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UNLOCKING BARRIERS TO CARE

British Society for Disability and Oral Health

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Guidelines for the Delivery of a Domiciliary Oral Healthcare Service

Revised by a working group on behalf of BSDH
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Introduction

The final report of the NHS Next Stage Review 'High Quality Care for All' [1] sets out the strategic direction for driving improvements in the quality of care across the health service. High quality oral healthcare should be available to all people regardless of their age or circumstances. People with long term and/or progressive medical conditions; mental illness or dementia, causing disorientation and confusion in unfamiliar environments; and increasing frailty are not always able to travel to a dental surgery. For some people, access to oral healthcare services is achievable only through the provision of domiciliary oral healthcare.[2]

The Purpose of This Document

The purpose of this document is threefold:

A. To alert PCTs and service providers to the need for maintaining and increasing the availability of Domiciliary Oral Healthcare Services (DOHCS)
B. To provide guidance for the commissioning of high quality DOHCS
C. To provide guidance to establish standards for the delivery of high quality DOHCS

This document draws on, and should be read alongside, the following documents:

- The Department of Health and British Association for the Study of Community Dentistry document '*Delivering better oral health: An evidence-based toolkit for prevention*' [3]
- The Department of Health document *'Valuing People's Oral Health: A good practice guide for improving the oral health of disabled children and adults* [4]
- The Department of Health commissioned *'Strategic Review: Meeting the Challenges of Oral Health for Older People'* [2], and
- The Department of Health world class commissioning document '*Primary care and Community Services: Improving dental access, quality and oral health*' [5].
- The Department of Health commissioned document '*Commissioning tool for Special Care Dentistry'* [6].

Definition of Domiciliary Oral Healthcare

Domiciliary oral healthcare can be described as a service that reaches out to care for those who cannot reach a service themselves. Domiciliary care is intended to include oral health care and dental treatment 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 mobile units. It will normally include residential units and nursing homes, hospitals, day centres and patients' own homes. Whilst domiciliary care includes preventive oral health care, it excludes dental screening procedures.

A. The Need for Domiciliary Care

1. Aim of Domiciliary Oral Healthcare

The aim is to deliver appropriate oral healthcare (in accordance with the requirements of the Disability Discrimination Act (DDA), 1995 [7], the General Dental Council (GDC) 1999 [8], the Mental Capacity Act, 2005 [9] and the NHS Constitution[10], 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 [11]. Domiciliary care may be provided via the general dental service (GDS), salaried primary dental care service (SPDCS) or hospital dental service (HDS).

The DDA (1995) [7] states that service providers must be fair and flexible in taking action to remove any barriers that exclude disabled people. The Act requires that, where a person is unable to access a service because of disability, the service provider makes it available via reasonable alternative means. In the case of a person being unable to access dental services provided in a conventional dental surgery setting, a reasonable alternative means of access to dental care would be for the dental practitioner to provide domiciliary care. However, it must be cautioned that domiciliary dental care provision is not a panacea and the GDC (1999) recommends that dental treatment provided on a domiciliary basis should be appropriate within that setting, taking into account the nature of the dental problem, the facilities available and the welfare of the patient [8]. Surgery-based care remains the best option for irreversible treatment procedures, but where this is not reasonable or possible patients should not be unduly disadvantaged by having to receive domiciliary oral healthcare. Ideally, they should have equitable oral health outcomes in terms of self esteem, appearance,

social interaction, function and comfort. This requires careful assessment and treatment planning which takes account of all associated factors, including the skills required to manage delivery of care in a sometimes compromised situation [6]. The ability of carers to facilitate delivery of the preventive aspect of the oral healthcare plan must also be taken account of.

2. The Need

As more people retain their natural teeth into old age, this presents challenges to the dental profession in providing care to medically compromised, multiply disabled and older people who may require a wide range of interventions in a heavily restored dentition, at a time in their lives when they are less able to cope with treatment. It is projected that the number of people with NO natural teeth will decline from 40-45 % of people over 65 years in 2005 to only 20% (1 in 5 people) in 2025. It is also expected that 40-50% of over 65 year olds will be dentate with 21 or more natural teeth (a functional dentition) by 2025 [2]. Additionally, as dentate older people become disabled they are more likely to use dental services more regularly than edentate older people. Therefore, the demand for care will increase for DOHC, as will the requirement for the skills and equipment to provide a more comprehensive service than the provision of dentures.

Functionally dependent older adults are often best served by bringing dental services to them[12]. People over the age of 90 have shown a preference for home visits, as it enables them to use their limited energy in receiving care rather than travelling for care[13]. Younger people with disabilities and/or additional needs may also be confined to home and, if so, will also require domiciliary oral healthcare.

There is evidence that people in residential care (such as those, people with a learning disability or mental health problem , people who are physically or medically compromised older people [14] and people in secure units [15] are more likely to have poor oral health and inadequate or restricted access to dental services [14]. Whilst people confined to home perceive a high dental care need, difficulties in getting to a dentist, paying for dental care, and poor oral health have been cited as barriers to obtaining dental care by American researchers [16,17].

A recent study demonstrated that a domiciliary denture service improved oral health related quality of life of older people confined to home [18]. Despite the increase in older people keeping more teeth for longer, currently investment in DOHCS would help to meet the oral healthcare needs of around 50% of all people aged 85 years and over until 2018 [2].

The document '*Meeting the Challenges of Oral Health for Older People: A Strategic Review*' concluded that there is a need for Primary Care Trusts to invest in domiciliary denture care services [2].

3. Availability

Domiciliary care should not be considered as the last resort. It should be offered amongst the routine options for dental care for people who are mostly confined to home or for whom leaving or travelling from home can cause unwarranted upheaval and distress. However, access to, and availability of dental domiciliary services for disabled older people is relatively low.

Analysis of health service records reveals that less than 40% of dentists in general dental practice provide home visits and this figure is falling [19]. Some of these dentists restrict their domiciliary practice to prosthodontics, and a proportion of these restrict it further to complete dentures only. A study of availability of domiciliary dentistry indicated that only 21% of dentists who were willing to do domiciliary work would undertake restorative treatment [19]. The salaried primary care dental service (SPCDS) acts as a safety-net for people who are unable to obtain care within the general dental services. Even so, only a minority of community dentists provide domiciliary care.

B. Commissioning Domiciliary Oral Healthcare Services

Domiciliary services are necessary to provide professional advice and treatment to residents of nursing and care homes as well as to the increasing numbers of frail people living at home or in sheltered housing [20]. PCTs will need to commission comprehensive and appropriate oral healthcare services for older people that include domiciliary services and specialist care, as identified by their local needs assessment[2].

1. Commissioning

Commissioning domiciliary oral healthcare services should be set in the context and current agenda of equality, diversity and human rights in both health and social care and reducing healthcare inequalities through personalisation, consultation and partnership working. Thus, it is fitting that '*Our Vision for Primary and Community Care*' [21] draws together the main conclusions of '*The Next Stage Review*' for community-based NHS services, including primary dental care and sets out an agenda based on the following four key areas:

- Shaping services around people's needs and views
- Promoting healthy lives and tackling health inequalities
- Continuing improving quality
- Ensuring change is led locally

From April 2006, Government conferred a statutory responsibility on Primary Care Trusts (PCTs) for commissioning services, devolved commissioning budgets and introduced a system of local contracts with dental providers [5]. Out of these reforms grew commissioning for '*additional and specialist services* [5]', including domiciliary services.

The 2009 -10 Operating Framework[22] clarifies the priority for PCTs to develop NHS dental services to meet the local needs for access, quality of care and oral health in order to provide services to anyone who seeks help in accessing them. The key elements for a successful dental commissioning strategy that will enable this to be delivered include:

- Assessing local needs
- Mapping current services
- Developing a strategic commissioning plan
- Delivering improvements through:
  - transparent use of performance information
  - supporting quality improvement
  - information for patients and public
  - assuring minimum standards
  - promoting patient choice
  - developing the market, and

— commissioning new and or additional capacity

- Improving premises and estates, including domiciliary equipment
- Top-level (eg Board) ownership, and
- A systematic approach to monitoring for performances. [5]

2. World class commissioning [5]

Effective commissioning, which is essential to improving the quality of primary care services, has led to the development of the World class commissioning (WCC) programme. WCC requires all PCTs to developing their five year strategic plan, which sets out the PCT vision, its priorities and how these will be delivered. It includes the high level '*patient offer*', which sets out what the PCT is accountable for delivering to its local community.

Strategic plans will explain:

- What services will be provided
- Where they will be available, and
- Who will provide them.

PCTs are also required to prepare an annual operating plan, setting out how it will implement its strategy in the coming year. Both the strategic and operating plans should address how the PCT will improve its primary care services and, where there is a need, this should include domiciliary oral healthcare services.

The annual cycle of this WCC assurance process holds PCTs to account. At the same time, PCTs need to be able to provide clear assurance that the services being accessed provide safe and effective care and good patient experience, in line with the objectives of *High Quality Care for All*.[1] The distinctive features of commissioning primary dental care are set out in '*Primary care and Community Services: Improving dental access, quality and oral health '[5].*

3. Mapping the baseline

In order to make improvements to primary care services, including domiciliary oral healthcare, a baseline needs to be established. There are three key stages to mapping the baseline:

1. Assessing needs
2. Mapping existing services, and
3. Identifying what needs to change.

These key areas allow for identification of:

1. Service gaps
2. Potential for redesigning services, and
3. Level of resources required.

Stage 1 Assessing local needs – this is usually done through a Joint strategic Needs Assessment (JSNA) which entails having a clear understanding of the diversity of the local population (including associated patterns of oral health and service demand); specific communities with unmet or comparatively greater health needs (such as older people in residential care or confined to home); and how these needs compare with similar populations elsewhere, through benchmarking [5]. Obtaining patient feedback and assessing levels of patient satisfaction are essential to the commissioning process.

Assessing oral health needs and assessing demand for dental services are also essential elements of the process. '*Valuing People's Oral Health – best practice guidance for improving oral health in disabled children and adults'* [4] contains useful information on needs assessment. Assessing demand for dental services is not straightforward. The current access indicator, of the number of people using services within a two year period, is not an accurate proxy for levels of unmet need or demand. It is suggested that the simplest way of gauging unmet demand is to set up a well-publicised dental access helpline for both people seeking urgent care and those seeking a regular NHS dentist, monitor the nature of the requested needs and the ability to offer services to meet them [5].

It is recognised that this approach needs to be sensitive to the needs of easily overlooked groups, such as older people who may need domiciliary care and people

with disabilities [5]. Effective marketing and community engagement are required to promote awareness of how to access services amongst these groups and their families and carers. For example for older people confined to the home, this may include targeting local social services home-meals and shopping services, and facilities such as day centres and care homes.

Stage 2 Mapping exiting services – this refers to gaining a clear understanding of how services are currently provided, their quality, and any gaps that need to be addressed. To achieve this, it requires drawing a number of strands of data together, including:

- Capacity, range and type of current services
- Effectiveness and safety
- Patient experience, and
- Access and choice [5]

The last point should include an estimate of the number of people unlikely to be able to leave home to attend a dental practice and the current commissioned domiciliary oral healthcare service capacity.

Stage 3 Identifying what needs to change – a comparison of the needs assessment with existing service provision will highlight what needs to change. This will differ for every PCT, however common themes will include:

- Levelling access and improving choice for the segments of the population who cannot access or have difficulty accessing services
- Addressing areas of poor health
- Developing specialist services, and
- A stronger focus on commissioning preventive services [5]

Dental services for people who require domiciliary care and for people with disabilities will need to be considered in each of the above parameters. In order to identify required service need accurately, an assessment of complexity of treatment is essential so that the appropriate workforce can be commissioned in a co-ordinated way. For example how much of the need can be met by the primary care dental team (including hygienists), how much requires a dentist with a special interest and how much requires specialist input. The DOH publication, National guidelines for the appointment of dentists with a special interest (DwSI) in special care dentistry[23]

provides guidance to PCT's on the appointment of dentists with a special interest in special care dentistry including the competency framework for the scope of treatment that can be undertaken.

Specialist oral healthcare provision for older people with disability, dementia or complex medical conditions falls within the remit of Special Care Dentistry. Quality assurance criteria for a specialist in Special Care Dentistry are set out in '*The Commissioning Tool for special Care Dentistry'* [6]. They are set out alongside those of a generalist dental practitioner and the dentist with a specialist interest in Special Care Dentistry in order to facilitate PCTs ability to identify what level of care is required to meet the identified need in their area.

4. Developing the vision

Commissioners should develop a clear picture for future dental services that is informed by their five year strategic plan [5] . It should include:

- **A clear '*patient offer*'**, explaining what people can expect from NHS dental services and what their responsibilities as patients are
- **A clear *strategic commissioning plan*** to deliver the patient offer, taking account of current unmet need, predicted changes in the pattern of services needed (such as for older people with physical or learning disabilities), the range and type of services, the interface between primary and secondary care, and the capital and revenue elements associated with improving the infrastructure, including physical access, equipment (including domiciliary equipment) and IT.

All this needs to be done with the backdrop of the NHS 2009 constitution [10] in mind, and in particular that:

- ***The NHS provides a comprehensive service, available to all*** - irrespective of gender, race, disability, age, sexual orientation, religion or belief. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population. And

- **Patients have the right** to expect their local NHS to assess the health requirements of the local community and to commission and put in place the services to meet those needs as considered necessary.

5. Making it happen

'Primary care and Community Services: Improving dental access, quality and oral health' sets out commissioning levers under nine broad headings, which if used intelligently can deliver rapid improvement and the reader is referred to that document for further information on each of them [5]. It also provides a useful list of the relevant regulations from which the legislative framework related to PCTs powers to manage contracts is drawn.

This view of WCC fits well with the four aims of the commissioning strategy set out in *'The Commissioning Tool for Special Care Dentistry'* [6] which are:

1. A patient centred service, which aims to provide and maintain the optimum oral health for the individual or group
2. Integrated front line delivery which is organised around the needs of the vulnerable adult rather than professional boundaries
3. Integrated processes which lead to effective joint working
4. Joint planning and commissioning

Use of these two guidance documents [5, 6] in combination will lead to the provision of a robust strategy and operational plan to meet the needs of people requiring domiciliary oral healthcare services.

C. Establishing Domiciliary Oral Healthcare Standards

In order to deliver the domiciliary dental care operational plan, it is necessary to set out the objectives of the service, how it is accessed and how it is delivered. This section provides guidance that covers these domains.

1. Objectives of Domiciliary Oral Healthcare Service

The objectives of a domiciliary oral healthcare service are primarily to:

- Establish a system which will identify individuals in the community who have an oral healthcare need and for whom domiciliary provision is the only reasonable option.
- Provide an oral healthcare service to address patients' needs, taking into account their personal circumstances and their wishes, consistent with the most appropriate use of resources.
- Deliver high quality oral healthcare in a person- centred way that respects the dignity of the individual receiving it.

2. Access to a Domiciliary Oral Healthcare Service

a. ***Liaison*** with health and social service professionals, carers and the voluntary sector will enable clients who require a domiciliary service to access care. PCTs need to ensure that appropriate referral pathways are put in place so that oral healthcare and/or dental treatment become part of any healthcare plan and any healthcare measures for older people who are confined to home [2]. Older people can be referred to the DOHCS by any member of their multi-disciplinary team (see Appendix 1).

b. ***Routine referrals*** should be made on the appropriate domiciliary referral form, which will facilitate assessment of the individual's suitability for domiciliary care (see Appendix 2). Referrals should include essential information, such as the nature of disability, social/family situation, carer information, communication issues, medical information and the oral problem.

c. ***Urgent referrals*** can be difficult to fit into an already scheduled working day and both eligibility for a visit and the degree of urgency will need to be assessed (see Appendix 3). 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 (see Appendix 2).

d. ***Care homes*** should have access to information on local dental services including advice on referrals and information on domiciliary care [14].

e. ***New patients*** should all have a domiciliary visit risk assessment carried out *(*see Appendix 4) and the decision on whether to carry out dental treatment through a DOHC service reached following a risk-benefit analysis. 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 patient's home environment. Furthermore, there are also travel costs to consider, which can be significant in rural areas owing to the sometimes long distances involved. 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 SPCDS budget, nonetheless, represent a cost to the public purse. Appendix 5 provides an example of good practice from Oldham PCT CDS, to help with decision-making regarding the appropriate provision of DOHC.

3. Referrals Accepted for Initial Assessment

The receipt of the referral should be acknowledged, and, where possible, an indication given of the likely time from receipt of referral to assessment. 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 also 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. A separate judgement would then be made as to whether they would qualify for SPCDS by virtue of a special dental or medical need[11]. Appendix 6 sets out a care pathway for domiciliary oral healthcare. For patients who qualify for SPCDS 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 referred for DOHCS do not qualify either for domiciliary or SPCDS care. 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 remains with the referrer, who should be given guidance on the most appropriate route locally.

4. Mix and Match care

Mix and match care is the term used to describe when domiciliary and surgery-based care are mixed and matched according to the need to develop rapport and trust between the patient and the dental team, or according to the complexity of the dental procedures that need to be undertaken. For example, profoundly anxious patients may feel able to attend the surgery once rapport built with the dental team, through a domiciliary visit, has helped to reduce their fear; or a disabled patient taking anticoagulants attends the surgery for extraction of a tooth because of the risk of postoperative bleeding, whilst dentures can be safely constructed on a domiciliary basis.

5. Requirements of the Dental Team

The domiciliary dental team may vary depending on the individual needs of the patient. Initially it will require at least the dentist and the dental nurse. However, at times it may include a dental hygienist or therapist. Where the needs of the individual are predominantly related to oral hygiene needs and prevention of dental disease, the dental team may comprise of a dental hygienist and dental nurse. Whoever is in the team, domiciliary oral healthcare requires the dental team to transfer their professional standards and skills to a non-clinical environment. This requires a specific set of skills, amongst which ***teamwork*** and ***flexibility*** are essential. The acronym '***CAMPING***' can be used as an aide memoire for the other key skills required to deliver an effective DOHC service. CAMPING stands for:

- **C** communication
- **A** assertiveness and anticipation
- **M** manual handling and map reading
- **P** planning and time management
- **I** improvisation
- **N** networking and liaison (see Appendix 1)
- **G** gerodontology - knowledge of and experience in the field, including a knowledge of medical conditions, associated problems and management of medical emergencies

It has been suggested that a great deal of the procedure and process of domiciliary visiting is similar to camping. Time is spent preparing and packing equipment and kit

required. This is then taken to the visit and time is spent unpacking and setting up for the necessary treatment. Afterwards, everything needs to be dismantled ready to pack away again.

The dentist can become a central figure in the social network of a person confined to home, and the established rapport can lead to the individual feeling supported by the healthcare provider which can have a positive impact on the immediate and long-term well being of the patient [24].

6. Preparation Prior to the Initial Visit

Careful preparation prior to the visit will help ensure that all the necessary information is available. Time invested in planning the visit will be paid back through its contribution to the success of the visit.

a. ***For emergency visits,*** telephone ahead to clarify the dental problem and the need for a visit.

b. ***For non-emergency visits*** the following '*Telephone Tick List*' is helpful. The acronym '*CAMPING*' can again be used as an aide memoire:

- **C** check full address and helpful directions
- **A** appointment to be sent in writing if possible
- **M** medical history and consent - note need to liaise with relevant people
- **P** parking facilities
- **I** information about who will be present, eg carer, relative, neighbour
- **N** name of dentist visiting, provided for security
- **G** gain access to any special instructions or requirements, eg need to collect key from neighbour, dog barks but does not bite, etc...

c. ***Contacting the client***

If telephone contact is not possible, write to the patient or carer to negotiate a mutually convenient date and venue. Where necessary ask for maps or directions. Follow up by sending written confirmation prior to the visit which gives clear instructions on how you can be contacted if last minute changes are required.

d. *Health and safety Issues*

An important part of organising a DOHC service is to consider the following health and safety issues:

- Risk assessment (see Appendix 4)
- Staff protection
- Chaperoning
- Employer's liability
- Personal protection
- Manual handling skills.
- Insurance for vehicles and equipment

7. Procedures

a. *The initial visit*

The following procedures help the initial visit to go well:

- Telephone the patient at the beginning of the day to confirm the timetable
- Try to be punctual. If a delay is anticipated, then a telephone call to apologise, explain and reassure will usually be appreciated. Carers may have made special arrangements to be available for a particular time
- Every member of the dental team should carry official identification, and all staff should be introduced on arrival by name and status
- Establish at the outset the relationship of any carer(s) to the patient
- The clinician (dentist, therapist or hygienist) must be chaperoned at every visit by another member of the team in the interests of personal and patient safety
- Confirm the patient's personal details
- Consult with the carer regarding the patient's capacity to give a reliable history and valid consent; and check who, if anyone, is the patient's Court Appointed Deputy
- Check the reason for, and source of the internal referral as an update on past medical history /past dental history is often necessary. Importantly, before doing so, establish that confidentiality is not being compromised by the presence of a person such as a home help or support worker when this is done.

b. *Adhesive dentistry*

With the advent of adhesive dentistry, the restorative options available to the increasing numbers of people who are dentate receiving domiciliary care have improved. Consideration should be given to the use of the Atraumatic Restorative Techniques (ART) and Carisolv [25].

c. *Infection control*

Within the domiciliary environment, 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. The procedures detailed in local SPCDS policies for control of infection will apply to domiciliary procedures in the same way as for clinic-based procedures.

d. *Treatment planning* and su*bsequent visits*

After examination, the provisional treatment plan should be discussed with the patient and/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 (see Appendix 6).

In planning future treatment it is important to consider what treatment is required and what, if any, of it is appropriate in a domiciliary situation. This is the time to plan and make provision for any 'mix and match' requirements.

e. *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 healthcare provision. Care must be taken that where other people are present (such as, 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 consent for disclosure.

f. *Consent*

The law in relation to consent clearly places the duty on the practitioner who proposes to carry out treatment to ensure that a valid consent is obtained. This is no less the case with domiciliary oral healthcare provision. Consent must be informed and where a client is considered not to have the capacity to consent, the procedure set out in the Mental Capacity Act (MCA) 2005 [9] or Adults with Incapacity Act, Scotland [26] must be followed. For more information see the section on the MCA on pages 20 - 22 and Appendix 7.

8. Training

Providing effective domiciliary oral healthcare requires skills that extend well beyond clinical dentistry [2]. 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. In the GDC's guidance '*Maintaining Standards*' attention is drawn to the possibility that a medical emergency could occur at any time in premises where dental treatment takes place. The nature of the patients being treated in a domiciliary setting means that there is likely to be a greater chance of encountering a medical emergency. It is, therefore, imperative that the 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, including domiciliary settings, 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
- A portable source of oxygen, and
- Emergency drugs [8]

In order to comply with this guidance, the domiciliary dental team will need to take this equipment with them. The carriage of oxygen requires that the car owner informs their insurance company, secures the oxygen in the car to stop it rolling around and carries an oxygen safety data sheet and TREM (Transport Emergency) card. A mobile phone is also necessary to ensure that emergency services can be phoned, if required.

Undergraduate training must include experience in domiciliary oral healthcare and care homes if graduates are to have any understanding of what domiciliary care provision involves.

Local policies and procedures will apply to many of the above considerations. Staff providing domiciliary care should be aware of, trained in, and operate in compliance with the local rules of their employing authority.

The portable domiciliary kit should always be complete and ready to go. This requires a designated member of the dental team to have responsibility for keeping it this way (see the section on Equipment on page 16).

9. The Mental Capacity Act 2005 (MCA 2005)

This Act came into force in 2007 and the law applies to everyone involved in care, treatment or support of people aged 16 years or over in England and Wales who lack capacity to make all or some decisions for themselves.[9] In Scotland, the needs of adults with incapacity are met through the *Adults with Incapacity (Scotland) Act 2000* [26,27].

The MCA clarifies the terms '***mental capacity'*** and '***lack of mental capacity***'. There is an assumption that people have the capacity to make decisions for themselves unless proved otherwise. An assessment regarding capacity may be supported by the use of a tick box check list within the patient's dental records (see Appendix 7).

The new law states that a person is unable to make a particular decision if they cannot do one or more of the following:

- Understand information given to them
- Retain that information long enough to be able to make the decision

- Weigh up the information available to make the decision
- Communicate their decision - this could be done by talking, using sign language or even simple muscle movements such as blinking an eye or squeezing a hand.

Healthcare workers are able to diagnose conditions and carry out treatment for patients who do not have capacity as long as they have complied with the MCA, and are acting in the individual's '*best interests'*. The MCA indicates that the individual's past values, attitudes and behaviour should be taken into account when providing a healthcare service for people who do not have the capacity to consent (see Advance Decisions in the MCA 2005). For example, where an individual has attended the dentist regularly throughout their life, and they have retained their natural teeth into old age and/or there is evidence of advanced restorative treatment, the implication is that they value their teeth. Were they to have the capacity to consent it is likely that they would choose restoration of a tooth rather than extraction. Thus a treatment plan including prevention and restorative care is likely to reflect their values, attitudes and past dental history.

A new criminal offence of '*ill- treatment*' or '*wilful neglect*' of people who lack capacity came into force in April 2007. Within the law, "*helping with personal hygiene*" (which includes toothbrushing) will attract protection from liability as long as the individual has complied with the MCA by assessing a person's capacity and acted in their best interests. The following check list may be used to determine what is in the 'best interests' of a person lacking capacity:

- Involve the person who lacks capacity
- Consult with others involved with the care of the person
- Do not make assumptions based solely on a person's age, appearance, condition or behaviour
- Be aware of the persons past and present wishes and feelings
- Give consideration to whether the person is likely to regain capacity to make the decision in the future.
- The individual must be supported to make a decision as far as possible even if it is what others may feel is an unwise decision.
- The decision should always be recorded in writing.

Appendix 7 provides a check list that can be used to document the process followed to assess capacity.

The Mental Capacity Act takes account of the role of '*Advance Directives*'. These include:

1. ***Advance decisions*** - people 18 years of age and over can make advance decisions, while still capable, to refuse '*specified medical treatment'* for a time in the future when they might lack the capacity to consent or refuse
2. ***Lasting power of attorney*** (LPA) - LPA allows adults aged 18 and over, who have capacity, to appoint attorneys to make decisions about their personal welfare, including healthcare and medical treatment decisions, and their property and affairs. This is something that people may well do in the early stages of dementia when they can still make decisions. It is likely that their LPA will be a family member
3. ***Court Appointed Deputy*** (CAD) - this is someone who can act for and make decisions on behalf of an individual whose condition makes it likely that they will lack capacity to make decisions in the future. The CAD must follow the Act's statutory principles, act in the person's best interests, and only make decisions authorised by the Court. CADs are more likely to be used for people with learning disability. Again, it is likely that family members will be appointed.

10. Disputed or unusual treatment plans

In cases where there is any disagreement over proposed treatments, the principle of '*wide consultation*' should be adopted. Where proposed treatments are disputed, 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, or peers, before proceeding except where over-riding necessity indicates otherwise.

11. Equipment

There is an increasing selection of domiciliary equipment available. What you need should be assessed on the basis of:

- Frequency of use
- Types of treatment likely to be carried out
- Facilities already available
- Ease of adequate decontamination

- Weight of equipment and ease of transporting it
- Any other relevant features associated with the service you provide, and
- Cost

Appendix 8 lists some items of equipment with approximate prices, current at the time of publication of these guidelines.

Organisation of the domiciliary kit into sub-kits is a useful way of ensuring everything required is in place, ensuring that the kit is kept clean and ready for use, and of taking only those sub-kits necessary into the patient's home. Appendix 9 outlines the way a domiciliary kit might be organised into sub-kits.

12. Shared Care

An example of shared care between the Salaried Primary Care Dental Service in Sheffield and selected General Dental Practitioners who provide a domiciliary oral healthcare service to people in care homes is cited as an example of good practice in Appendix 10.

Summary

These guidelines are intended to provide advice and support for all those involved with the commissioning and provision of DOHCS.

There is an increasing need to deliver oral healthcare to patients with complex additional needs. As well as contributing to deteriorating oral health, physical and mental impairment may present problems as regards the delivery of, and access to, oral healthcare. The availability of DOHCS will need to be maintained and improved to meet the needs of this growing population. This requires adequate training and more opportunities to gain experience to develop the necessary knowledge and skills as well as appropriate remuneration to reflect the additional time and skills required for DOHC. At the same time it is important, that domiciliary oral healthcare provision is targeted through world class local commissioning of appropriate services.

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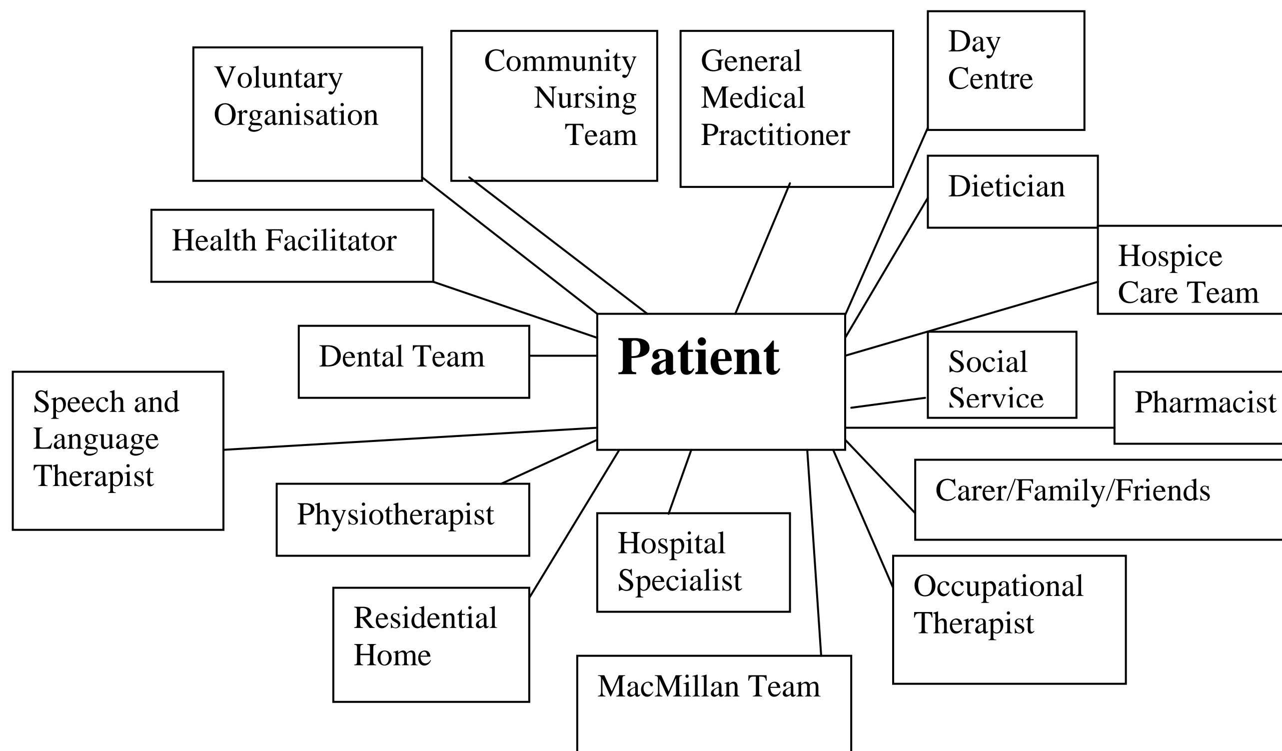
Appendix 1 Multidisciplinary Team for Older People



Adapted from Clinical guidelines and integrated care pathways for the oral healthcare of people with learning disabilities BSDH RCS 2001

Appendix 2 Domiciliary Referral Form

DOMICILIARY REFERRAL FORM

Date____________________________

Referred by (Name, address and status) ____
____
______________________________________ Tel No.____________________________________

Patient's name____ D.O.B.____________________

Patient's address ____
____ Post code_____________________

Tel. No.________________________

Name of contact person eg relative, key worker, social worker, etc
____
Address____
____ Tel. No.____________________________________
Reason for referral// Treatment need

Urgent ☐ Non-urgent

Does the person go out at all? Yes ☐ No ☐

If Yes, could they travel to a dental surgery with transport? Yes ☐ No ☐

Medical/ Mental/ Social History____
____
____

Mobility problems____

Physical Disability____

Mental Disability____

Sensory Disability____

Communication difficulties____
Any other relevant
information____
____

Appendix 3 Eligibility Criteria for Domiciliary Oral Healthcare

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 ☐ Confined to home ☐

Additional Comments:

____

____

____

Source: Lothian PCDS 2003

Appendix 4 Guidance notes for an Environmental Risk Assessment for DOHC

DOMICILIARY VISIT RISK ASSESSMENT	
Patient name	Mr/Mrs/Miss__________________________
Address **Tel no**	____ _____________________________________ ____ _____________________________________
Number of persons living in premises	
Can the patient understand and communicate at an acceptable level?	
Does the medical history indicate any potential problems?	
Are there any special risks arising from the treatment planned?	
Is there an appropriate level of social support and after care if treatment is to be provided at home?	
Others present e.g. carer, relative, support worker etc	
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
Obvious fire hazards	Smokers at the location Children with access to cigarettes, lighters, matches Use of chip pans, electric blankets, portable gas heaters
Slips, trips and falls Any items that have a potential to cause slips, trips or falls	Slippery kitchen / bathroom floors Flooring stained with bodily matter (environmental hazard) Broken furniture Lack of space due to furniture / other clutter
Electrical safety	Frayed cable, damaged plugs etc

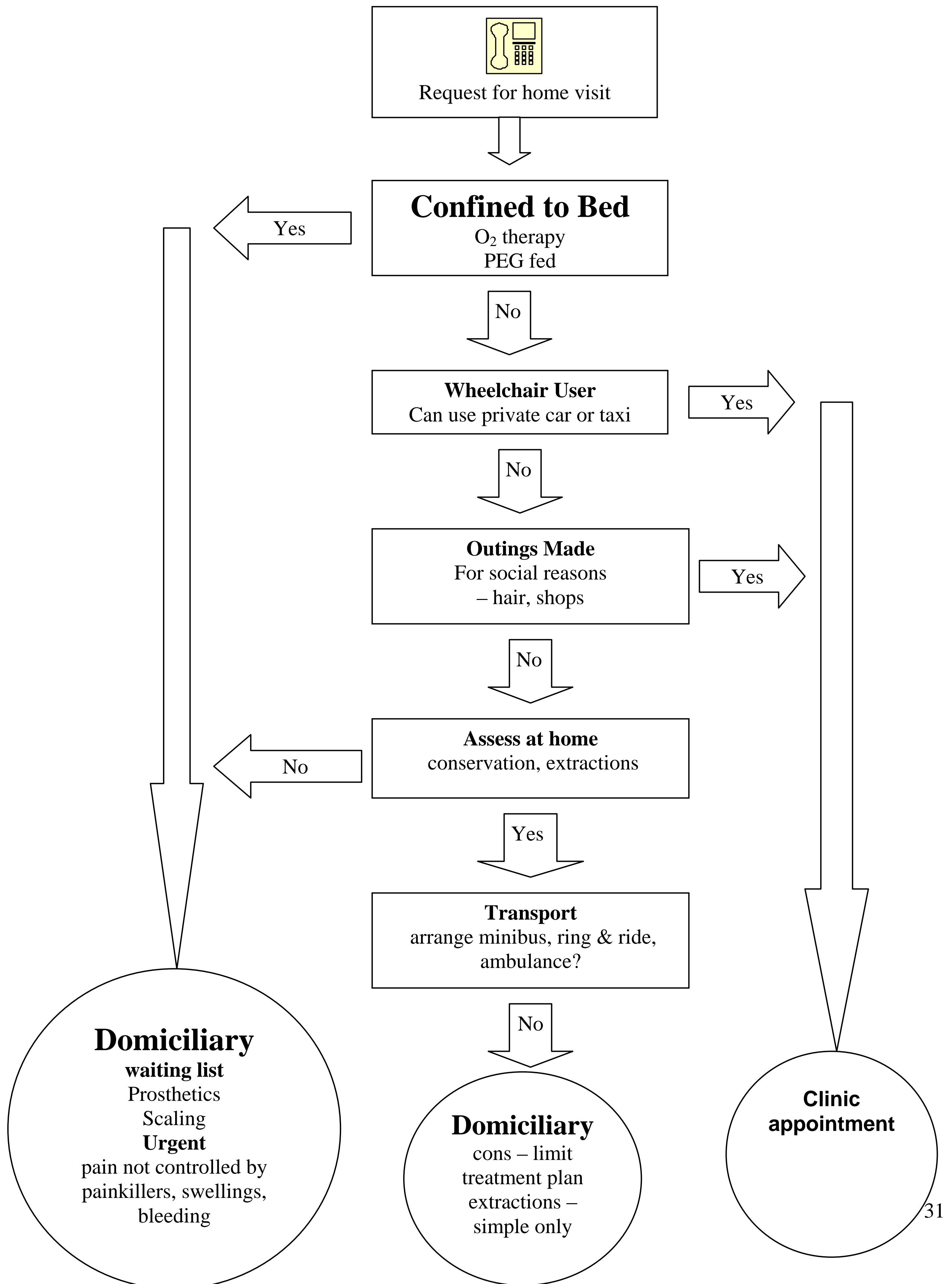
Other hazards e.g. animals	Pets within treatment area
Manual handling assessment	**Complete according to trust Policy/ local rules**
Furniture	Low seating causing manual handling problems
Space availability	Sufficient space to enable treatment of the patient in an appropriate manner with privacy and dignity eg exclude smokers from treatment area and any other person not required for support with agreement of patient
Additional Comments	Any further information that is relative to the risk assessment in question. It is important that this information is as accurate as possible. Although assessments can be subjective, hearsay should not be used as a basis for assumption
Is the physical environment safe for the procedures intended?	
Assessment Outcome	This is an overall measure of the assessment itself. The assessor is required to categorise the assessment by ticking a single box
Green flag	Assessment did not highlight any significant problems
Amber flag	Assessment includes additional comments which must be read by any individual visiting premises or patient
Red flag	Anyone visiting premises must contact assessor or case manager to discuss hazards before visiting premises or patient

Name of person completing assessment________________________________

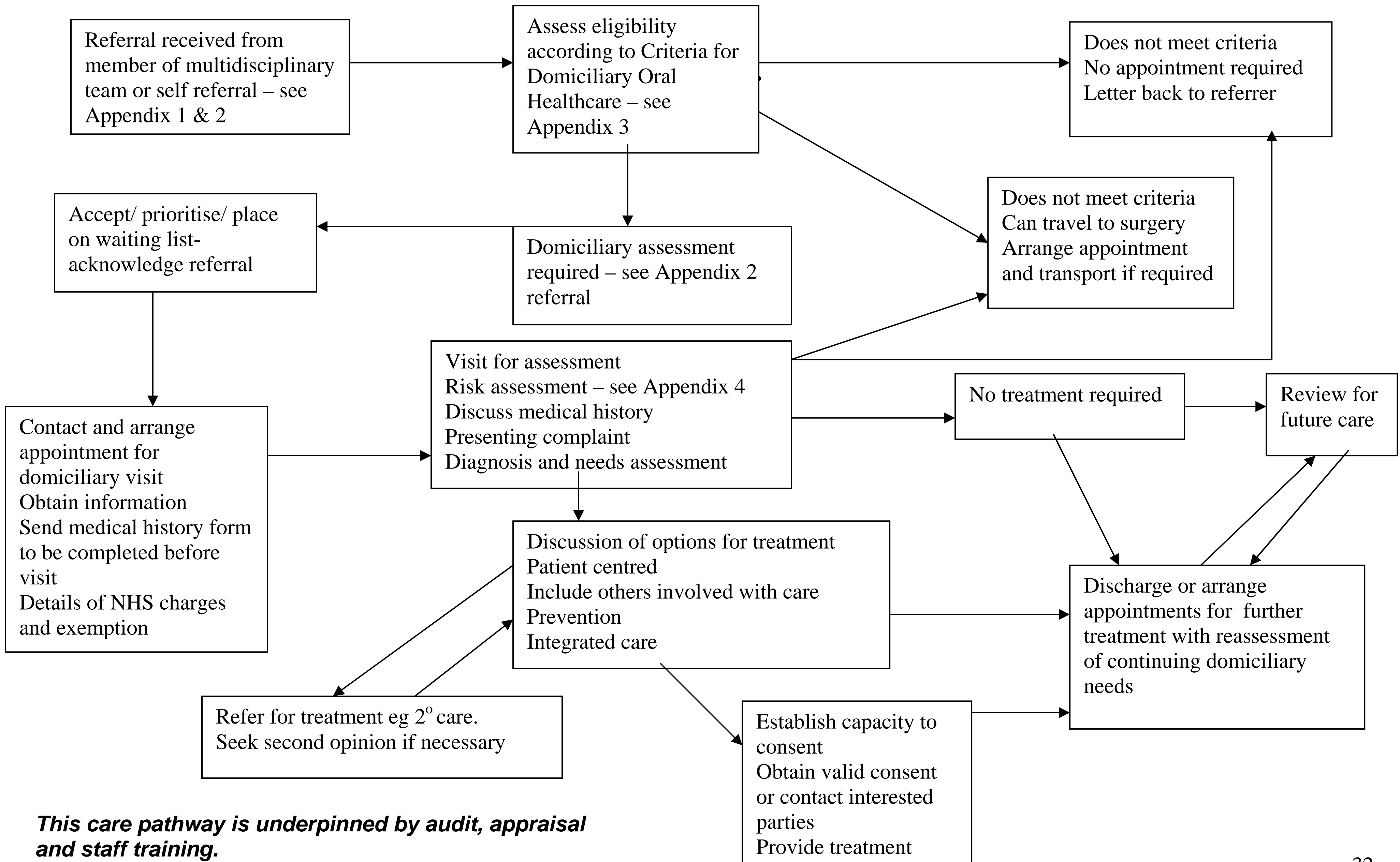
Signature________________________ Date of completion___________________

Source: All Wales Special Interest Group- 2006

Appendix 5 Decision Making Process for Domiciliary Dental Treatment



Appendix 6 Care Pathway for Domiciliary Oral Healthcare



This care pathway is underpinned by audit, appraisal and staff training.

Source: Wessex Domiciliary Care Group 2006

Appendix 7 Assessment of capacity for proposed dental treatment/decision

Name ………………………………..	**NoK** ……………………………………..
Address ……………………………	**Relationship to patient**
………………………………………	…………………………………………..
………………………………………..	**Tel** ……………………………………..
Tel …………………………………	**GP** …………………………………….
DOB …………………………………	**Tel**

Summary of proposed treatment plan/decision to be made
……
……………………………………………………………………………………

Is the proposed treatment plan/decision unusual?
Yes ▢ No ▢ Don't know ▢

If yes, state why ………………………………………………………………………….
……………………………………………………………………………………………..

Does the patient have a condition/impairment which may affect their capacity to consent to dental treatment? Yes ▢ No ▢ Don't know ▢

If yes, record reason for impaired capacity (e.g. Learning disability, dementia, brain injury, stroke etc)
…………………………………………………………………………………………….

Is the impaired capacity likely to be temporary or permanent?

Temporary ▢ * Permanent ▢ Don't Know ▢

*If temporary, defer non-urgent treatment until capacity returns if possible

Assessment of capacity

Can the patient understand the information given to them about their treatment?
Yes ▢ No ▢ Don't know ▢

Can the patient retain that information long enough to be able to make the decision?
Yes ▢ No ▢ Don't know ▢

Can the patient weigh up the information available to make the decision?
Yes ▢ No ▢ Don't know ▢

Or can the patient communicate their decision (whether by talking, sign language or any other means)?
Yes ▢ No ▢ Don't know ▢

Was consultation with other professionals required to assess capacity?

Yes ☐ No ☐

If yes, record name & status …………………………………………………..

Does the patient have mental capacity? Yes ☐ No ☐ Don't know ☐

Best interests check list if the patient lacks capacity

What methods have been used to involve the person who lacks capacity in making the decision?
……………………………………………………………………………………………..
…………………………………………………………………………………………….

Has the patient's past or present wishes, feelings and beliefs been taken into consideration?
Yes ☐ No ☐ Don't know ☐

Have others been consulted regarding the treatment/decision?
Yes ☐ No ☐ Don't know ☐

Names and relationship to patient who can act in service user's best interest contacted?
……………………………………………………………………………………………..
……………………………………………………………………………………………..

Does the patient have an appointed Lasting Power of Attorney or Court of Protection appointed deputy?
Yes ☐ No ☐ Don't know ☐

If yes, record name and date contacted…………………………………………………….

Are you aware or any advance directives regarding dental/personal care?
Yes ☐ No ☐ Don't know ☐

If the patient does not have any personal or legal advocates, do you need to involve the Independent Mental Capacity Advocate (IMCA)? Yes ☐ No ☐ Don't know ☐

If yes, provide
Name of IMCA ………………………………… Date consulted ……………………..

Outcome of consultation
……………………………………………………………………………………………….
……………………………………………………………………………………………….
……………………………………………………………………………………………….
……………………………………………………………………………………………….

Signature ………………………… Designation ……………………….

Name …………………………….. Date …………………………………

Vicki Jones Gwent Healthcare NHS Trust Nov 2007

Appendix 8 Domiciliary Equipment Details

Name	Manufacturer		Price ex VAT
Portable units	Dentalman		£15,241
	Lysta MU 1000		£19,205
	DNTL Procart		£4,400
	NewCoDent unit		£8,995
	Dentronic Mini Dent		£10,309
Hygienist units	Lysta		£2,299
	Dentsply Cavitron		£1,575
Portable suction units	Lysta		£1,811
	Dentalman		£1,298
	Dentrovac		£4,434
Portable handpieces (rechargeable)			
Derota	Quayle		£349
		Handpiece	+£111
Dentalman Cordless	Dentalman	Battery	£193
		Motor	+£234
		Handpiece	+£398
Portable Light source			
Lightpen	Daray		£5
Voroscope MXL LED Portable light with rechargable battery pack	Nuview		£640
NewCoDent Mirror light			£ 49
Mirror light	Dentalman		£560 incl.charger

Orascoptic	Evident	£1000
Heat source		
Safe Air	Healthco	£290
Registration block trimmer	Accutrim	£240
Extra autoclavable plates		£26
Electric wax knife	Alibaba.com	£22.50
Carrying boxes		
Stanley	B&Q	£20
Emergency O2 bag	SP services	£112
Trolley	Screwfix	£40
Other equipment		
Smartlite	Dentsply	£480
Portable three in one	Dentalman	£529
Coaguchek -portable INR machine	Roche	£700

Useful equipment websites include:

www.lysta.dk

www.dentalman.biz

www.js-davis.co.uk (Dentronic and Dentrovac)

www.dentsply.com

www.silvertree.co.im (Accutrim)

www.Alibaba.com (Electric wax knife)

www.daray.co.uk

www.coaguchek.com

www.quayledental.co.uk

Info @ DNTLworks.com– Portable equipment from USA- contact www.kabdental.com for UK source

www.Vorascopes.co.uk

www.orascoptic com

www.spservices.co.uk (Emergency oxygen bag)

www.screwfix.com/prods/66107

SiggiJokumsen @ aol.com (New Codent)

Appendix 9 Organisation of a Domiciliary Kit into Sub-kits

This list is an *aide memoire,* and is **not** prescriptive. Other items may be included according to individual need and preference.

General Kit
This is likely to include:

- Portable light
- Portable suction
- Examination instruments for initial assessment visits, eg mirror and probe
- Finger Guard
- Infection control items and equipment:
  - Gloves
  - Masks/Face visors
  - Protective clothing for dentist and nurse, e.g. plastic aprons
  - Sharps disposal
  - Alcohol gel
  - Plastic over-sheaths/cling film
  - Disinfection wipes
  - Waste bags
  - Paper towels, rolls, tissues
  - Dirty instrument-carrying receptacle
- Protective spectacles for patient
- Laerdal resuscitation pocket mask
- Emergency equipment/ drugs kit / oxygen

Administrative Items
The following items are useful:

- Identification badge
- Diary
- Appointment cards
- Record cards
- Referral forms
- Laboratory forms
- Post-op instruction leaflets
- Consent forms
- FP 17's
- Prescription pad
- BNF
- Mobile phone
- Pen
- A - Z Route Map/ Satellite Navigation system
- Change for parking
- Medical history forms
- Health promotion literature
- List of contact phone numbers

Prosthetics Kit
This requires all the items that you would usually use for removable prosthetics

- Impression material
- Impression trays & mixing equipment
- Safe air heater
- Portable motor, handpieces, burs
- Adhesive/fix
- Shade guide
- Articulation paper
- Plastic bags

Waxes
Pressure relief paste
Bite registration material
Wax knife
Bite gauge
Paint scraper/ occlusal rim trimmer
Denture pots
Scalpel
Impression disinfection
Gauze
Cotton wool rolls
Vaseline
Denture fixative
Dividers
Indelible pencil
Denture marking kits
Tissue conditioner

Conservation kit

Portable unit (motor and suction)
3 in 1 syringe
Handpieces and burs
Light source
Syringes, needles, needleguards
Mirrors
Conservation instruments and tray

Materials

Temporary dressing materials
Restorative materials
Matrix bands
Gauze
Suture materials
Haemostatic agents
Bite packs
Dry socket medicament eg Alvogyl
Local anaesthetic cartridges
Topical anaesthetic cream/spray
Oraquix local anaesthetic plus applicator
Cotton wool rolls and pellets
Vaseline

Periodontal kit

Hand scalers
Portable ultrasonic scaler
Toothbrushes, toothpastes and therapeutic agents, e.g. Corsodyl, Tooth Mousse

Surgical kit

Syringes, needles, needleguards
Mirrors
Forceps
Elevators
MOS instruments including instruments for suturing

Appendix 10 ROCS project Sheffield- example of good practice

The Residential Oral Care in Sheffield (ROCS) domiciliary project was instigated in 2000 as a result of discussions between one of the dental advisors in Sheffield and SDO gerodontology regarding the ad-hoc dental care arrangements available for older people in care homes in the city. Its aim was to provide a more coordinated approach to improve access to dental services for this often neglected group. Neither the CDS, nor GDS were able to provide the service to the 100 plus homes alone, and it was clear that collaborative working should be the way ahead.

A small group of interested General Dental Practitioners, the consultant in Dental Public Health (DPH)and the local Salaried Dental Service applied to the Modernisation Agency for funding under the Options for Change initiative and were successful. ROCS was launched in February 2004 and has evolved to now cover 50% of the care homes in the city, adapting since then to the many changes in the dental contract. An annual screening is offered to all residents and treatment provided if appropriate, either on a domiciliary basis, at the surgery or referred on to the salaried service for the more complex cases.

The ROCS process is relatively simple and consists of the following stages:

1. Contact is made by the GDP with the home to be covered and an appointment arranged with the care-home manager.
2. A meeting is convened to explain the details of the dental package. The ROCS charter is explained - what the home can expect from the dentist & vice versa. The residents are all offered a screening & appropriate information, and payment status is collated by the home
3. At the screening visit(s), data is collected and forwarded to DPH consultant for use. in needs-assessment exercises
4. Information is recorded in the patient care plans
5. Treatment visits are planned and provided, with referral to the Salaried Dental Service if appropriate
6. Input from the Oral Health Promotion department on regular basis
7. Meeting with care-home manager to report on recommendations

The ROCS process has been well received and appreciated by those taking part as the following quote illustrates:
A newly appointed Care Home Manager, following a screening visit: "*In the 20 years I have been working in Care Homes, you are the first dentist that has talked to us and explained things to us, about the residents' dental care. Dentists previously have visited, seen the resident and dashed off again.*"

ROCS is now funded on a sessional payment basis. A good working relationship with the PCT commissioners is essential to the continued success of the project. The ROCS group meet regularly as a team and continue to evolve through peer review and audit.

If you require any information please feel free to contact us:
Gill Heyes, SCD, Sheffield Salaried Primary Dental Care Service, Sheffield PCT
Gillheyes @ btinternet.com Tel:0114 226 1721
and/or
Richard Taylor, GDP, Dental Practice Adviser, Sheffield PCT
richard.taylor @ sheffieldpct.nhs.uk Tel: 0114 305 1027