Modernise and strengthen professional self-regulation
- Strengthen systems for quality control based on good practice and learning from the lessons from poor performance
- Minimise the risks of untoward events

Clinical governance is well advanced and some of us are already involved in the process. With the government's intention of radically modernising and improving the NHS over the next 10 years all clinicians will be involved, hopefully with enthusiasm rather than negative resistance.

CONTRIBUTIONS:

Thank you to all who have sent items for publication in this newsletter. We would like to invite further items for future issues - please do have a look at the guidelines for contributors on the back page. Many submissions are far too long for the available space and substantial revision is required.

Short articles on completed projects are always welcome but letters,

TGB and SR

BOND FAILURE - TWO MINI BRACKET SYSTEMS

B Irwin, Community Northern Regional Group

AIMS:

1. To compare the rate of bond failure of Spectrum II (Ortho-Care) and Gemini (3M Unitek) brackets
2. To determine the pattern of bracket loss.

STANDARD:

There should be less than 10% bracket loss during the treatment process.

PROCESS OF AUDIT:

The same orthodontist and nurse undertook all the bonding of 50 consecutive single arches. The two types of bracket system were placed alternately, using Bond-Fast adhesive. The arch wire was placed 20 - 25 minutes after completion of bonding. If a palatal arch was fitted, the arch wire was placed at a second visit. The average observation period was 114 days, the minimum 48 days.

DISCUSSION: There are many possible reasons for bracket failure, including bracket type, adhesive, operator factors and patient factors. A high proportion

RESULTS	Spectrum II	Gemini
Brackets	199	205
upper appl.	15	16
lower appl.	10	9
age	14.3yrs	14.7yrs
failure - 1st	38 (19%)	38 (19%)
failure - rpt.	10	4

of failures in this study seemed to be associated with poor patient care.

CONCLUSIONS:

1. Bond failure was relatively high (almost one bracket in five).
 2. High failure rates were associated with second premolars (upper 45%, lower 28%), and upper incisors (24%).
- Lowest failure rates: 1st premolars (5%), and canines (12%).

IMPLEMENTATION:

1. Review bonding technique
2. Improve patient education
3. Re-audit in six months.

AUDIT CO-ORDINATORS MEETING TORQUAY SEPTEMBER 1998

The annual meeting of regional orthodontic audit coordinators took place at the BOC with twenty people present.

Review of audit activity in the regions:

Members exchanged experiences of successes and difficulties in audit projects in the past year. Useful audits were reported in the following areas:

follow up appointments; standards of casenotes and photographs; a joint audit with an x-ray department which led to improved communication and understanding of dental needs; the effect of circulating guidelines on appropriateness of referrals; appliance breakages and unscheduled appointments; cross infection control; consecutive PAR scoring of cases; outcome of removable appliance treatment plans etc..

Some difficulties had been experienced in the following areas, generally as a result of the projects being ill-defined or complex:

audits of palatal canines where outcomes were difficult to identify; joint audits with oral surgeons on orthognathic cases. It had been found in prospective audits that awareness of the audit could alter behaviour giving an unexpectedly optimistic picture of standards in practice.

Discussion led to the following conclusions:

1. The most satisfactory audit projects were those which were kept simple, preferably asking a single question and using a simple measure of outcome
2. Many audits were taking place on non-clinical issues such as patient satisfaction and records, often at the request of audit committees and managements. Audits of outcomes were less common.
3. Sustained enthusiasm of audit groups depended on the success of their projects. A good policy was to undertake at least a proportion of topics which could produce clear-cut results in a short period of time.

Clinical governance and outcomes:

The implications of the proposals for clinical governance in Trusts were discussed. There will be a greater need for audits based on clinical outcomes in the future in order to provide evidence of clinical standards in a department. *Co-ordinators were advised to try and shift the emphasis of their work in this direction.* Orthodontics as a specialty is well able to document outcomes.

Audit recipe book:

Around 30 audit recipes had been collected so far towards the audit recipe book. Some were needed for the Faculty of Dental Surgery audit publication and it was suggested that the remainder be put together in an orthodontic audit booklet including some guidelines on planning and conducting a successful orthodontic audit project.

David Tidy

Guidelines for Contributors

The authors of this Newsletter welcome contributions in the form of short articles or letters on any audit topic or related subject. As the newsletter is "home produced", it would be appreciated if submissions could be:

- double spaced on no more than 3 pages of A4 paper using 12 point type.
- sent on disk, with one hard copy, preferably in Word 6.0 or 7.0.

TITLE:

The title should be short enough to adequately describe the subject area (usually not more than 8 words)

AIMS OF THE AUDIT:

The aim of the audit should be clear and well defined.

STANDARD TO BE TESTED:

The standard to be tested must be clearly stated and achievable.

PROCESS OF AUDIT TECHNIQUE:

(Materials and Methods)

The way the audit process was undertaken should state;

- audit criteria (i.e. how the standard was judged)
- number and type of sample
- sampling technique
- process of audit
- time period
- outcome assessments

RESULTS AND ASSESSMENT:

Present the results in a clear manner. Tables or figures may be used.

DISCUSSION:

A brief account should be given of the important findings and implications of the study.

CONCLUSIONS:

Conclusions must be made from the study findings preferably in bullet form

PLAN FOR IMPLEMENTING FINDINGS:

A brief outline should be provided indicating how the audit findings could be implemented as well as necessity and time scale for re-auditing.



Please send copy for Newsletter 13 to:

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