ALL WALES SPECIAL INTEREST GROUP - SPECIAL ORAL HEALTH CARE

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Guidelines

for the delivery of a

Domiciliary Oral Health Care Service

This document is offered as the basis for developing guidelines in the provision of domiciliary oral health care as a part of a special care dental service. Its purpose is to state clearly the aims and objectives of a putative domiciliary oral health care service, to define the criteria by which clients referred to such a service may be assessed, and to formulise as guidelines, the procedures which might be undertaken by such a service.

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1. INTRODUCTION

➢ WHY OFFER A DOMICILIARY SERVICE?

Levels of significant morbidity in the population are increasing as greater numbers of people are living into old age and/or surviving life-limiting disease. Furthermore, many old and infirm people retain their teeth for much longer and therefore the range and complexity of oral/dental problems is greater than it has been in previous years. Many people may also have mobility or other problems which severely limit their ability to present themselves at a dental surgery. The Disability Discrimination Act (DDA, 1995) places a duty on public service providers to make provision for access to services for people with disabilities and makes it an offence not to comply (1).

Domiciliary oral health care may be provided by the General Dental Service (GDS), Community Dental Service (CDS) or Hospital Dental Service (HDS). There may be difficulty, however, in arranging domiciliary dental provision from the GDS, either because Practitioners do not wish to provide the service, or due to lack of GDS availability, or because clinical treatment need indicates a requirement for specialised portable equipment which a General Dental Practitioner (GDP) may not possess. Alternatively, a person may have been referred in from a GDP specifically for CDS treatment.

There is also increasing concern that the

The role of the CDS as defined in WHC (89) 28 (2) provides justification for offering a domiciliary based service to people, who, by virtue of their circumstances, are housebound, or for whom it would otherwise be unreasonable or impractical to expect them to attend at a clinic for treatment.

➢ DEFINITION OF DOMICILIARY ORAL HEALTH CARE

The term 'domiciliary' is intended to include dental care which is carried out in an environment where a patient is resident either permanently or temporarily, as opposed to that care which is delivered in dental clinics or dental mobiles. It will normally include residential and nursing homes, long-stay hospitals and the patient's own home.

2. AIM

The aim of a domiciliary oral health care service should be to deliver appropriate oral health care in accordance with the requirements of the DDA (1995) and the General Dental Council (GDC), to patients whose circumstances make it impossible, unreasonable, or otherwise impracticable for them to receive that care in a fixed clinic, a hospital site or from a mobile dental clinic.

3. OBJECTIVES

- To establish a system which will identify individuals in the community who have an oral health care need and for whom domiciliary provision is the only reasonable option.

- To provide an oral health care service to address patients needs, taking into account their personal circumstances and their wishes, consistent with the most appropriate use of resources.

4. RATIONALE FOR ACCEPTING CLIENTS REFERRED FOR DOMICILIARY ORAL HEALTH CARE

Surgery based care must be considered the best option for irreversible procedures, but where this is not reasonable or possible, patients should not be unduly disadvantaged by having to receive domiciliary oral health care.

Provision of dental care as a domiciliary procedure is an expensive aspect of service provision. In addition to time spent seeing the patient, there is often considerable time spent in travelling to and from the clinic base, and in preparing (and clearing up afterwards), a suitable working area in the patients home environment. Furthermore, there is also motor mileage cost to consider - which in rural areas, owing to sometimes large distances involved, can be significant.

In any consideration of the costs of providing domiciliary care versus surgery based care, it is necessary to bear in mind that there are 'hidden' costs in bringing patients to the surgery and these may include the cost of providing an escort and specialist or ambulance transport, which, whilst they do not necessarily impact on the CDS budget, represent nonetheless, a cost to the public purse.

It is important, therefore, that domiciliary dental care provision is properly targeted to meet the needs of only those patients for whom no reasonable or practical alternative exists.

To this end it may be necessary to reinforce the guidelines for the acceptance of patients for this costly aspect of service provision. It may also be useful locally to explore ways of demonstrating that referrals are screened for appropriateness, or otherwise audited, and that people referring into the system are periodically reminded of the acceptance criteria.

Risk assessment is an important aspect of assessing the appropriateness of domiciliary care, as is a consideration of the limits of the care that will be offered. Local criteria should be considered for when domiciliary care may no longer be appropriate, discontinued or otherwise limited.

5. REFERRALS

➢ URGENT REFERRALS

There may be a case for agreeing some objective criteria for inclusion on a referral form which would allow for an appraisal to be made by a clinician at the stage of allocating priority for follow-up (Appendix I). Eligibility will need to be assessed (Appendix II).

➢ ACKNOWLEDGEMENT OF RECEIPT OF REFERRAL

The referrer should be given an acknowledgement that the request has been received and will be attended to. If possible, some indication of the likely time this will take should be offered.

- **Referrals Accepted for Initial Assessment**

  The receipt of the referral should be acknowledged.

  If the initial assessment indicates that a domiciliary visit is needed, the patient should be placed on the local waiting list for dental examination. Ideally, the dentist should be able to give the patient some indication of how long they will need to wait for a first visit.

If the patient could be reasonably expected to travel to a dentist, then by definition, they would not require domiciliary care (Appendix ll). A separate judgement would then be made as to whether they would qualify for CDS care by virtue of a special dental need.

For patients who qualify for CDS care but not domiciliary care, the patient's name should be placed on the local waiting list for examination at the clinic, and the patient should be given some indication of how long they are likely to have to wait.

Occasionally, patients who do not qualify either for domiciliary or CDS care may be referred. In these cases, it will be necessary to ensure that the referrer is made aware that the request is not appropriate and has not been accepted. Responsibility for arranging dental care will still lie with the referrer, who should be given guidance on the most appropriate route locally.

6. PREPARATION BEFORE INITIAL VISIT

➢ CONTACTING CLIENT

Telephone or write to patient / carer to negotiate mutually convenient date and venue. Where necessary ask for maps or directions.

Send written confirmation prior to visit and give clear instructions on how you can be contacted if last minute changes are required.

Clarify issues relating to:
- Attendance of carer / relative
- List of medications
- Special requirements / translator

Consider:
- Risk assessment (Appendix lll)
- Staff protection
- Chaperoning
- Employer's liability
- Personal protection
- Manual handling

7. PROCEDURES

➢ THE INITIAL VISIT

- It is useful to telephone the patient early in the day to confirm the timetable.

- Be punctual. If a delay in excess of 1 hour is anticipated, then a telephone call to apologise / explain / reassure will usually be appreciated. (NB Carers may have made special arrangements to be available for a particular time).

- Every member of the team should carry official identification, and all staff should be introduced on arrival by name and status. It is important to establish at the outset the relationship of any carer/s to the patient. The clinician must be chaperoned at every visit by another member of the team.

- Confirm the personal details. If the patient is hesitant, consult with the carer regarding their capacity to give a reliable history / valid consent.

- The reason for, and source of the internal referral should be checked.

- Because an update on Past Medical History / Past Dental History is often necessary, it is important to establish that confidentiality is not being compromised by the presence of a person such as a home help or support worker.

- Cross-infection control procedures, including the establishment of a clean work area should be maintained as far as is reasonably practicable and in accordance with professional and local trust guidance.

- All clinical waste including sharps must be disposed of according to local rules.

- After examination, the provisional treatment plan should be discussed with the patient or carer as appropriate. At this stage, the need for further investigations, liability for any charges, and the anticipated treatment timetable should be discussed and a record made in the patient's notes.

- Acute conditions including pain may need intervention at this first visit, subject to consent or procedure in lieu of consent.

- At the end of the visit the next action should be agreed with the patient / carer.

N.B. **Para 4.7 of Maintaining Standards states: "A medical emergency could occur at any time in premises where dental treatment takes place. It is, therefore, imperative that a dentist ensures that all members of the dental team are properly trained, have available the necessary resources, and are prepared to deal with an emergency including a collapsed patient. Training should include preparing for medical emergencies, including the use of emergency drugs, and practice of resuscitation routines in a simulated emergency.**

It is essential that all premises where dental treatment takes place have available and in working order: portable suction apparatus to clear the oro-pharynx, oral airways to maintain the natural airway, equipment with appropriate attachments to provide intermittent positive pressure ventilation of the lungs, and a portable source of oxygen together with emergency drugs" (GDC) (3).

SUBSEQUENT VISITS

➢ Consider:-

- What treatments are appropriate in a domiciliary situation?
- Medical / clinical emergencies
- Local Health Boards, Primary Care Trusts and others are aware of risk assessment.

8. CONFIDENTIALITY AND CONSENT

➢ CONFIDENTIALITY

All patients have the right to expect that information they give to health workers will be treated in confidence and used only in the context of their health care provision. Care must be taken that where other people are present, eg relatives or significant others, no breach of patient confidentiality is allowed to occur either in the collection or imparting of information unless the patient has given for disclosure.

➢ CONSENT

The law in relation to consent clearly places the duty to ensure that a valid consent is obtained, on the practitioner who proposes to carry out treatment. This is no less the case with domiciliary dental care provision.

- **Clients unable to give Consent**

  The procedure for proceeding without consent for clients unable to give consent by virtue of mental incapacity should be followed; this must be documented by the clinician in charge at the start of a proposed course of treatment. This procedure is outlined in detail in relevant guidance from the Welsh Assembly Government issued in 2003 (4) and summarised in 'Principles on Intervention for People unable to comply with routine dental care' (5).

- **Disputed or Unusual Treatment Plans**

  In cases where there is any disagreement over proposed treatments, the principle of wide consultation should be adopted. While proposed treatments are disputed, or could be considered unusual, or would for special reasons fall outside that which may be considered to be within the recognised body of professional opinion, further advice must be sought from senior colleagues before proceeding except where over-riding necessity indicates otherwise.

9. CROSS-INFECTION CONTROL

The procedures detailed in local CDS policies for control of cross-infection will apply to domiciliary procedures in the same way as for clinic based procedures.

10. CLINICAL WASTE

Procedures for disposal of clinical waste are defined in local Trust policies and will apply with equal force domiciliary oral health care procedures.

11. TRAINING

Training in the understanding, planning and delivery of all aspects of domiciliary services should be provided to all members of the dental team who are likely to be involved. This should be planned and organised according to local requirements and based on relevant professional guidance. Understanding of, and proficiency in risk management needs to be an integral part of any such training.

13. DOMICILIARY EQUIPMENT

➢ GENERAL

- Portable light
- Portable suction
- Cross-infection control disposable items:
  - Gloves
  - Masks
  - Sharps disposal
  - Disinfection materials
  - Waste bags
  - Paper towels
- Resuscitation equipment including oxygen and appropriate emergency drugs
- Mobile phone

➢ ADMINISTRATIVE

- Identification badge
- Diary
- Record cards
- Referral forms
- Laboratory forms
- Post-op instruction leaflets
- Health promotion literature
- Prescription pad
- British National Formulary
- List of contact phone numbers

➢ PROSTHETICS KIT

- Impression materials
- Impression trays
- Tissue conditioners
- Safe air heater
- Portable motor, hand-pieces and burs
- Waxes
- Bite registration material
- Wax knife
- Bite gauge
- Paint scraper
- Shade guide
- Articulation paper
- Plastic bags
- Impression disinfection
- Denture pots
- Denture marking kit
- Gauze
- Cotton wool rolls
- Vaseline

➢ **CONSERVATION KIT**

- Portable unit (motor & suction)
- Hand-pieces and burs
- Operating light
- Syringes, needles
- Mirrors
- Conservation tray instruments

➢ **MATERIALS**

- Temporary dressing materials
- Filling materials
- Gauze
- Cotton wool rolls and pellets
- Vaseline
- Alvogyl
- Local anaesthetic cartridges
- Topical anaesthetic cream / spray
- Suture materials
- Haemostatic materials

➢ **PERIODONTAL KIT**

- Hand scalers
- Portable ultrasonic scaler

➢ **SURGICAL KIT**

- Forceps
- Elevators
- Minor Oral Surgery instruments
- Haemostatic agents

This list is described as an aide memoir, and is not prescriptive. Other items may be included according to individual preference.

References

1. Disability Discrimination Acct (1995).
2. WHC (89) 28.
3. 'Maintaining Standards'. General Dental Council (1999).
4. Good Practice in Consent Implementation guide: Consent to examination or treatment. Welsh Assembly Government (April 2002).
5. British Society for Disability and Oral Health. Principles on Intervention for People unable to comply with routine dental care. (2004) www.bsdh.org.uk

Appendix 1: Model Referral for Domiciliary Oral Health Care (DOHC)

Appendix 2: Assessment of Eligibility Criteria for DOHC

Appendix 3: Guidance for Environmental Risk Assessment for DOHC

Appendix 1 **Model Referral for Domiciliary Oral Health Care**

Name: _____	**Next of kin Relationship**: _____
Address: _____	**Name**: _____
_____	**Address**: _____
DOB: _____ **Hosp No**: _____	_____
Tel: _____	**Tel**: _____

GMP: Dr _____	**Contact**: Social/Key Worker/Community Nurse (please specify)
Address: _____	**Name**: _____
_____	**Address**: _____
Tel: _____	_____ **Tel**: _____

Medical / Social History: _____

_____

_____

_____

_____

_____

Dental Complaint: Pain: Yes ☐ Urgent: ☐ Non-urgent: ☐

Dental status: Edentulous: ☐ Dentate: ☐ Dentures worn: ☐

_____

_____

Sensory impairment:	**Mobility**:	**Services**:
Hearing ☐	Walks unaided ☐	Community Nurse ☐
Vision ☐	Needs assistance ☐	Meals on wheels ☐
Communication ☐	Wheelchair user ☐	Home Care ☐
	Bedfast ☐	Day Centre /Hosp ☐
	Own transport ☐	Mon / Tues / Wed / Thurs / Frid

Action requested: _____

_____

Domiciliary assessment please: ☐ **Please arrange continuing dental care**: ☐

Signature: _____ **Status**: _____ **Date**: _____

Appendix 2 Assessment of Eligibility Criteria for Domiciliary Oral Health Care

Has patient / carer contacted a local dentist?

Yes ☐ No ☐ Don't know ☐

Does the patient attend her/his Doctor?

Yes ☐ No ☐ Don't know ☐

If the patient has a hospital appointment, how does he/she get there?

Ambulance ☐ Taxi ☐ Car ☐ Other ☐

When was the last time the patient was able to leave the house?

Does the patient have someone to bring them to the surgery?

Yes ☐ No ☐ Don't know ☐

Does the patient use a taxi for other activities?

Yes ☐ No ☐ Don't know ☐

Does the patient attend a hairdresser / chiropodist?

Yes ☐ No ☐ Don't know ☐

Mobility:

Walks unaided ☐ Needs assistance ☐ Wheelchair user ☐ Housebound ☐

Additional Comments:

Appendix 3 Guidance notes for an Environmental Risk Assessment for DHOC

Definition of Hazard: A physical situation with the potential to harm life or limb

Personal and location details	**Example of information required**
Name of Assessor Discipline	Name of person completing assessment Job title / Position held
Patients Name & ID number	As in patient's record
Address	Address of premises being assessed
Telephone	Telephone number of location being assessed
GMP Contact Number	Name and telephone number of patient's GMP
Number of persons living in premise	Number of individuals living at the address

Examples of Hazards

External access	Difficulty in reaching premises due to location eg access gained via back streets or alleyways items stored on entrance steps or corridors steep stairs, poorly laid paths lift frequently out of action
External lighting	Unsafe parking due to lack of / or inadequate street lighting Dimly lit stair wells
Internal access	Steep steps, items stored in corridors
Internal lighting	Poorly lit households, Insufficient light to carry out procedure
Pets	Pets within treatment area (cats, dogs, birds etc)
Obvious fire hazards	Smokers at the location Children with access to cigarettes, lighters, matches Use of chip pans, electric blankets, portable gas heaters Broken flexes, faulty plugs and sockets Storage of Oxygen cylinders Lack of smoke detectors
Slips, trips and falls	Any items that have a potential to cause slips, trips or falls Eg Ill fitting carpets and floor coverings Slippery kitchen / bathroom floors Flooring stained with bodily matter (environmental hazard) Broken furniture Lack of space due to furniture / other clutter
Furniture	Low seating causing manual handling problems
Space availability	Sufficient space to enable treatment of the patient in an appropriate manner with privacy and dignity eg exclude smokers from treatment area and any other person not required for support with agreement of patient
Manual Handling Assessment	Complete according to Trust policy / local rules
Additional Comments and Actions Required	Identify control measures to deal with identified hazards. Any other information to be noted eg experience of personal aggression or suspicion of abuse
Assessment Outcome ➔ Green flag ➔ Amber flag ➔ Red flag	An overall measure of assessment as categorized by assessor ➔ Assessment did not highlight any significant problems ➔ Assessment includes additional comments which must be rea by any individual visiting premises or patient ➔ Anyone visiting premises must contact assessor or case manager to discuss hazards
Signature / Date	Risk assessment must be signed and dated on completion

The Assessment Outcome may change. The Risk Assessment should be amended and updated when there is a significant change in the treatment to be provided or in the assessed environment.