



**British Society for
Disability and Oral Health**
UNLOCKING BARRIERS TO CARE

BRITISH SOCIETY FOR DISABILITY AND ORAL HEALTH

**PRINCIPLES ON INTERVENTION FOR PEOPLE UNABLE TO
COMPLY WITH ROUTINE DENTAL CARE**

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1. INTRODUCTION

This policy document is written within the context of UK dental services, mindful of the differing legislation relating to health care workers in the constituent countries of the UK. It was the general consensus of the Working Group that the existing documentation pertaining to physical intervention focused very much on the management of aggression and challenging behaviour, which, although an issue within dental care, did not address the more specific concerns of appropriate physical intervention when delivering oral/dental care for people with, predominantly, intellectual disability.

Guiding principles:

- It is assumed that those providing care share common values and a commitment to working within the law, adherence to accepted clinical and professional standards and above all, operating within the best interest of the service user ¹ .
- All individuals have a right to equal standards of health and care ^{2,3} .
- All individuals have a right to autonomy as far as possible, in relation to decisions made about them.
- Good oral health has positive benefits for health, dignity and self-esteem, social integration and general nutrition. The impact of oral ill-health on an individual's quality of life can be profound ⁴⁻⁶ .

2. RATIONALE FOR POLICY.

This policy document has been developed to assist in the provision of oral health care for people whom it is judged do not have the capacity to consent and/or whose behaviour requires further support to facilitate the safe delivery of oral and dental care.

The principles outlined must be communicated not only to members of the multiprofessional team managing the patient's care but also to all oral health care staff. The patient, even when unable to give consent, must, wherever possible be part of the decision-making process about oral/dental care and how it is to be carried out. Where it is judged that an individual does not have the capacity to consent, the views of parents/carers should be sought and taken into account .

The emphasis however, must be on a proactive approach to care, rather than merely managing aggression and disruptive behaviour.

3. LEGAL FRAMEWORK

It is a general legal and ethical principle that consent must be obtained before starting treatment or for the use of physical intervention, as well as providing personal care for an individual⁷. No-one can give or withhold consent on behalf of another adult. at the present time unless a Court order exists. In Scotland (except in an emergency), if an adult, judged incompetent to give consent, is to be treated, a Certificate of Incapacity should be obtained from the General Medical Practitioner responsible for the patient's general care (See Appendix 2) This principle reflects the right of the individual to determine what happens to his or her own body – the right to self-determination – a principal robustly upheld by the Law which is also a fundamental part of good practice^{8,9}.

As providers of a service, the dental team need to work within the law and as such, need to be aware of the legal protection available to all as well as knowledge of the laws that may be infringed by the use of physical intervention.

The British Institute for Learning Disability (B.I.L.D.) in its document – Physical Interventions, A Policy Framework¹ quotes from Ashton and Ward: 'a duty of care exists when duties or responsibilities are placed on paid carers¹⁰.' This is defined further as 'taking reasonable care to avoid acts or omissions, which are likely to cause harm to another person.' Judgements about what is or is not a reasonable course of action may be made with reference to the following:

1. The conduct of other practitioners with similar skills and responsibilities
2. An appropriate body of expert opinion
3. What is reasonable in the circumstances
4. The foreseeable risk associated with a course of action

(Diamond 1995).¹¹

It is the dentist's duty of care to act in the best interest of the patient. Within that, dentists must strive to alleviate pain and maintain oral health. This duty of care encompasses the following:

- Communication with patient and family, carers and other health and social care professionals.
- Undertaking appropriate risk management and decision-making regarding the proposed intervention and the consequences of not carrying out the treatment.
- Promotion of disease prevention to minimise interventions.

4. CONSENT - AND CAPACITY TO CONSENT (See Appendix 1+2)

The principle of obtaining consent before embarking on dental care reflects the right of individuals to determine what happens to their own bodies and is a fundamental part of good practice. Every adult has the right to make their own decisions and must be assumed to have the capacity to do so unless it is proved otherwise¹².

An appropriately informed person, whom it is judged has the capacity to consent to the intervention in question, must give consent voluntarily. If the person does not understand what an intervention entails they must be considered not to have the capacity to give consent.

For a person to have capacity to consent he/she must be able to understand and retain information relevant to the decision being made, especially as to the consequences of having or not having the intervention in question and must be able to use and communicate that information in making a decision. Thus patients may have the capacity to consent for some interventions e.g. dental examination, but not to others, e.g. multiple extractions and partial denture construction.

Throughout the United Kingdom ¹³, it is the responsibility of the clinician providing the treatment to assess the capacity of the person to consent to care. This is not always a straightforward process and if there is any doubt it is important to be able to demonstrate that the capacity to give consent has been considered (Appendix 1).

In Scotland, however, The Adult with Incapacity Act 2000 requires that if a dentist is of the opinion that the patient lacks the capacity to consent to the proposed treatment, in most cases the authority to treat must be obtained from the person's Medical Practitioner primarily responsible for the patient's general medical care (MPPR). This person is usually their general medical practitioner but may in certain instances be another person known as the Welfare Attorney or Welfare Guardian. In some instances it may be appropriate for the Hospital Consultant who is responsible for the patient's care to give a Certificate, lawfully. The Act does not give the MPPR the role of making treatment planning decisions, but simply permits them to confirm that it is their belief that the person lacks the capacity with regard to consenting to the particular treatment and the decisions about such treatment that is being proposed. The dentist will still be required to demonstrate that a consenting process has been gone through and it would therefore be advisable that a dental treatment plan (particularly a complex treatment plan or a plan involving physical intervention, sedation or general anaesthesia) be discussed with a second clinician (Appendix 2).

In all jurisdictions, once it has been decided that an individual does not have the capacity to consent, certain principles should be considered ¹⁴:

- Clinicians have a duty of care to do the best for their patients
- Decisions made must be in the best interest of the patient.
- Decisions about care must involve the individual as much as possible
- The views of others who have an interest in the best interests and welfare of the individual must be sought

5. BEST INTEREST

Any decision made on behalf of a person without capacity should be in their best interest; best interests of the person must not be confined to medical interests alone but a number of wider issues taken into consideration:

- The patient's own values and wishes, where these can be ascertained, including any advance statements
- Clinical judgement about the effectiveness of the proposed treatment, particularly in relation to other options
- Where there are various options for treatment, consideration should be given to the option that is in the best interest of the patient taking into account present as well as future choices

- The likelihood and extent of any degree of improvement in the patient's condition if treatment is provided
- The view of people close to the patient, especially close relatives, partners, carers, or proxy decision makers, about what the patient is likely to see as beneficial
- Any knowledge of the patient's religious, cultural and other non-medical details that may have an impact on the patient's wishes.
- If the patient is an infant (under 18 in England and Wales) or a child (under 16 in Scotland) the patient's capacity to consent must be ascertained and if the young person is judged competent for the procedure, they may consent themselves. However, in England and Wales this ability of an infant to give consent does not supersede the parents right to consent on the infants behalf.

It may, for some patients, be in their best interest to employ some form of physical intervention when treating or in order to treat. There will be people who, because of an impairment(s) are unable to respond to the usual behaviour management strategies and who will require some form of adjunct in order to accomplish dental care safely and effectively, for example those with:

- Profound and multiple learning disabilities
- Movement disorders and/or challenging behaviour
- Advanced medical problems related to CVA, multiple sclerosis, brain tumours
- Mental health problems such as dementia, severe depression and schizophrenia
- A persistent vegetative state or who are unconscious for whatever reason
- An addiction or substance abuse problem.

The issue for this group of people is often more about the delivery of oral and dental care rather than the care itself. Clinicians who have a duty of care also have a duty to provide that care in a manner that is beneficial to the patient. Both the method of delivery and the treatment must be considered during the consenting process.

There are a number of factors that must be considered and included within any oral care plan. These should be included as an integral part of multiprofessional discussions leading to decisions made about oral care. Consideration must be given to the fact that:

- Compliance may not be consistent or predictable and may vary with different procedures on different days or with different carers or operators present.
- Acclimatisation, behaviour modification and constancy may improve compliance for some people
- There will be known triggers for behaviour change in some individuals
- The timing of appointments, medication and other aspects of daily routine, may be crucial
- The use of non-conventional relaxation techniques, for example, music therapy, may be beneficial.

On occasions, where other behaviour management strategies have failed, or are obviously not appropriate, some form of intervention will be required. Physical

intervention, oral, intravenous, inhalation sedation or general anaesthesia used as adjuncts to facilitate dental care, must all be viewed as forms of clinical restraint. It is important to realise that there are times when reasonable physical intervention is preferable to more extreme alternatives and might be acceptable for single, short interventions. However, such an approach should only be countenanced when all other approaches have been considered. There will be occasions on which resort to general anaesthesia (GA) is appropriate but it must be recognised that rendering a patient unconscious constitutes the ultimate in physical intervention (a patient lacking the capacity to consent also lacks the capacity to withdraw treatment). A competent patient can withdraw consent at any time and this must be considered; rendering a patient unconscious will entirely remove their ability to withdraw consent and even the use of sedation may hamper their ability to withdraw consent.

6. GUIDING PRINCIPLES ON PHYSICAL INTERVENTIONS

The Department of Health in England defines:

Restraint as ‘The positive application of force with the intention of overpowering the person’, which, by definition, is without that person’s consent.

Holding still as immobilisation, which may be used to help a person cope with a painful procedure effectively and is carried out with the person’s consent. It differs from restraint in the intention and degree of force required.

Containing as physical restraint or a barrier aimed at preventing the person from harming themselves or others¹⁵.

Whilst the term restraint has been in common usage, there is a move away from it and instead to substitute the term, physical intervention, to avoid the negative connotations that the word ‘restraint’ has in the Learning Disability field.¹

The Department of Health Guidance for Restrictive Interventions¹⁶, gives advice on the provision of safe services for people with Learning Disabilities and Autistic Spectrum Disorder. The Guidance distinguishes between ‘planned interventions’ and ‘unplanned or emergency interventions’, both of which may be appropriate in the provision of oral care. The Guidance is however aimed less at those providing therapeutic interventions but more towards carers in schools and day centres.

Good decision-making about physical intervention, holding still or containing, requires that there is:

- An ethos of caring and respect for the person’s rights where physical intervention, holding or containing without the person’s consent are a last resort and not the first line of intervention
- Openness about who decides what is in the best interests of the person in relation to physical intervention, holding and containing and clear mechanisms for staff to be heard if they disagree with a decision
- A policy relevant to the client group and setting, which lays down when physical intervention, holding or containing may be necessary and how it may be done
- Sufficient numbers of staff who are trained and confident in safe and appropriate techniques and in alternatives to physical intervention, holding and containing.

(Yorkhill NHS Trust 2001)¹⁵

The responsibility for therapeutic/procedural physical intervention lies with the 'treating' dentist. This is the case irrespective of who undertakes the intervention – a member of the dental team trained in physical intervention, or a parent or accompanying person with responsibility for the client. Parents or accompanying responsible persons have a vital role to play not only in supporting any physical intervention but also in expressing their concerns if they are uncomfortable with the procedure. However, they must be made fully aware of the consequences of not only continuing with, but also prematurely curtailing, the procedure and the implications for not completing dental care.¹⁷

It is acknowledged that physical intervention may deal with an incident of challenging behaviour in isolation; it does not help the person with a learning disability adopt a more appropriate behaviour. The BILD Guidelines¹ state that physical interventions should:

- Only be used in conjunction with other strategies designed to help the service user learn alternative, non-challenging behaviours
- Be justified in terms of what is known of the client from a formal multiprofessional assessment, the alternate approaches that have been tried, evaluation of the potential risks involved and with reference to a body of expert knowledge and established good practice.
- Be subject to regular review

In addition, the Yorkhill Guidelines¹⁵ state that:

- The person to whom the physical intervention has been applied should be kept under observation, at a level to be determined by individual circumstances
- No form of physical intervention should be used for longer than is absolutely necessary for the safety and well-being of the individual
- All those involved in the use of physical interventions, which could be perceived by themselves or others to be excessive, should have opportunity for a debriefing session as soon after the event as possible.

7. PRACTICAL APPROACH

Any patient for whom it is anticipated that physical intervention may be required should be assessed beforehand for any contraindications to the use of such an intervention. For example, patients with a history of heart disease, difficulty in breathing, gastro-intestinal conditions and those with recent fractures or a history of dislocated joints, and persons with Down syndrome who have atlanto-axial joint instability.

It is important to listen to parents/guardians/accompanying person(s) for information on details of the environment or settings that predispose to non-compliance and the ways in which the dental team can organise the visit so as to avoid triggers for disruptive and/or non-compliant behaviour. Similarly, advocates and family members can help plan the most comfortable form of intervention.

If there is a dispute regarding the appropriateness of the use of physical intervention for a particular patient between staff, care workers, relatives or friends of the patient, attempts should be made to resolve these, if necessary, with the use of facilitators. If agreement cannot be obtained then it may be necessary, and indeed obligatory, to obtain a ruling from the Court.

Examples of good practice

Case scenario 1

Jane has Sturge Weber syndrome. She has moderate learning disability, is profoundly deaf and has sight in her left eye only. She has a haemangioma on the right hand side of her face, which extends to involve the intra-oral tissues. She gets very irritated and agitated if she is approached suddenly or if anybody attempts to look in her mouth from her right side. Jane's carers advise you that she will be reasonably compliant if you approach her slowly from her left side. She also finds tooth brushing acceptable if she is given a face mirror in her right hand and if the person assisting with brushing offers to guide the toothbrush held in Jane's left hand.

Physical intervention, if it is judged to be required, may be achieved by a member of the dental team, a parent or guardian or an accompanying responsible person as follows:

- Physical intervention should not cause pain
- Forming an 'arc' over the patient's body, which permits the individual to move freely since no contact is made with their body. More extensive movements of the patient's body are restricted by contact with the person's arcing arm.
- Gently holding the part of the patient's body. Pressure is only applied, in the form of resistance or 'drag' in response to excessive movement. The patient is not completely immobilised rather that the speed and force of their movement is contained.
- Using a blanket to swaddle the patient. Whilst this technique will rarely be used this approach permits the procedure to be completed safely and rapidly whilst minimising the psychological and physical stress to the patient. This technique is only used when:
 - There is an urgent need for treatment
 - The accompanying person(s), parent/guardian/responsible other agree with the need for urgent treatment and agree that this approach is merited.
 - The patient is unable to voluntarily comply with verbal requests and it is anticipated that they are likely to respond aggressively to any attempts to provide treatment.

Any form of physical intervention should be terminated if there are signs of:

Extreme distress

Breathing difficulties

Seizures or convulsions

Vomiting

Blue colouration of extremities (indicative of poor blood circulation)

Mottling/blotchiness (indicative of restricted blood circulation)

Bone fracture

Any physical intervention should be withdrawn slowly, in a measured way for example, gradually lessening muscle tension, resting a hand instead of holding the patient, increasing the space between you and the patient, reducing the number of staff involved, seeking verbal assurance that they are all right, that they are calmer.

Case scenario 2

An adult patient attends for a routine check-up having previously had most invasive dental care provided under general anaesthesia. The patient is reasonably cooperative for examination but has unpredictable movements and resists protracted oral examination. You note a carious lesion on the buccal surface of a lower canine tooth. The patient has extremely limited understanding and is not competent to discuss treatment options. Whilst the treatment of this accessible lesion is not urgent it does need to be completed. Examination of lateral oblique radiographs do not reveal any other pathology. In discussion with carers, agreement is reached to consult with the parents, who live elsewhere, and to propose a plan to attempt to restore the accessible carious lesion using a combination of Carisolv™ and atraumatic restorative techniques (ART), with assistance from the carers who agree to hold the patient's hands. It is agreed that treatment under a general anaesthetic would be inappropriate but that IV sedation is a possibility if this more conservative approach fails. Alternatively, if this too is unsuccessful, the lesion may be treated with topical fluoride varnish and invasive treatment deferred until it is judged that dental and/or other treatment is required and recourse to general anaesthesia might be considered.

8. PHYSICAL INTERVENTION FOR HOME ORAL CARE

In order to provide care in the best interests of the patient, it may be necessary to control behaviour in some way, even for elements of home oral care. The caregiver may have no choice but to intervene physically to perform an essential health care intervention such as administering medication or personal hygiene procedures such as toileting or tooth brushing. Clinicians working routinely in Special Care Dentistry may encounter conflict with carers who consider that some degree of physical intervention for oral hygiene measures is unacceptable.

In such circumstances it is also important that caregivers realise that the recent Department of Health publication 'No Secrets'¹⁸ states that a consensus has emerged identifying 'neglect and acts of omission' as a form of abuse. This includes ignoring medical and physical care needs, failure to provide access to appropriate health services and withholding the necessities of life, such as medication, adequate nutrition and heating. Such statements apply to oral hygiene and access to oral health care.

It is vital that the risks to oral and general health that are associated with inadequate oral hygiene, both in the short and long term, are identified in collaboration with caregivers, and that appropriate management strategies are identified and written into care plans.

The assessment process must identify the factors that may cause problems or impact on the quality of life of the individual patient concerned. To reach such a decision, it is essential that the assessment is approached in a multiprofessional way, in

collaboration with all those involved in the care of the patient. Specific issues around the degree of physical intervention that may be necessary to achieve oral health need to be balanced against the consequences of non-intervention.

In terms of oral well being, the consequences of inadequate oral hygiene interventions include halitosis, gingival and periodontal disease and dental caries. Neglect of these may ultimately necessitate an emergency general anaesthetic to treat pain and other associated consequences of dental disease. General anaesthesia carries with it a risk of morbidity and mortality. Such an approach frequently results in rendering a patient edentulous, in circumstances where the individual is unlikely to cope with the construction and wearing of dentures as an alternative to natural teeth. However, effective oral hygiene established as a daily routine has the potential to reduce or even eliminate factors (like halitosis and periodontal disease as well as preventing tooth loss), all of which can have a negative effect on the patient's general health, quality of life and social integration ².

Case scenario 3

Carers of a patient with dementia are concerned because the patient is unwilling to have teeth cleaned on some days without forcing the issue. In discussion with the carers it emerges that the patient is usually co-operative for routine personal hygiene practices as soon as they get up but that compliance declines after breakfast and is lost almost entirely by the evening. It is agreed that the carers should attempt to include tooth brushing when the patient gets up, first thing in the morning and that one carer should gently hold the patient's hands as necessary whilst another cleans around his mouth, allowing the patient to do as much as he is able and guiding where the brush needs to go. The use of a 'Superbrush' or Collis Curve, with the facility to brush three surfaces at a time, may expedite effective oral hygiene.

A joint multiprofessional approach to formulating an oral care plan must include the following key elements:

MEDICAL Factors that impinge on oral health
Oral side-effects of prescribed and over-the-counter medication
Factors that influence dental management eg diabetic routines, dialysis timing
Drugs influencing dental management eg Warfarin, steroids etc
Risk factors for sedation and general anaesthesia

ORO-DENTAL Access to the mouth for examination
Dental status and function
The presence of existing hard and soft tissue disease
Habits that cause hard or soft tissue damage
Safety of the airway
Future likely treatment needs
Assessment of dental disease risk factors
- diet analysis
- co-operation for oral health measures

PREVIOUS DENTAL HISTORY	Treatment provided Adjuncts used, eg local anaesthetics/sedation, general anaesthesia
ORAL HYGIENE SKILLS	Self care skills Level of support/assistance required
CARER ASSESSMENT	Current oral hygiene techniques, equipment and materials Factors influencing patient cooperation Behaviour associated with oral hygiene practices The number of carers required to facilitate tasks such as washing and dressing etc., should be ascertained to ensure that a similar number are available to assist with dental treatment, which is likely to put similar or more stress on the patient.

Oral hygiene techniques must be based on individual assessment and agreed with the multiprofessional team. There should be a risk assessment for the agreed approach.¹⁹ The following recommendations are based on comprehensive guidelines developed to enable clinical care. Where a physical intervention is involved, in order to effectively accomplish the task, it must be:

- The minimum to be effective
- Clearly documented to include type and reason for use
- Beneficial for the individual in completing the treatment
- Not seen or used as a punishment or convenience
- Not likely to cause physical trauma
- Not likely to cause more than minimum psychological trauma
- A means to avoid more severe forms of restraint, for example, GA
- To control involuntary movements
- To avoid injury to the patient and/or others
- Agreed, if possible, with those close to the patient, remembering that the clinician is ultimately responsible through the duty of care.
- Additionally, evidence that a consenting process has been undertaken should be recorded in the records with regard to both the treatment and the physical intervention.

(After Shuman and Bebeau, 1994)²⁰

A Pilot Study

Case Scenario 4

A study carried out in an institution for people with a learning disability arose as a result of increasing reluctance of care staff to provide oral hygiene for dependent residents. This was associated with a staff training programme to deal with aggression and provide safe restraint. Some of the techniques advocated for physical intervention for oral hygiene were not considered acceptable and cited as excessive restraint. A working group with experience in special care dentistry was established to develop an assessment and protocol to address the issues and overcome barriers to physical intervention for oral hygiene. Dentate residents were selected from a number of wards. The resident's past and present dental history was summarised from dental case notes. Nursing staff completed an oral health risk assessment that included an assessment of the individual's need for support with oral hygiene. Assessments were discussed by the multi-disciplinary team, which included the residents' advocacy service. A further assessment was completed in order to assess how oral hygiene was currently provided and the optimum conditions and environment to maximise the resident's cooperation or compliance. Individual techniques for physical intervention for oral hygiene involving up to three members of staff were risk assessed and approved as being safe and acceptable. Key staff were trained in the specific techniques for individual residents. There were significant improvements in residents' oral hygiene and a marked improvement in their cooperation for tooth brushing. Staff providing oral hygiene found the techniques acceptable and confirmed their awareness of improvements both in oral hygiene and cooperation. This project stresses the value of highlighting the short and long-term risk factors for oral health, the importance of individual assessment and of working with carers to support them with the challenges of providing oral hygiene.¹⁹

Level of Intervention.

The duration and degree of physical intervention should be kept to a minimum and during the process eye contact and verbal encouragement must be maintained between the patient and parent/guardian/accompanying person(s). In circumstances where the patient becomes distressed, and the physical intervention or treatment appears ineffectual, treatment should be discontinued and plans discussed with the parent/guardian/accompanying person(s) about further attempts on a different day. In situations where it is evident that physical intervention will cause greater anxiety to the patient, the treatment should be abandoned. At this stage, the care plan should be re-evaluated by the multiprofessional team.

Case scenario 5

A patient is brought to your surgery because the carers think she has pain from her teeth. The patient has not been seen by a dentist for a number of years and has a generally neglected mouth. There are heavy deposits of calculus both supra- and sub-gingival. A premolar tooth has fractured at gingival level. The patient is only reasonably compliant for an oral examination although the carers forcibly restrain her and encourage the clinician to go-ahead and 'do whatever is necessary doctor, we will

hold her down'. The patient appears frightened with wide-open eyes and noises consistent with distress. The clinician is not prepared to continue since any attempts at scaling are likely to be ineffectual and no attempts are being made by carers to help/assist with oral hygiene in the home and thus maintain in-surgery efforts. An appointment is made as soon as possible with the manager of the residential home, the daily carers, the patient's next of kin and the dental team to discuss future treatment plans to manage the patient's oral care long-term.

9. RISK: BENEFIT ASSESSMENT (adapted from BILD 2002) ¹

This is a key area for the oral health care team. There are 2 areas of risk

- The risk of the individual not having the intervention and thus no oral care and
- The risk of the particular technique employed

In considering these two areas of risk, it must be clear that any decision made is in the patient's best interest, and that any intervention is reasonable and proportionate in the circumstances. Risk: benefit assessment involves the following considerations, once the need for physical intervention has been agreed :

- What, if any, physical interventions are currently in use/sanctioned for use by staff?
- What, if any, are the potential hazards associated with using each procedure?
- Who is at risk when the different physical interventions are employed:
 - The patient ?
 - The staff ?
 - Other service users and staff ?
 - Parents/guardians/accompanying person(s)?
- What measures are in place to minimise the likelihood that physical interventions will have adverse consequences for patients, other service users, staff and parents/guardians/accompanying persons?
- What is the least restrictive physical intervention that will enable staff to respond effectively to foreseeable incidents involving the individual patients?

Accurate records are vital, not only to inform future episodes of care but also medico-legally, to confirm correct procedures have been utilised to assess competency and that an appropriate consenting process has been undertaken. Records serve also to avoid confusion amongst staff as to what has or has not been undertaken. The following should be noted in the patient's record:

- The oral/dental procedure carried out
- The type of physical intervention
- The people consulted about the decision to use physical intervention
- The outcome and future plans.

10. FORMULATING POLICY

Law

Physical interventions should be consistent with the legal obligations and responsibilities of care agencies and their staff, acting in the patient's best interests.

Values

Patients should be treated with fairness, courtesy and respect. Patients should be helped to make choices and involved where possible in decisions that affect them directly.

Prevention of challenging behaviour

If managed correctly, situations that encourage non-compliance can be avoided and a more positive environment in which to accomplish care can be achieved. Working with parents and/or carers can be beneficial in identifying situations likely to lead to non-compliance.

Promoting the best interest of the patient

Physical interventions should only be used in a planned way in conjunction with other strategies to minimise the likelihood of non-compliance and longer term, to help the patient learn non-challenging behaviours.

Planned interventions should be justified in respect of:

- What is known about the patient from a multiprofessional assessment
- The alternative approaches that have been tried
- An evaluation of the potential risks involved
- Reference to a body of expert knowledge and established good practice.

The use of physical intervention must be subject to regular review and audit.

Risk assessment

The potential hazards associated with the use of physical interventions must be systematically evaluated and should never involve unreasonable risk.

Management responsibilities

- Dental Service managers have the responsibility of developing, implementing and overseeing physical intervention policies and protocols.
- Employers and managers are responsible for the safety and well being of staff and all staff should be inducted in the procedures to be adopted, both verbally and in written form. Training must be provided.
- Staff deployment should be organised to ensure that appropriately trained staff are available to assist in patient care when physical intervention is required.
- Managers have the responsibility of ensuring that all incidents arising out of the use of physical restraint are documented and acted upon accordingly.
- All patients and families must have recourse to a formal complaints procedure.
- Consideration needs to be given to the impact of resource management on the use of physical interventions.

Staff training

Staff must be provided with, and take part in, the formulation of relevant policies and protocols on interventions and in particular, receive appropriate training in their use, before they are able to employ any forms of physical intervention.

Training must encompass knowledge, skills and values; it should be documented, ongoing, audited and regularly reappraised for appropriateness and in accordance with contemporary practice in that particular jurisdiction.

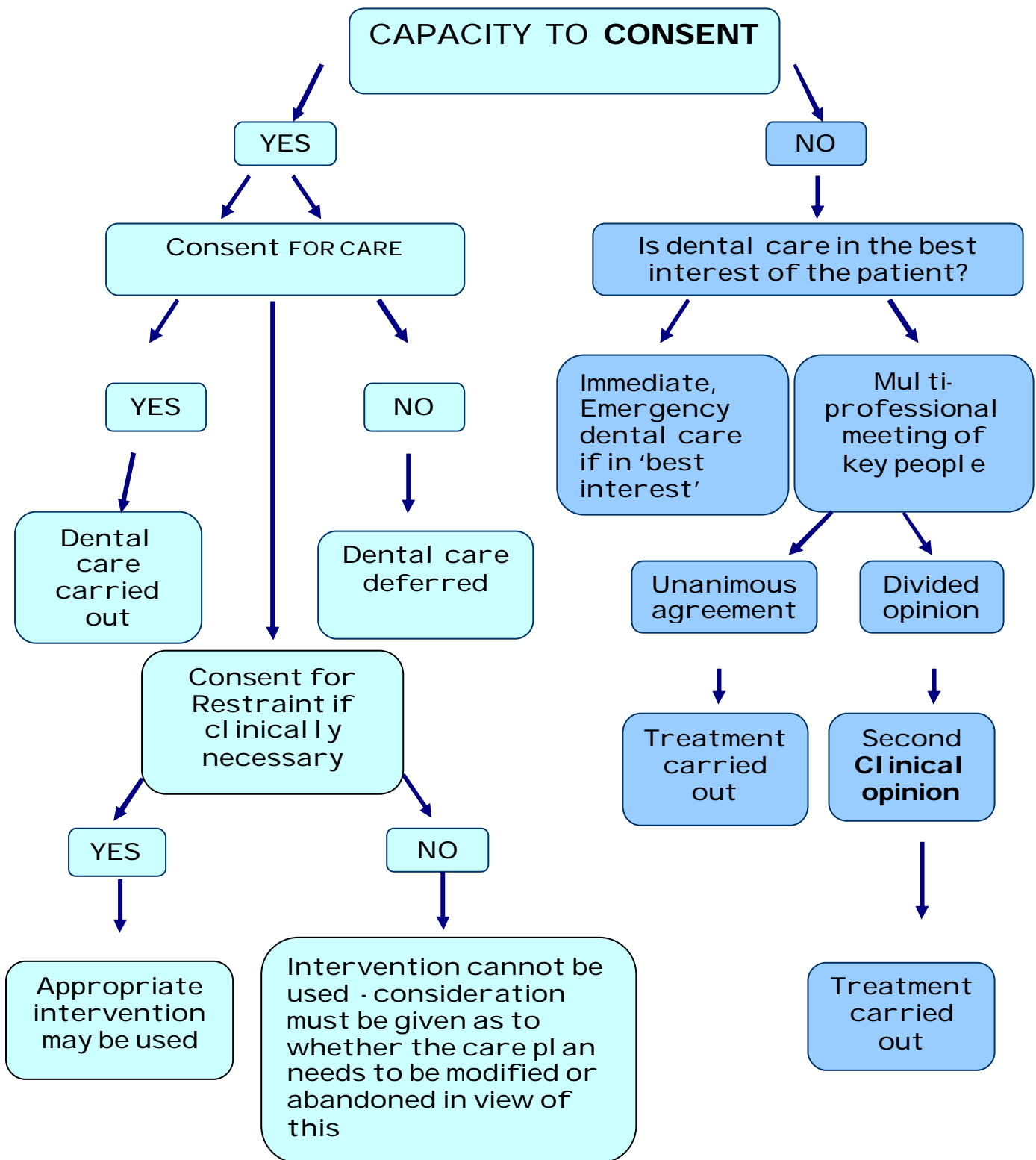
Staff need to be encouraged to monitor all physical interventions and to report concerns.

‘A Quote’

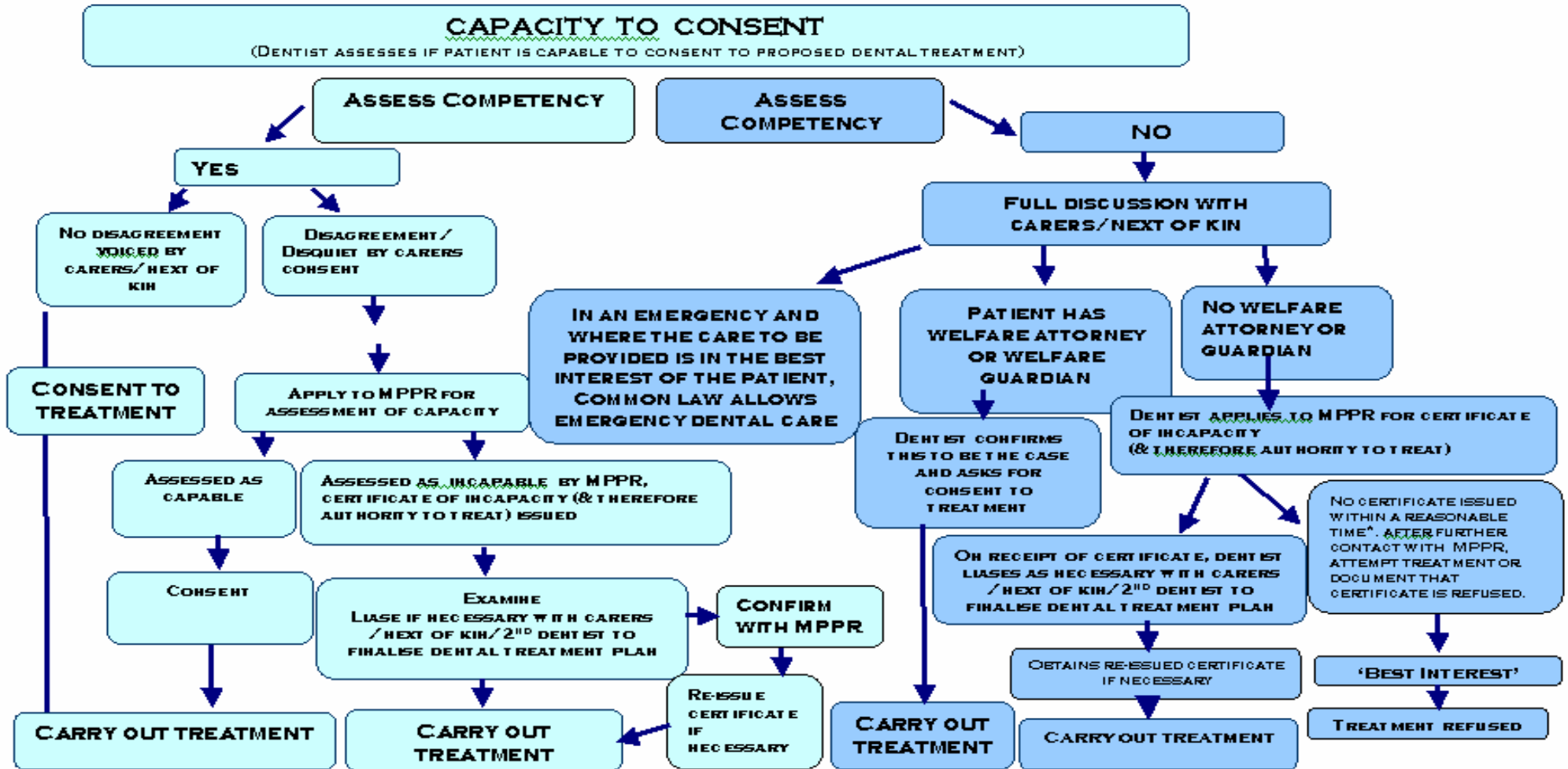
In the third of a series of papers by Bridgman and Wilson ²¹, reference was made to a way out of the dilemma of deciding on the approach to be adopted in situations where the use of physical intervention is contemplated; ‘the Court of Appeal has confirmed accepted opinion that the use of physical intervention is implicitly part of the ‘best interest’ test and that the decision, or authority, to use restraint lies with the medical or dental professional. Lady Butler-Sloss considered that: *“it follows from the decision that a patient is not competent to refuse treatment that such treatment may have to be given against her continued objection if it is in her best interests that the treatment be given, despite those objections. The extent of force or compulsion, which may become necessary, can only be judged in each individual case and by the health professional. It may become for them a balance between continuing treatment, which is forcibly opposed, and deciding not to continue with it. A clinical decision “* ²².

It is important therefore that because the Law regards the use of physical intervention as a clinical decision, all the normal steps regarding appropriate treatment planning are identified, carried out and documented; what is due regard with respect to consideration having been given to the appropriateness of the use of physical intervention must be clearly evident from the clinical record and practice procedure protocols.

APPENDIX 1
Capacity to Consent – England and Wales



APPENDIX 2 Capacity to Consent Scotland



Note:

*** Whilst the length of time waited depends on the individual patient's clinical presentation, if the MPPR has not responded within one month then it would be reasonable to consider making a further request to the MPPR.**

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