

## 10 EASY Steps to ensure you pass a DRO Inspection

Just when you've mastered your relationship with your PCT, along comes another surprise!

**The DRO wants to visit you.....in a few weeks' time.**

**What do they want, why do they want it .....and what do you have to do?**

Well, they want to ensure you are performing according to their and other regulators' requirements!

**What do you mean – manage my performance?**

In that remarkable period BEFORE nGDS and nPDS, you would have raised your eyebrows if someone mentioned "Performance Monitoring" or "Performance Management". Perhaps a few of your colleagues were using these terms as they tried to manage their own businesses. For most of you however, they are new concepts.

And, to accompany their new titles, the DRO and the BSA are changing dramatically - they have now become the agents of the PCTs by providing data and making checks on general practices and practitioners.

**Why do the PCT's want to manage our performance?**

Simply stated – they have commissioned your services to their patients – so they are entitled, according to the contract you signed, to check both the **Quantity** of work you are doing (UDA achievement and other services offered) and the **Quality** of that work (DRO inspection).

From a quality perspective, the PCTs are most interested in **3** key performance areas:

**Qualitative - includes core areas:**

- environmental checks (practice inspection)
- clinical record checks
- patient information leaflets
- patient involvement and changes introduced after patient surveys (quality questionnaires)
- lessons learned from patient complaints handling.

**Processes and protocols – includes checking:**

- the clinical governance and quality assurance systems that are in place in the practice
- the use of evidence based and best-practice treatment methodologies, determined through the continuous use of clinical audit and CPD.
- the provider accepts responsibility to ensure compliance with guidelines on the employment of DCPs and performers.

**Staff & resources – includes checking:**

- the day to day working procedures of the practice including:
  - the way you manager your practice
  - how often and how you run your team meetings
  - the development plans you have in place for all your staff as both individuals and members of the team
  - the way you train your staff, in line with their development plans
  - the frequency and quality of your staff appraisal process

**The BSA** also has a duty to provide monthly data to the PCTs as already mentioned, covering:

- details of the contractor's contract value
- the amount of PCR recovered
- the net superannuable pay for each performer
- the number of UDAs completed
- the number and status of PCR-exempt patients treated.

**The PCTs** have a policy of ongoing "risk management" and can demand detailed information of each practice from the BSA including:

- a patient record audit (carried out by the DRO)
- a comparison of treatment patterns
- checks on patient identity and treatment history
- checks on the accuracy of PCR
- a projection of annual UDA activity and any projected shortfall.

**The PCTs will raise any concerns with you, the provider at its regular review meeting or earlier if necessary.**

So, now you know the "what" and the "why" of your "obligations" to satisfy the PCT's insatiable appetite for information - which you agreed to as part of signing your contract!

What can you do to make the whole process as painless as possible?

**Firstly**, it's important to recognise that these demands are not "bureaucratic" and unnecessary. They are entirely consistent with best-practice, as set out by the GDC and BDA and, as such represent what all well-run practices should be doing. If you are able to accept the sense of that, you are well on the way to having the right mind-set.

**Secondly**, if you were unfortunate enough to be unable to satisfy the Inspector within the required period after the inspection, your PCT would have the ability to re-negotiate your contract at the end of the financial year - so your livelihood could be at risk.

**Thirdly**, your professional standing with the GDC might be prejudiced, further damaging your ability to practice.

**So, you must conclude that** conducting your practice to the highest possible standards is great for you, your staff and your patients. And we are not suggesting that you aren't - we're just reinforcing the logic of the process.

**You must be aware of what is happening and be fully prepared**

Let's look in depth at one aspect of the new inspection process and give you **10 easy steps to ensure you pass this phase** – and if you perform this stage effectively, you can be reasonably assured of dealing very successfully with the remainder.

**And we know our advice works:**

**"Help from [thedentistrybusiness](#) was invaluable in passing our recent practice inspection. Their attention to detail made a potentially harassing situation pass without stress and produced very flattering comments from the examining team. We recommend them wholeheartedly." DON & ANN BIDWELL, Macclesfield**

## **The Clinical Record Audit is at the heart of your practice and of every inspection process**

At the heart of the audit are your Patient's notes - what should they contain?

It may seem somewhat demeaning to spell this out - we know how experienced you are. **We also know that the reason you requested this report was to ensure you got it right;** so read through these notes carefully and then carry out a check against half a dozen randomly chosen record cards and note your performance.

1) **Patient's personal details.**

When did you last check their address and telephone number? Have you also requested their email address and mobile phone number, so you can improve your communication with your patients at much lower cost to you than "snail mail"?

2) **Medical history.**

Is it updated at the start of every new course of treatment? Remember that this process of communicating with the patient before you start your examination or restoration process can also generate new business opportunities

3) **Dental history.**

If you are still using cards, when was the last time that you did a full charting?

4) **Clinical examination.**

Have you noted a full extra-oral & intra-oral examination of both hard & soft tissues including TMJ function? Have you been carrying out routine periodontal checks and recording a BPE score? Have you discussed the results with your patient and agreed alternative therapies to improve these conditions?

5) **X-ray examination.**

Have you given a reason for taking X-rays and recorded your findings? Have you audited the radiographs with regard to their diagnostic quality? Have you started to use plastic wallets for storage or are you still using paper envelopes? Are you signing each radiograph, adding date and time?

6) **Diagnosis and Treatment Plan.**

Have you recorded your diagnosis and the rationale for your treatment plan? Have you looked at the treatment plan options with regard to appropriateness, clinical effectiveness and cost effectiveness?

7) **Consent.**

Have you discussed all the options for treatment with the patient? Have you discussed the costs, the pros and cons and given the patient sufficient information to make an informed choice? Have you given the patient a written treatment plan and estimate of cost?

8) **Identification of the operator.**

Have you signed or initialled the notes?

9) **Further information.**

Have you provided the patient with information with regard to any after-care and post-operative instructions?

10) **Recall.**

Have you assessed the patient in line with NICE guidelines as to the most suitable recall interval?

Those are the 10 steps to a successful process for maintaining clinical records. We know that compliance with these 10 steps will contribute substantially to a favourable inspection.

If you cannot answer “**YES**” to all the above questions, then you may not be fulfilling your obligations under the NHS contract **NHS CONTRACT**. In addition, and potentially more damaging, you are likely to be **FALLING SHORT OF GDC GUIDELINES**.

Please make sure that neither of these problems befalls you – your colleagues who are our clients have benefited greatly from our support:

**“We were greatly aided by your notes and guidance and were very happy with the successful outcome of our inspection visit” – Dr. Ian Tyldesley and Dawn Brown (Practice Manager), Holmes Chapel**

Depending on your specific situation, you may be able to comply with just a small tweak of your procedures. Others among you may need to make more significant changes to your working methods – so the sooner you take on this need, the better for you and ultimately for your patients. We are acutely aware that full compliance with these requirements may have financial implications for your business; but failing to comply will have even more severe consequences, so we all know the right action to take.

Contact me as soon as possible to discuss how we can help you get over this particular hurdle, and make your future business much better controlled and more marketable.

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**Note:** Carl qualified at the Welsh National School of Medicine in July 1969 and since early 1974 has been a GDP based in Macclesfield, Cheshire. He was elected to Cheshire LDC in 1976 and served for over 25 years. Between 1988 and 2003 he served as the elected representative for Cheshire and Wirral on the GDSC. From 1992 to 2003 he was involved with postgraduate education in the Mersey Deanery holding the posts of Regional Adviser in VT and Associate Postgraduate Dental Dean. He has recently project managed a PDS field site of over 20 practices. After 28 years in the NHS he converted to private practice in 1998 and now spends his time between working in practice and as a dental business consultant for The Dentistry Business.