Übers./mh
07.02.2014

QUALITY IN DENTISTRY

How could ‘Quality in Dentistry’ be covered by an ERO working group in a reasonable and beneficial way?

For many years, the ERO has focused on the topic of ‘quality in dentistry’ and therefore, in the last 20 years, has established various working groups that have addressed this issue from different points of view. Since this issue is very complex many problems arose to answer satisfactorily. This is mainly because quality in dentistry is interpreted very differently among dentists and the implementation of quality support measures is strongly influenced by the health care system of each member state, and its funding and level of education, as well as level of science and technology. Furthermore, the dental profession is skeptical about this issue, in particular when it comes to quality measures required by politics, health insurance funds or patients’ mandatory.

To my knowledge, in the early 90s, a working group of the ERO focused on quality in dentistry for the first time. During the ERO session in Budapest in 1994, and further in Malta in 1995, the “Principles of Quality Assurance” were adopted. Even today, to a great extent, these principles are still relevant, the important statement of which is that quality assurance should be ensured by the dental profession itself. After this, the issue had not been treated any more for a long time, but was taken up again by a working group chaired by Francisco Rodríguez Lozano mid-00s. In 2007, Nermin Yamalik published her two surveys on “Quality Systems in Dentistry”, a project of the FDI - Dental Practice Committee. During the ERO plenary session in Moscow in 2007, a “workshop on quality” was organized and a new working group chaired by Gerhard Seeberger was established. The results of a survey demonstrating that many member associations consider this issue to be of importance and that regulations for quality assurance, be it on a statutory basis or by dental associations’ proceedings, do exist in several countries, and that the exchange of good practice models being successfully implemented in some countries is required, whereas “quality management” should be especially focused on in future.

In Eriwan, in 2010, the working group was reestablished and chaired by Roland L’Herron. During numerous meetings the focus of activities was discussed and a comprehensive survey was designed focusing particularly on the conditions of basic and continuing education and the technical equipment of the practices in member countries. However, the feedback was poor. During the ERO plenary session in Potsdam in 2013, the results were finally presented. Further steps were suggested: to initiate the exchange of methods, initiatives and experience in terms of quality of

care. The question arose if this development would be supported by the plenary session. The new ERO board mandated the signatory to summarize the previous outcomes of the ERO working groups on quality in dentistry and submit a proposal for the future work of an ERO working group on 'quality'.

Definition: What does quality in dentistry mean?

There is a wide range of literature on the concept of quality in medical care but this is not the case with literature on quality in dental care where there is not that much literature. The terms quality/quality improvement/quality assurance in healthcare are considered to have very different concepts and measures. In terms of the quality of healthcare, in the 'reflection paper on quality of healthcare' of the European Commission it is stated: "a review of the available literature reveals a multitude of definitions of quality of care (version 2, 2010, 7). A latest article in the BDJ does confirm this especially with regard to dentistry: "There is no agreed or unique definition of quality of care… this applies more so to dental practice than to medical practice" (Campell & Tickle, 2013, 135). However, it would be reasonable to have a common understanding on only one definition in order to talk about quality at all, thus being able to compare, design and implement quality measures and quality instruments. In 1985, Donabedian stated: "we cannot access quality until we have decided with what meanings to invest the concept. A clear definition of quality is the foundation upon which everything is built" (cited in Campell & Tickle, 2013, 135).

Even if there is no generally accepted definition of quality, there is consensus on the attitude that quality in medical care should be a complex, multidimensional concept referring to different levels, dimensions, goals and measures. The levels distinguish between the health care system and the population (macro level), the equipment (meso level), and the individual health professional and the individual patient (micro level). These levels describe 'quality' in a different way and relate to different aspects. The well-known tripartition by Donabedian distinguishes between the quality of structure, and process and outcome. Quality in health care is characterized by different dimensions or features such as patient safety, acceptance, effectiveness, efficiency, justice in care, access opportunities, professionalism, patient-oriented treatment, patient satisfaction. Quality improvement in health care pursues different goals that ‚depending on actors' perspective in health care – that is public, politics, health insurance funds, doctors, patients – have a different meaning : a better health for the entire population, best outcomes while having limitedly available funds, avoidance of overtreatment in health care as well as lack of health care and inappropriate health care, best individual health care, professional treatment to the best of the doctor's knowledge. Finally, quality improvement or quality assurance comprises different measures or instruments by which the following goals are to be achieved: qualified education of health professionals, specialization and continuous

professional development, clinical guidelines, quality management procedures for processes in health care facilities and practices, management of adverse events and Critical Incident Recording Systems (CIRS), documentation, quality indicators, infection control and accreditation processes. The European Network for Patient Safety and Quality of Care (PaSQ) that has followed up the reflection paper since 2012 - the latter was initiated by the European Commission as a project set up for 3 years - describes high quality healthcare as follows: “Healthcare that is effective, safe and responds to the needs and preferences of patients” (PaSQ 2012). In my view, through the criterion ‘effective’ this definition focuses too much on quality of outcome and has not sufficiently been taken into account to satisfy a complex understanding of quality in health care.

Since there has not been any generally accepted definition of quality in health care so far - not to mention quality in dental care - a working group of the ERO should be aware of the complexity of the definition ‘quality’, but should confine itself to a concrete question that does not assess the aspects of quality in structure and outcome primarily, but the aspects of strategies for the improvement of process quality. It should not be applied to quality in structure since structures in practices differ from country to country or have already been covered (education or technical equipment were part of the survey of the WG chaired by Roland L’Herron), it should not be applied to quality in outcome since it is not easy to gain acceptance by the dental profession and since there are only a few tested instruments available that are applicable and evaluable only with great difficulty or under extreme effort – that is to say evaluation of oral-health-related quality of life.

What kind of quality measures are implemented in each country?

The following brief overview is a try to gather information from different countries by desk research. The information is incomplete due to limited numbers of sources that are: the EU Manual of Dental Practice of CED as amended in 2008/2009 in which the quality activities of member associations are only mentioned in passing, the outcomes on quality of the two questionnaires by the ERO working groups as well as the information from the websites of the ERO member associations which, if the word ‘quality’ appears at all, only provide brief and general information since a login is required if a dentist or an association member wants to receive further information. In addition, there are language problems since the websites only provide the language of the individual country.

In Austria, in 2008 a quality assurance regulation came into effect. The dental chamber was responsible for it and had an external institution carried out this regulation. It is about an evaluation of the practice by means of a self-assessment.

Divided into 15 quality sections, 51 questions on evaluation have to be replied to. The acquired certificate will then be in effect for 5 years.

In Belgium, since 1998 a voluntary accreditation system for quality assurance has been into effect. Organizational processes in dental practices are regulated by the Institut National d'Assurance de Maladie.

In Denmark, there is a Health Care Quality Assessment Programme on a voluntary basis and vision 2015 for all health care facilities was developed including quality of care.

In Germany, in 2004 the internal facility quality management was introduced by law for all dental practices. The dental profession was involved in developing the directive for implementing these statutory provisions – that is to say the optimization of work processes in dental practices according to the PDCA cycle. The dental organizations have developed quality management systems that are implemented by almost all dentists. The Dental Quality Management System (Z-QMS) developed by the Hessian Dental Chamber is used by many chambers: it is a systematic compilation of numerous quality assuring measures easy to apply. They are implemented in practices and meet the provisions of law.

In Italy, ANDI is involved in a project on quality and assurance of periodontics and dental implantology which seems also to refer to practice processes.

In Latvia, there are standards for the equipment and work processes of dental practices based on evidence-based methods and techniques. The quality of work such as the documentation is examined.

In Lithuania, quality improvement and assurance is supported by various measures such as continuing education, treatment standards and certifications issued by the dental chamber.

In the Netherlands, in 2004 an 'IQual' project was introduced guided by the PDCA cycle. This project is supported by the NMT through trainings, modules, programmes on various topics, registration for a quality register, audits along with visitations and a lot more; further information may be obtained on the NMT's homepage.

In Switzerland, the SSO has developed and updated quality guidelines. One of them consists of an external examination of practice processes and practice equipment – that is to say with waste management, X-ray units, sterilization, quality of performance. In 2009, the Swiss Federal Council adopted the quality policy of the Swiss Federal State Public Health primarily aiming at in-patient facilities creating

quality indicators for various disease patterns and using peer reviews as a kind of measure for quality improvement.

In Slovenia, work in dental practices is examined by the chambers' routine check-up.

In the United Kingdom, BDA has developed a 'Good Practice Scheme' as the leading quality assurance programme for dental practices. Dentists may join this programme to emphasize their commitment for high quality in dental care. It is about a practice self-assessment enabling all team members to examine the work process in practice thus to initiate an on-going educational cycle (further information may be obtained on BDA's homepage).

This brief and – due to a lack of further information – incomplete outline reveals that the quality issue in dental care is actively elaborated in many member countries through various measures and methods. Besides the handling of patients' complaints, (I did not go into detail since there are further information in the EU Manual of Dental Practice) quality assurance of practice and treatment processes seem to be of great importance to several countries for which instruments and measures are going to be developed.

How can 'quality in dentistry' - a very comprehensive topic - be narrowed down and worked on reasonably?

The comments show that 'quality in dentistry' is a very comprehensive and complex topic and that there is a full range of measures in the member countries. The hitherto existing activities of the two ERO working groups during recent years reveal that an exchange of best practices and methods, initiatives and experience on quality of care in dentistry has already been suggested. The exchange of best practices of quality health care is the very method sought by the European Union Network for Patient Safety and Quality of Care (PaSQ) for the entire field of health care. Since quality in dentistry will only play a minor part in this field, this focus would constitute a very useful and informative contribution supporting the tasks of the CED within the European network and thus could lead to a fruitful cooperation between ERO and CED.

What kind of quality measures should/could be analysed and worked on by a working group of the ERO?

In my opinion, for the time being, the exchange of best practices should be limited to just a few measures or to only one quality improvement measure but then, this quality measure should be described in greater depth. As mentioned before, measures

relating to process quality seem to be most suitable. I would suggest excluding quality measures in the following fields since they have already been covered and treated by different working groups: education and CPD, practice hygiene, handling of medical devices, patients’ complaints, malpractice as long as they are not part of the general quality management of a practice. I would also suggest working on measures relating to quality management in dental practices first since appropriate initiatives and instruments are going to be developed and implemented by several member associations (Austria, Belgium, Germany, Lithuania, the Netherlands and United Kingdom and others). The desire to have this field further elaborated by the ERO has also been the result of the survey submitted to member countries and carried out by the working group chaired by Gerhard Seeberger. In addition, it was also addressed in the survey carried out by the working group chaired by Roland L’Herron. As far as the exchange of best practices is concerned, the fields of quality indicators, error management/CIRS or the clinical guidelines might also be taken into consideration. With regard to these fields there is even less information available.

How could an ERO working group analyse these quality measures?

On gathering best practices, in my view and according to the past experience, we should however do without drawing up a general and comprehensive questionnaire sent to all member associations with just a few responses resulting in little relevant and reliable information. In contrast, it seems to be more promising to specifically address those member associations that have implemented already developed measures in order to be able to describe them in a well-structured way and in detail and to document them. This information platform could then be provided for other associations to start discussion.

The lesson is clear: **Proposal for topics and questions to be worked on by an ERO working group**

Based on the above I believe it would be reasonable to have an ERO working group with experts chosen from some member associations who will initiate an exchange of best practices in the field of quality management in dental practices. These programmes could then be presented to the plenary session and discussed. They could be an impulse for a member association to introduce its own models.

Barbara Bergmann-Krauss, 14 January 2014

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