Domiciliary Dental Care

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Abstract: Domiciliary dental care is an important and growing area of treatment provision. However, adequate training is required in order to develop the knowledge and skills necessary to perform such care. This article draws attention to the likely increase in demand for domiciliary dental care services and the reasons for it; and highlights the issues and skills involved for dentists, hygienists and their teams in providing domiciliary dental care in order to facilitate quality of care and safe practice.

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Clinical Relevance: The demand for domiciliary dental care is increasing. Dentists and dental hygienists will be called on increasingly to provide dental treatment on a domiciliary basis.

Domiciliary dental care (DDC) has been defined as a service that reaches out to care for those people who cannot reach a service themselves.[1] It includes dental care carried out in an environment where a person is resident either permanently or temporarily, as opposed to care delivered in dental clinics or mobile units. The aim of DDC is to deliver appropriate oral healthcare to people whose circumstances make it impossible, unreasonable or otherwise impracticable for them to secure care in a fixed clinic, hospital or dental mobile.[2]

INCREASING DEMAND

The demand for DDC is increasing and is likely to continue to do so[3] (see Table 1). There are a number of reasons for the increase in demand.

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Increasing Numbers of Disabled People

There are 6.5 million disabled people in Britain, equivalent to one in eight of the population, of whom 60% are over the age of 65. Advances in medical science and increased life expectancy means that more people are surviving with illness and disability. Their mobility and/or ability for self-care is often reduced by physical disability, mental disability or chronic disease. A combination of functional limitation, multiple drug use and limited access to dental care puts them at greater risk of poor oral health.[4,5] It may be unreasonable or impracticable for people who are housebound or living in institutions to attend a dental surgery for treatment. Their oral health needs will be unmet unless they receive DDC.

The Disability Discrimination Act 1995

This Act has implications for dentists and the provision of DDC as it makes the removal of barriers to participation in society of disabled people a legal requirement.[6] From October 1999, the Act requires employers and service providers to act fairly and to be flexible by taking action to remove any barriers excluding disabled people. The Act defines discrimination in two ways.

First, as 'failure to provide a reasonable adjustment'. Where dental premises create a physical barrier to access, the dentist has to consider providing the service by a 'reasonable alternative means'. For example, if a dental surgery is up a flight of stairs and inaccessible to a disabled person, it requires the dentist to offer domiciliary care. The second definition relates to 'less favourable treatment' which is unlawful for a reason related to disability (where it cannot be justified under the terms of the Act), even where a provider treats a disabled person less favourably or refuses to serve them because they think this is for the person's own good— for example, because they think that the person is incapable of benefiting from the service or that another agency would provide a service which would suit the disabled person's needs better. Not only does the Act open the door to an increased demand for DDC, it also opens the door to possible litigation if such a service is not offered.

Increasing Public Awareness

Domiciliary dental care services are still not widely known about— and even when they are there remains a public perception that only oral examinations and simple dental procedures can be carried out in the domiciliary setting.[4]

Despite this perception, in a recent study looking at barriers to dental care in

	Year ending							
	March 1992	March 1993	March 1994	March 1995	March 1996	March 1997	March 1998	March 1999
Courses of treatment in patients under 18 years	1353	1394	1258	1187	1225	1161	1488	1355
Courses of treatment in patients over 18 years	127,750	137,733	141,766	149,906	152,533	154,431	154,374	155,679
Total no. of courses of treatment	129,103	139,127	143,024	151,093	153,758	155,592	155,862	157,034

Source: Dental Practice Board, Eastbourne, East Sussex. Digest of Statistics.

Table 1. *Domiciliary visits, England and Wales 1992-1999.*

frail and functionally dependent older adults, most patients expressed a preference for treatment to be carried out in their own homes.[7] Knowledge about the Disability Discrimination Act, dental advertising, and word of mouth from friends and relatives about DDC will lead to greater demand for domiciliary care.

An Increasingly Dentate Disabled Population

The proportion of people retaining their teeth into old age is increasing.[8] As dentate elderly people become disabled they are more likely to use dental services regularly than edentate elderly people do. This will not only increase the demand for DDC but will also require the skills and equipment to provide a more comprehensive service than the provision of complete dentures.[9]

CLIENT GROUPS

It is usually more convenient and cost effective to treat patients in the surgery, but for some people the physical, emotional or psychological trauma of being transported to a dental surgery and the reliance on the availability of a carer will eclipse any benefits provided by the surgery environment. Therefore it is preferable to provide treatment at home for some client groups despite the inconvenience that this may cause the dental team.

Domiciliary care usually involves visiting residential units and nursing homes, day hospitals, day centres and individuals' own homes. However, it can also encompass visiting people in hospitals, palliative care units and hostels for homeless people. Most people requiring domiciliary care are elderly but a significant number of younger disabled people can also benefit from care at home. The client groups most likely to require DDC are people with:

- physical disabilities causing problems with mobility;
- medical conditions leading to disability—such as chronic obstructive airways disease, emphysema, stroke, Parkinson's disease, etc.;
- conditions that make them disorientated, confused or panicked when removed from a familiar environment—such as autism, Alzheimer's disease or agoraphobia;
- learning or mental disability that causes difficulty in making and keeping surgery-based appointments;
- severe dental anxiety and phobia such that people feel unable to enter a dental surgery.

A 'mix and match' approach, which mixes domiciliary and surgery-based care and matches it to the complexity of the dental procedures, can be adopted for some people. For example, anxious patients may feel able to attend the surgery once establishing a rapport with the dental team on a domiciliary basis has helped to reduce their fear. The dental hygienist can play a pivotal role in building this trust, while providing oral health education and dental prophylaxis/scaling in the home—allowing further treatment to take place in the dental surgery. Regular review of an individual's need for DDC is advocated as improved health may mean that some people are able to return to attending the dental surgery. Furthermore, experience shows that people are generally prepared to make the effort required to visit the surgery in the knowledge that it is only necessary occasionally. Thus, it may be prudent to use a minimum number of well planned visits to the dental surgery to perform technical or complex procedures (such as a surgical extraction for a person on anticoagulation therapy) whilst carrying out other procedures in the home (such as denture provision).

DOMICILIARY VISITING PATTERNS

On average an NHS dentist provides home care for 2.9 patients per month.[3,10] There are no easily available statistics for DDC visits made by independent/private practitioners or community dental staff. Most visits are made out of regular office hours, on the general dental practitioner's way into work or home. Treatment provision is mainly limited to examinations, hygiene procedures, denture provision and simple extractions[3,10,11] although the advent of adhesive filling materials and techniques allows restorations and adhesive bridges to be added to this treatment list. Dentists who do not provide DDC state their reasons as:

- not feeling adequately prepared or up-to-date in this area;[11]
- insufficient demand for the service;
- poor remuneration;

- inadequate equipment; and
- reduced quality of work.[12]

TRAINING ISSUES

Not surprisingly, research has established that dentists are more likely to provide DDC if they have already done it or if they have been shown how to do it.[1,13,14] Until recently, training in geriatric dentistry in the undergraduate curriculum has on the whole been confined to ambulatory, elderly people attending dental hospitals[14] and no experience in DDC was gained until individuals were required to provide this modality of care. Fortunately, this picture is changing.[13] However, when staff who do not have DDC experience join a practice, they require training in order to develop and maintain the knowledge and skills necessary for providing domiciliary care—perhaps by accompanying an already experienced clinician.

It is also prudent for the new member of the team to be trained in basic life support so that they are able to deal with emergency situations which may arise in the home, in manual handling to avoid personal injury whilst lifting and carrying domiciliary equipment, and in health and safety issues (to promote safe practice).

Knowledge and Skills

Domiciliary care requires the dentist or dental hygienist to transfer her or his skills from the dental surgery to the kitchen, sitting room or the bedroom whilst respecting the individual's culture, wishes and home.[15] The domiciliary dental team of dentists, hygienists and dental nurses can benefit from developing their knowledge and understanding of conditions leading to impairments and disabilities and how they can affect oral health. A good knowledge of medical conditions and their associated problems, the causes and management of medical emergencies, the use of domiciliary equipment and gerodontology is important. Teamwork is fundamental to the organization and smooth running of DDC; flexibility, improvisation, anticipation and assertiveness are necessary to cope with the plethora of environments and circumstances encountered.

Although many of the skills required for DDC are transferable from the dental surgery, they may need to be developed to facilitate quality of care and safe practice outside the traditional dental setting. For example, communication (used daily to build trust and rapport between dentist and patient) is enhanced by developing skills of non-verbal communication to deal with people who have learning disabilities or Alzheimer's disease. When treating patients with hearing impairments, the use of a face visor rather than a mask aids communication during treatment as it permits lip reading; and the provision of written information helps to ensure understanding. Networking and liaising with general medical practitioners, district nurses, community psychiatric nurses, social services staff and carers is essential in situations where information is required about patients or where patients require support from other services.

REMUNERATION

The provision of oral care to disabled people is more time consuming than the provision of oral care to non-disabled people. This means that their care comes at a higher cost. This cost is even greater when the care is provided outside the conventional dental setting, whether it is via mobile dental units or domiciliary dental care. Although some dentists set up mobile dental services or dedicate their practice to domiciliary dental care, they are the exception rather than the rule.[16,17] Additionally, such services tend to be targeted at elderly people in residential care where reasonable numbers of patients can be seen per visit. Individual house-bound people are not an attractive financial proposition. Indeed, they are often not a *viable* financial proposition.

Dentists cannot be expected to deliver more than the occasional home-based dental visit if there is no financial incentive to do so. So who should pay for the service—the government, the local authority, the disabled individual? The last would certainly not allow equitable access to oral care. Salaried general dental practitioners and the Community Dental Service (CDS) act as a 'safety net' to provide care for people who cannot access mainstream general dental practice. Both services provide the extra time required for the oral care of disabled people in the dental, or the home, setting. However, although the CDS also provides a degree of expertise in this field, it is constantly under threat of financial cutbacks. General dental practitioners working within the NHS are paid an additional fee for making a home visit—but this is a fee per domiciliary circuit rather than per visit, and is dependent on the distance travelled rather than the number of patients visited. The reverse situation (a fee per visit) would be more encouraging.

Unless these issues are resolved, disabled people living in non-residential settings are at risk of being denied access to continuing oral care services.

Figure 1. Rechargeable battery-operated portable handpiece.

Time Management and Planning

Provision of dedicated time during the week for domiciliary care is more cost-effective than responding to the need on an *ad hoc* basis; similarly, having a basic dedicated domiciliary kit (which can be added to as required) is time saving. Obviously, occasional emergency domiciliary visits will be required outside the 'dedicated' time but forward planning helps to prevent problems and maximize the use of available time and resources. In our experience it is useful, before the first visit, to telephone the patient and:

Figure 2. *Working in a domiciliary environment using the Dentronic portable domiciliary unit. (Reproduced by kind permission of J & S Davis.)*

- clarify the dental problem and the need for a domiciliary visit;
- check the correct address and obtain directions;
- enquire about parking facilities;
- determine any special requirements, such as the need for a carer or a translator, collection of a key from a neighbour, etc.

In addition, it is helpful to send a medical history questionnaire for completion and return and send a written appointment confirming the visit (this is a task which can be delegated to the practice manager or receptionist).

DOMICILIARY EQUIPMENT

The equipment and materials required by a practice depend on the number and type of visits planned and the resources available to purchase them. The principle to remember in assembling a domiciliary kit is to keep it simple—unless planning to do a reasonable number of home visits on a regular basis, adequate for most practices will be a basic examination kit, a prosthetic kit (including a portable hand-piece), a small box of hand instruments, an adhesive filling material and a selection of extraction forceps. A convenient method of housing the examination and prosthetic units is in a baby-care box. A small compartmentalized toolbox can be used for hand instruments and filling materials. The kits should be restocked after each visit so they are ready for anyone in the practice to pick up and use.

DDC restricted mainly to the provision of dentures and simple extractions places little demand on the provision of domiciliary equipment. The most sophisticated item required is a motor with a straight handpiece for denture adjustments (Figure 1). A rechargeable, battery-operated motor costs only £300-400 but can have a high return in terms of usefulness and convenience. They can be purchased with straight handpieces only or with both straight and contra-angled handpieces. Although 'hobbiest' drills are available much more cheaply it is not possible to sterilize them adequately as they are not designed with infection control in mind and we do not advocate their use.

The increasing demand for DDC by dentate people has led to the development of portable restorative dental units (Figures 2 and 3). Purchase of a portable dental unit is a considerable financial investment—in the order of £2000-7000—and research to find out which of the available units best fits your needs is recommended. Ideally, arrange a 'road test' before buying the unit. Units which house a compressor weigh between 11 and 17 kg. Units without compressors are much lighter, but require either a separate compressor or compressed gas cylinders to run them.

Lighting can range in sophistication. An anglepoise lamp with a clamp for use on a chairback or table edge is useful (Figure 3) and a portable fibreoptic light can help to diagnose caries in the absence of radiographic facilities. Portable dental chairs are available, but they add extra weight and bulk to the domiciliary kit. Christensen and Fiske[15] point out that some elderly and disabled people feel particularly vulnerable when receiving dental care in the reclined position and, if the dentist can work from in front of the patient, an upright chair with a cushion for a head support against a wall may be suitable. However, the lack of a dental chair can jeopardize the operator's posture. From an ergonomic point of view, the dentist may prefer to stand behind the seated patient, supporting the patient's head against their body (Figure 3). When taking lower impressions or scaling lower teeth, kneeling puts the dentist at a height where good posture and comfort can be maintained (Figure 4).

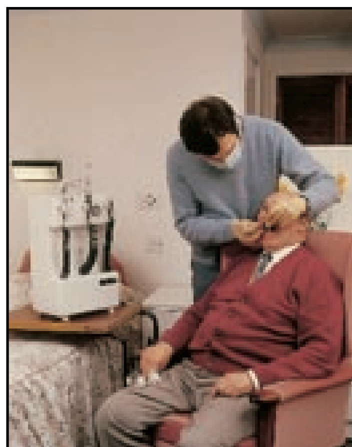

Figure 3. *Eddystone 'Gocase' in a domiciliary setting. (Reproduced by kind permission of Eddystone Dental Company.)*

Figure 4. *A domiciliary dental team at work.*

Table 2 lists some items of domiciliary equipment. A domiciliary kit checklist is available from the authors.

HEALTH AND SAFETY

Domiciliary care involves a wide variety of environments and the dental team may not always have complete control over the conditions. However, privacy, confidentiality, access to water and electricity and adequate lighting must always be ensured. There are a number of health and safety issues which must be addressed.

Safety of the Individual and their Home

These are paramount. People should be

Name	Manufacturer/supplier	Approximate price (excluding VAT)
Portable units:		
Eddystone Gocase	Eddystone Dental Company	£2800
Mini-dent domiciliary unit	Dentronic/J & S Davis	£5800
Pac-1	A-Dec Dental	£2500
Portable dental surgical unit	Den-doc	£5850
Portable handpieces (rechargeable):		
Etelna micromotor	Orthomax	£410
Derota	Quayle	£300
Light source:		
Denlite	Hemming Visual Aids	£225
Lightpen	Quayle	£275
Voroscope MXL	Garth Jessamine Healthcare	£175
Portable headrest	Ambulance Safety Systems, Yeovil	£85
Heat source:		
Safe Air	Healthco	£85
Carrying box:		
Baby box	Mothercare	£18

Table 2. *Domiciliary equipment details.*

dissuaded from allowing strangers access to their home without proper identification and the dental team should encourage good practice by carrying and showing identification.

The nature of the patients being treated means that there is greater chance of encountering a medical emergency on a domiciliary visit than in the dental surgery. Thus, the team should consider carrying (and ensuring they are able to use) oxygen and emergency drugs. The May 1999 General Dental Council revision of *Guidance on Resuscitation*[18] states that: 'it is essential that all premises where dental treatment takes place have available portable suction, oral airways, portable oxygen and attachments to provide intermittent positive pressure ventilation'. As a minimum the dentist should carry a Laerdal mask, Guedel airways, oxygen and Ambubag to facilitate cardiopulmonary resuscitation, should it be necessary, and a mobile phone so that the emergency services can be called. If oxygen is carried, not only must health and safety guidelines on transportation of flammable gases be complied with but also the vehicle insurance company should be informed.

Risk Assessment

Risk assessment of the environment at each new establishment should become routine. For example:

- ensuring that there is an obstacle-free passage from the patient to the work surface, sink, etc.;
- routinely using a circuit-breaker on all electrical appliances;
- employing safe practice such as avoiding the use of naked flames.

Infection Control

Infection control in the domiciliary setting uses the same principles that are applied in the dental surgery. All environments can be zoned for identification of clean and dirty areas, and disposable items used whenever possible. Dirty instruments must be kept separate from the domiciliary kit and transported in rigid containers, and sharps must be transported in a sealed sharps container. Any local health authority guidelines for disposal of clinical waste in the home should be complied with. In their absence, it is reasonable to dispose of non-sharp waste in the household rubbish, as this is what would happen if the person had a nose bleed. If working in an establishment such as a residential home, where yellow bags and sharps containers are available, they should be used. Any waste that is to be transported back to the surgery should be double-bagged and transported in a rigid container.

Personal Safety

Personal safety is also important. It is a legal requirement that a third party is present when a dentist or dental hygienist makes a home visit. It is recommended that the dentist/hygienist should be accompanied by a member of the dental team in an individual's home, and accompanied by a staff member or a member of the dental team in a residential home or hospital. Personal alarms and/or mobile telephones should be carried by the dental team. In accordance with manual handling training and guidelines, domiciliary equipment and materials should be transported on a trolley when possible (see Figure 5) and patients should be lifted or moved only using proper procedures.

TREATMENT PLANNING

The principles applied in the domiciliary environment should be the same as those used in the dental surgery setting. In many instances it will be necessary to discuss the management of patients with complex medical conditions with their general medical practitioner or hospital

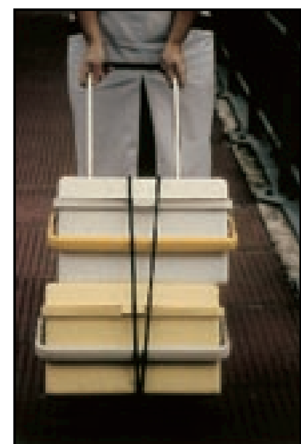

Figure 5. *Transporting heavy equipment using a trolley.*

consultant before drawing up a definitive management regime. The provisional treatment plan, the need for further investigations, the possibility of any changes to the treatment plan and the timetable for treatment needs should be discussed with the patient and/or carer and recorded in the patient notes. When working with people with learning disabilities or mental illness, consideration must also be given to the issue of informed consent. In such a situation it is a legal requirement to gain a second opinion from another health professional (a doctor or another dentist) that the proposed treatment is in the best interests of the patient. Legally, a family member or carer cannot give consent on behalf of another adult; however, it is prudent to involve them.

In this way an appropriate and realistic treatment plan can be negotiated and agreed before the individual is issued with a written treatment plan and estimation of cost (where charges are incurred).

In a situation where domiciliary care is required over only a short period of time (for example, a person recovering from a fracture of the neck or the femur), it is reasonable to delay the provision of elective dental procedures until the patient can visit the surgery. Liaison with the local CDS is worthwhile as the staff can often provide expert support for patients requiring either additional management because of their disabilities (such as people with Alzheimer's disease) or additional time because of communication difficulties (for example, people who have severe Parkinson's disease or who have had a stroke).

ADVANTAGES OF DDC

To the Patients

The advantages of DDC to the client include better access to dental services and increased independence as they are not reliant on a carer or transport service. They may feel less anxious, and more involved in their dental care, when it is provided in a familiar environment. A person may feel more able or inclined to disclose personal information to the dental team, or to ask questions of them, as confidentiality is increased. A visitor may be a welcome contact and the fact that the dental team are guests can give a service user more control and confidence.

To the Practitioner

There are also a number of advantages for service providers. It gives the dental team the opportunity to meet the client in their own surroundings and to provide a holistic approach to care. It gives access to medication and any patient-kept medical notes, and provides clues about eating habits. It allows an assessment of the person's ability to comply with oral hygiene advice—for example, can they get to a bathroom/sink? Can they stand/ sit at the sink and manage toothbrushing? The client is usually more comfortable and relaxed in their own surroundings, rapport is improved and there may be more compliance with treatment and preventive regimes.[15] Additionally, DDC reduces the frustrations of failed appointments and waiting for transport to arrive, and it is a pleasant change of scenery to visit patients out of the surgery environment.

DISADVANTAGES OF DDC

To the Patient

The disadvantages of DDC from a user's viewpoint are that there can be a longer wait for treatment and a limited choice of service provider. The individual may feel more vulnerable and see the visit as an invasion of their privacy. A domiciliary visit can cause disruption of the patient/ carer's routine.

To the Practitioner

There are also disadvantages for service providers, who often feel a lack of control when working outside the conventional dental setting. It is difficult to anticipate all requirements and compromises may have to be made. There is lack of emergency back-up and potentially increased vulnerability to personal safety. Domiciliary visits can be time consuming, and it is more difficult not to become involved with a client's personal life and problems. Also, the range of treatment which can be provided may be limited.

CONCLUSION

The increasing numbers of dentate elderly and disabled people results in an increasing need for the provision of domiciliary care.[7] Legislation to improve access of disabled people to care will contribute to greater demands for domiciliary services[6] and therefore domiciliary dental care services are needed to improve access to dental care for people unable to receive such care in a dental surgery and to make the services acceptable to patients, their carers and their families. This requires improved training and more opportunities to gain experience for both undergraduates and practising members of the dental team, and revision of the remuneration system is needed to reflect the additional time and skills required for DDC.

Acknowledgements

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BOOK REVIEW

Introduction to Dental Ethics and Law (Teaching Pack). The Dental Defence Union, 1998. Available from Rupert Hoppenbrouwers, Head of Dental Defence Union, 3 Devonshire Place, London W1N 2EA.

This is not a book, it is a teaching pack designed to complement or assist with the teaching of ethics and law. Its target groups are those tutoring students, in the later stages of the undergraduate programme of study, or vocational dental practitioners. In producing the pack the DDU have augmented their own expertise by consulting widely throughout dental academia and with the legal profession.

The subject matter of this 'introduction to dental ethics and law' is divided into three broad areas; professional ethics, consent and confidentiality. As an aid to teaching, each of these subjects is presented as a lecture. For each lecture the pack contains a CD Powerpoint slideshow presentation and the same on OHP acetate, recognizing the extremes of facilities available at educational centres. It would be hoped, as I have not tried, that the Powerpoint slideshow can be transferred for conventional projection. In addition, there are audience handouts, which are paper copies of the slideshow, and lecturer's notes which contain the occasional footnote to the slideshow. All the material is contained in a large A4 ring binder.

The lecture devoted to professional ethics covers this subject in its broadest sense; that of professional conduct. It lays down the responsibilities of the profession and its members to the patient. It refers, for the most part, to the General Dental Council – 'Maintaining Standards'.

The matter of consent is often perceived as a difficult area in the practice of dentistry. The general issues are covered well in this lecture, even if not to any great legal or moral depth, the slide sequence presenting them in a logical and coherent way. The specific issues of the treatment of minors; the child as the decision maker and refusal of treatment is dealt with more than adequately. It is a little disappointing, then, that the specific issue of the incompetent adult is limited to the last slide in the series. This area of ever increasing concern deserves a little more attention, indeed this topic could be the subject of one lecture!

Confidentiality is one of the most difficult areas of ethics and the law. The presentation beguiles that complexity. The lecture leads through the reasons for the duty, to whom it applies, record keeping, patient access to records (omitting computerized records), to the justification/requirement for disclosure, and ending with a 'confidentiality checklist' which is a useful reference for any dentist who may find themselves in this situation.

The provision of ready made lectures may be a most helpful resource for some, not so for others. Many lecturers in this subject are very experienced and will no doubt have their own style or format for delivery and may have different ideas on the precise content. It is not always easy to deliver a lecture prepared by someone else. One small point on the presentations is that the DDU/MDU logo is prominent. It is clear that each lecture is prepared by the DDU and I am not sure that this approach to 'sponsorship' will be acceptable to all.

The absolute strength of this teaching pack lies in the case studies; 19 in all. The cases not only cover the subject areas of consent and confidentiality so providing additional teaching material, but also pay attention to other issues; whistleblowing, negligence, giving appropriate advice, the provision of services and even dealing with the press. Each case study has tutors' notes attached which provide a concise discussion of the issues, but there are few references to any supplementary reading material (excluding judgements). The beauty of the cases, in addition to the fact that they are probably based on real events, is two-fold. First, they will fulfil the promise that this teaching pack will stimulate debate because there is not always a right (or wrong) answer. Second, the cases will allow other members of the teaching staff to support the, very often sole, lecturer in this subject. There is no reason why, for example, the case studies relating to children should not form part of the teaching programme for Paediatric dentistry.

For some reason the case studies are contained within the lecture on confidentiality. When presenting the case studies through Powerpoint this may cause a minor difficulty. I think it would be better if they could be placed in a separate presentation on the CD; this is not so much of a problem for the OHP acetates.

The DDU is to be commended for producing this teaching pack, which, notwithstanding the above comments, is excellent. It will be an invaluable aid to many responsible for the delivery of this increasingly important area of the vocational training programmes. There are many other areas of ethics and law in relation to dentistry and it must be hoped that further volumes will be published.

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