NEBDN Special Care Dentistry

SATURDAY 4TH OCTOBER

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CONSULTANT IN SPECIAL CARE DENTISTRY (BHSCT)

Part 3

Saturday 4th October	Subject
9.30am – 11am	Definitions, models and philosophies & Development of Disability Awareness
11.15am – 1pm	Barriers to Provision of Oral Care & Legislation, guidelines and Policies
1.45pm – 3pm	Communication, Organising Care and Supporting the Patient
3.15pm – 4.30pm	Pain and Anxiety Control & Conscious Sedation & General Anaesthetic

Communication, Organising Care and Supporting the Patient

Subject	Knowledge *.....should be able to describe:*	Skills *.....should be able to:*	Attitudes and Behaviours *.....should:*
7.1 Communication	7.1.1 the basic elements of communication and the importance of each 7.1.2 the impact of impairment and disability on the mode of communication of the individual 7.1.3 person –centred communication e.g., communicating with people who hear voices, communication with people with autistic spectrum disorder, people with aphasia or dysarthia, people with sensory disorders 7.1.4 alternative and/or augmentative communication	7.1.5 communicate effectively with patients, parents, families and carers, other members of the extended care team and within the dental team 7.1.6 modify communication methods to be appropriate for each individual 7.1.7 should be able to deliver person-centred oral health messages 7.1.8 liaise/arrange for the appropriate communication assistance e.g. BSL	7.1.9 demonstrate good communication 7.1.10 demonstrate listening skills 7.1.11 demonstrate a positive attitude to using a variety of communication skills
7.2 Organising care	7.2.1 appropriate referral systems to and within special care teams where care is shared according to the needs of the individual 7.2.2 appropriate referral systems from and to other specialities 7.2.3 seamless care and integrated care referral pathways 7.2.4 preparation of the dental environment for people with impairments and disabilities	7.2.5 manage and process referrals in the manner most appropriate for the individual patient 7.2.6 schedule appointments in a manner that will maximise the ability of the patient to attend and receive care 7.2.7 refer to relevant guidance within special care documentation 7.2.8 liaise with all members of the multidisciplinary team	7.2.10 strive to ensure seamless care for the individual 7.2.11 demonstrate understanding of the needs of the individual when planning appointments and organising care 7.2.12 demonstrate understanding of the importance of pre-appointment communication with individual patients/carers and wherever possible be a 'named nurse'

Subject	Knowledge *.....should be able to describe:*	Skills *.....should be able to:*	Attitudes and Behaviours *.....should:*	Teaching and Learning method(s)	Assessment method(s)
		7.2.9 arrange suitable transport where appropriate			
7.3 Supporting the individual during treatment	7.3.1 the use of different methods of supporting the individual during care including the use of adjuncts 7.3.2 moving and handling protocols including the use of equipment 7.3.3 the use of wheelchair tipping devices 7.3.4 person - centred care 7.3.5 a definition of clinical holding	7.3.6 adopt a holistic approach to caring for the individual 7.3.7 use moving and handling equipment to help an individual transfer to the dental chair/trolley 7.3.8 perform a risk assessment to help agree if clinical holding would/would not be advised 7.3.9 help arrange for an appropriately trained team to carry out any clinical holding necessary 7.3.10 communicate effectively with the individual throughout the treatment – in the most appropriate manner for that person	7.3.11 work within limits of training and expertise 7.3.12 ensure that equipment is serviced and in good working condition 7.3.13 ensure moving and handling training is up to date	CE SDL ST	FA RoC

Levels of care for Special Care Dentistry. Taken from NHS England8

Level of Care	Summary
Level 1	Special care needs that require a skill set and competence as covered by dental undergraduate training and dental foundation training, or its equivalent.
Level 2	Is defined as procedural and/or patient complexity requiring a clinician with enhanced skills and experience who may or may not be on a specialist register
Level 3a	Special care needs that require management by a dentist recognised as a specialist in Special Care Dentistry at the GDC-defined criteria.
Level 3b	Special care needs to be managed by a dentist recognised as a specialist in Special Care Dentistry at the GDC defined criteria and holding consultant status.

guid-comms-specl-care-dentstry.pdf

Level 1 complexity of care (SCD)	
Preventative care for patients with additional needs:	Appropriate oral hygiene advice; for example, adapted tooth-brushing aids or unflavoured toothpaste Diet advice Fluoride prescription and applications Liaison with carers or relatives in preventative care Use of appropriate skill mix; for example, dental care professionals.
Reasonable adjustments for patients with additional needs:	Time; for example, longer appointments or flexibility with cancellations, times of day Equipment and facilities; for example, ground floor surgeries, disabled parking, disabled toilets (reasonable adjustments as per the Equality Act 2010) Communication; for example, access to interpreters including British Sign Language, provision of information in a patient-centred format such as Easy Read Print.
Awareness of relevant guidance:	Safeguarding Consent and capacity Guidance relevant to certain medications such as anticoagulants or bisphosphonates.
Shared care with level 2 or 3 services where appropriate:	Refer patients following local referral criteria and pathway as per local managed clinical network in SCD To carry out a written treatment plan from a SCD specialist provider where appropriate Where contractual agreements and appropriate team training allow, provision of Advanced Mandatory Services; for example, conscious sedation or domiciliary care, to treat some patients with additional needs in primary care.

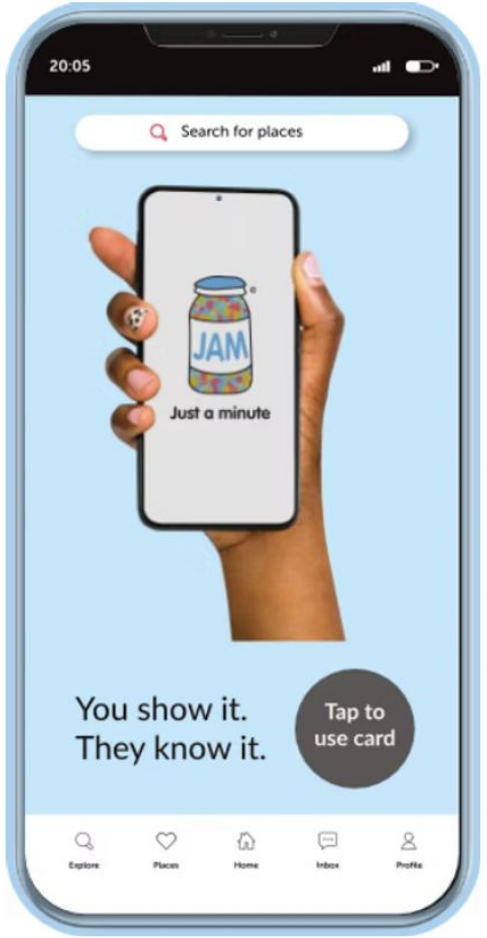
General Dental Service

Special Care Patients:

- Independent living or with family / carers who can bring
- Mild to moderate disabilities
- Mild to moderate medical problems
- Domiciliary care (variation UK)
- Sedation services (variation UK)
- Access issues – accessible premises, interim bariatric chair (Up to 28 Stone)
- No GA facility (Poswillo, 1990)
- Knowledge and skill mix
- Shared care – prevention, regular exams

Services in Northern Ireland (GDS)

- Domiciliary care
- Sedation services (ASA 1,2)
- Dementia friendly dental practice
- JAM card friendly dental practice



Community Dental Service

Variation across the UK:

- Paediatric and special care dentistry
- Sedation services
- General anaesthesia
- ‘Safety net’ service people who cannot access GDS
- Epidemiology
- Oral health promotion
- Screening and oral health prevention programmes
- Inclusion services
- Secure units
- Manual handling adjuncts
- Bariatric care
- Long term or acute inpatients
- Domiciliary care

Level 2 Care[11]	Level 3 Care[12]
Facilities Providers must provide within the service: • Hoists • Wheelchair recliner • Positioning aids • Access to specialist transport services • Variety of communication aids • Bariatric facilities • Equipment to support the delivery of all modes of conscious sedation to the contemporaneous standard[13]	**Facilities** Providers must provide: • Access to facilities for providing general anaesthesia • Medically supportive hospital settings to enable care of people with highest medical risk

Who can be referred?

- Learning disability
- Mental health
- Physical disability and/or access issues
- Complex medical needs
- Anxiety or phobia
- Cognitive impairment
- Frail older person
- Bariatric patients
- Vulnerable groups

CDS

Socially or geographically disadvantaged:

- People experiencing homelessness / unhoused
- Asylum seekers
- Prisoners
- In-patients secure units
- Centres for rehabilitation substance misuse
- Rurally isolated, who may require special conditions or scheduling of appointments

Mobile dental units

Patient groups	Access points
• Learning disability • Neurodiversity • Physical disability • Mental health • Prisoners/ offenders • People experiencing homelessness / unhoused • Substance misuse • Travelling community • Remote or rural areas • Older people • Migrants • Looked after children	• Day centres • Community mental health teams • Community drug and alcohol crisis teams • Secure units • Homeless shelters • School based programmes • Extended care facilities • Housing complexes • Work sites • Nursing or care homes

Domiciliary Care

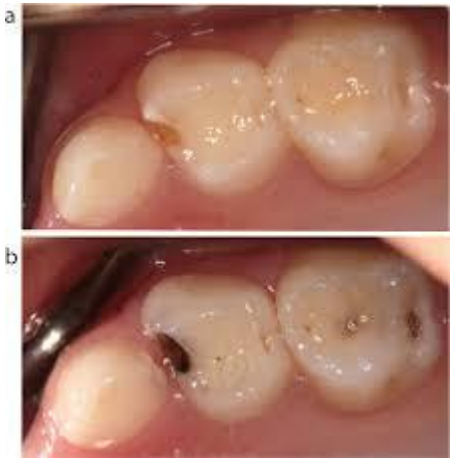
Location and facilities available

Surgery-based care remains the *gold standard* for irreversible treatment

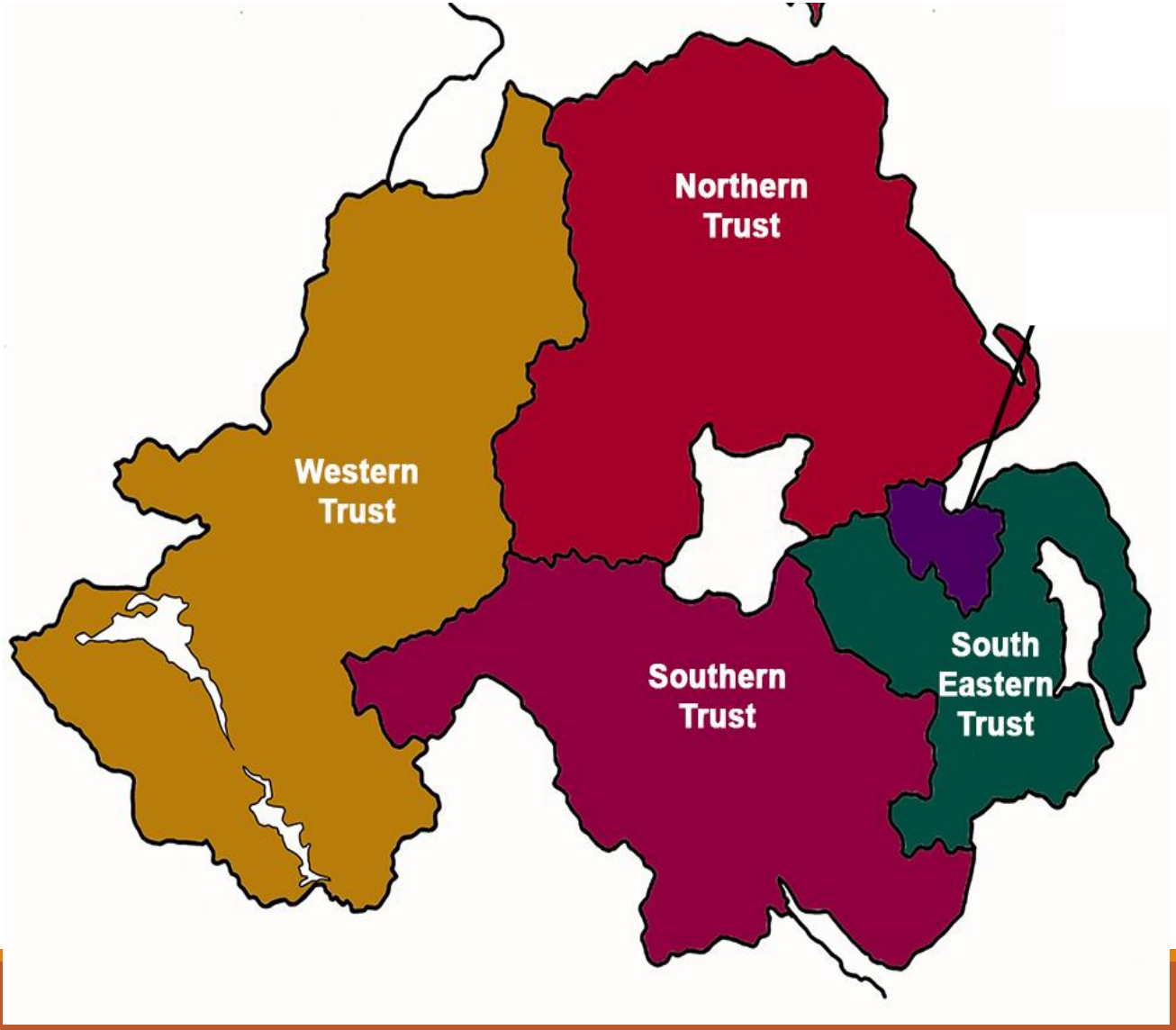
Demand for services increasing

Increasing patient expectations

Increasing dentate disabled population



Services in Northern Ireland



Secondary Special Care Dentistry Services

Community Dental Service

Hospital Access

- Adult Special Care GA

(except Belfast Trust)

The Community Dental Service

Department of Health, Social Services and Public Safety
www.dhsspsni.gov.uk

Scope of Service Specification

HSC

12/29882

Statement of Purpose

The Community Dental Service (CDS) serves the community by providing direct patient care and preventive programmes to people who, because of their special care needs, are unable to access appropriate dental services elsewhere. These services are provided in both Community and Hospital settings.
We will be a model of best practice in providing oral healthcare which is high quality, evidence-based and timely.

Values

In order to ensure that we achieve our statement of purpose we will:

- Ensure that we have the necessary **skills and competencies** to deliver a quality service
- Ensure that our delivery of oral healthcare service enshrines **best practice and the available evidence-base** and is open to innovative approaches to working
- Ensure that we have robust **accountability arrangements**
- **Manage our resources**, including our time, as efficiently and effectively as possible
- Demonstrate a **commitment** for fairness, equality and respect for each other and our patients
- Promote **team-working** and working in partnership with others both inside and outside the health sector

1. Scope of Service

(a) Providing oral care, including GA/Sedation, for people with Special Care Needs:

i. a learning disability
ii. a compromising medical condition
iii. a mental illness
iv. physically disabled
v. housebound/ institutional resident
vi. patients with significant anxiety or behavioural difficulties who cannot be treated in a general dental practice
vii. children identified as high risk by demographic or health indicators who are not suitable for general dental practice.

(b) Evidence based oral health improvement programmes

i. evidence-based Caries Reduction Programme (EBCRP); for the following groups: young children, the elderly, special care needs
ii. all Oral health education and oral health improvement programmes should be agreed with the Northern Ireland Oral Health Improvement Group (NIOHIG)

(c) Needs Assessment (Epidemiology)

i. screening groups identified as part of the local Service Agreement (SA)†
ii. undertaking national and local surveys as directed by the HSCB/DHSSPS

(d) Research

undertaking/facilitating agreed research

2. Governance & Accountability

(a) Production of annual business plan in line with the SA†

i. defining long and short-term objectives
ii. setting targets
iii. identifying milestones
iv. producing activity returns and management information

(b) Governance

i. develop a sound system of internal control that supports achievement of targets and objectives
ii. review the adequacy of clinical governance, risk management and standards compliance.
iii. participate in an annual accountability review with the HSCB to review performance against the SLA.
iv. take part in uni- and multi-disciplinary audit/peer review as required

† The SA is an agreement between the HSCB and HSC Trust

Offer patient care to people who are unable to access appropriate dental services elsewhere because of their special care needs

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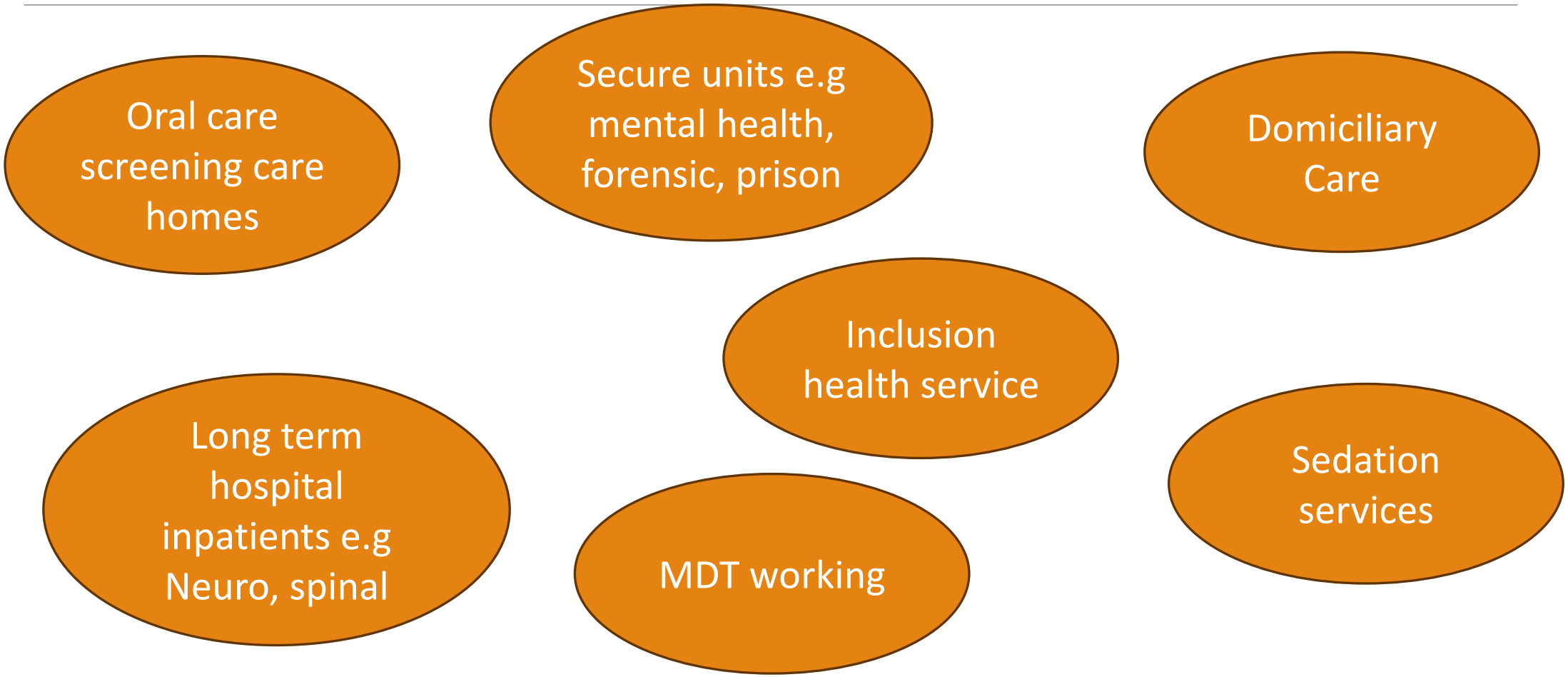
Community Dental Services in NI



Belfast Health and Social Care Trust

caring supporting improving together

SCD tertiary service in NI

QUEEN'S UNIVERSITY BELFAST

BHSCT SCD tertiary service

Belfast Health and Social Care Trust

caring supporting improving together

- Consultant SCD delivered service since 2012
- Referrals received from trust catchment area
  - Local anaesthetic monitoring
  - Anaesthetic led intravenous sedation
  - General anaesthetic
- Referral from all other trusts in Northern Ireland for higher risk patients and those requiring overnight stay / inpatient treatment

BHSCT SCD tertiary service

Belfast Health and Social Care Trust

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- Consultant SCD delivered service since 2012
- Referrals received from trust catchment area
  - Local anaesthetic monitoring
  - Anaesthetic led intravenous sedation
  - General anaesthetic

ACID TEST:

Is anaesthetic team required due to special care needs to ensure safe delivery of treatment ?

- Referral from all other trusts in Northern Ireland for higher risk patients and those requiring overnight stay / inpatient treatment – Copy / letter anaesthetic assessment

Hospital Dental Services for SCD in UK

Hospital dental services manages those unsuitable for CDS:

- Severe physical, neurological and/or movement disabilities
- Severe learning disabilities
- Complex behavioural and psychological conditions
- Unstable medical conditions ASA 3,4
- Complex medical conditions need support from medical specialities

For example; Haematology, haem-oncology, immunology – Type 1 allergic reactions, C1 esterase deficiencies, unstable epilepsy

- Access - Ambulance transport, stretchers, bariatric care
- Sedation not suitable for CDS or ASA 3 and above – anaesthetic or dental operator led
- General anaesthetic services – day case, inpatient

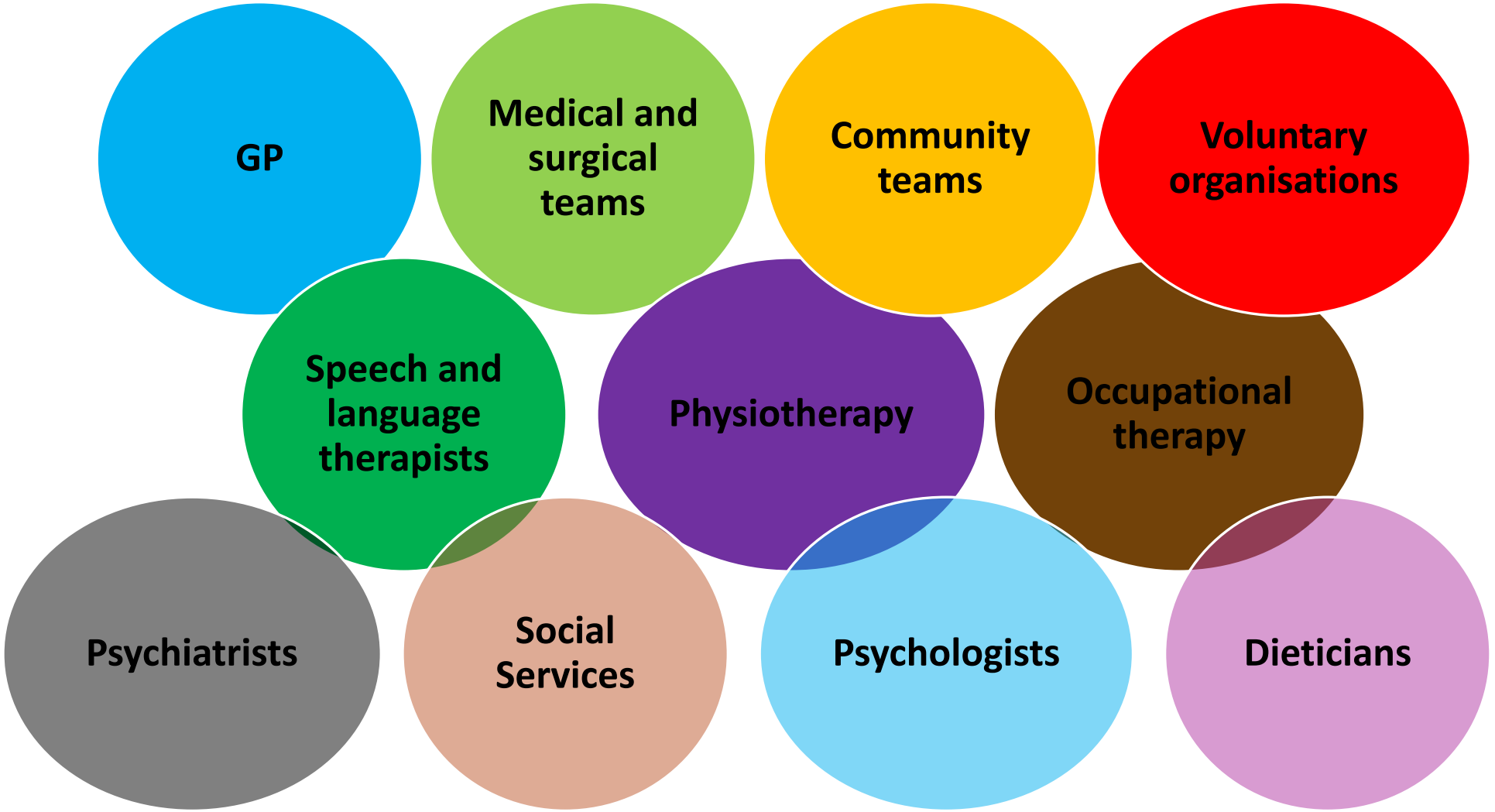
Shared care within dental services

Skill mix in the dental team

- Dental Care Professionals – oral health promotion, fluoride application, quality improvement projects
- Dental hygiene and therapists – domiciliary, in clinic, sedation, secure units, mobile dental units
- Lab technicians e.g. pathological lip biting in acquired brain injury

- Oral surgery
- Paediatric dentistry – transitional care
- Orthodontics
- Oral medicine
- Restorative

Multidisciplinary Care



Managed Clinical Networks in SCD

Set up in England and Wales following published commissioning guidance and clinical standards for dental specialties

Provide clinical leadership in order to facilitate patient-centred care

Develop clearly defined care pathways in SCD

Support the implementation of evidence-based pathways across all sectors

of service provision

Monitor service provision across the region

Communicate with other regional MCNs in order to either adopt or adapt relevant systems and approaches that may be of benefit to the local population

Promote oral healthcare programs

Membership of the MCNs are variable but may include consultants and specialists in SCD and public health, trainees, academic representatives, dental officers, GDPs, DCPs and management

South East Wales MCN - NHS Wales

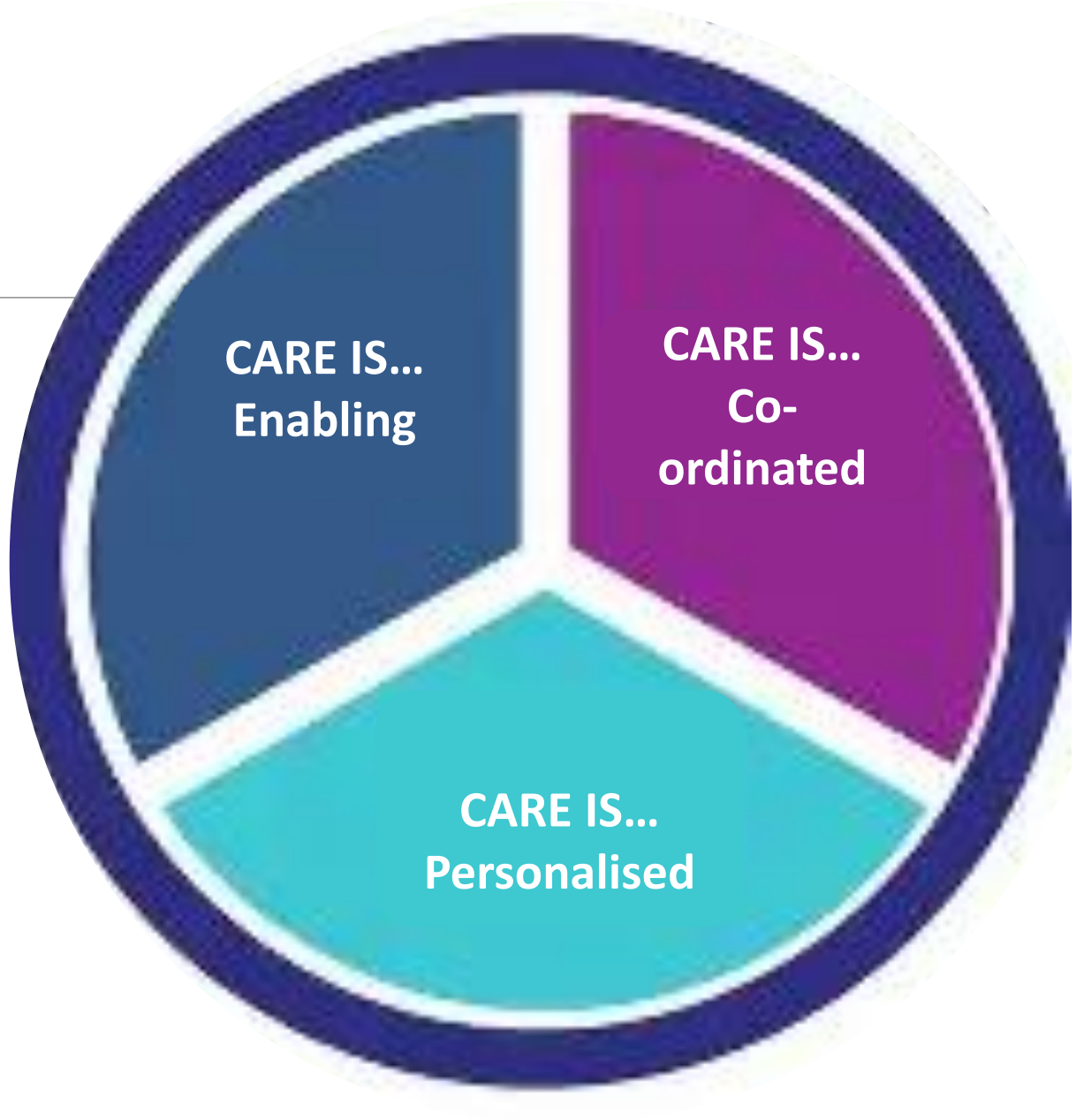
Website link to South East Wales MCN to look at published care pathways

https://www.nhs.wales/sa/managed-clinical-networks-for-special-care-dentistry/south-east-wales-mcn/

Patient Centred Care

Focuses on the care needs of an individual

Person is treated with dignity, compassion and respect

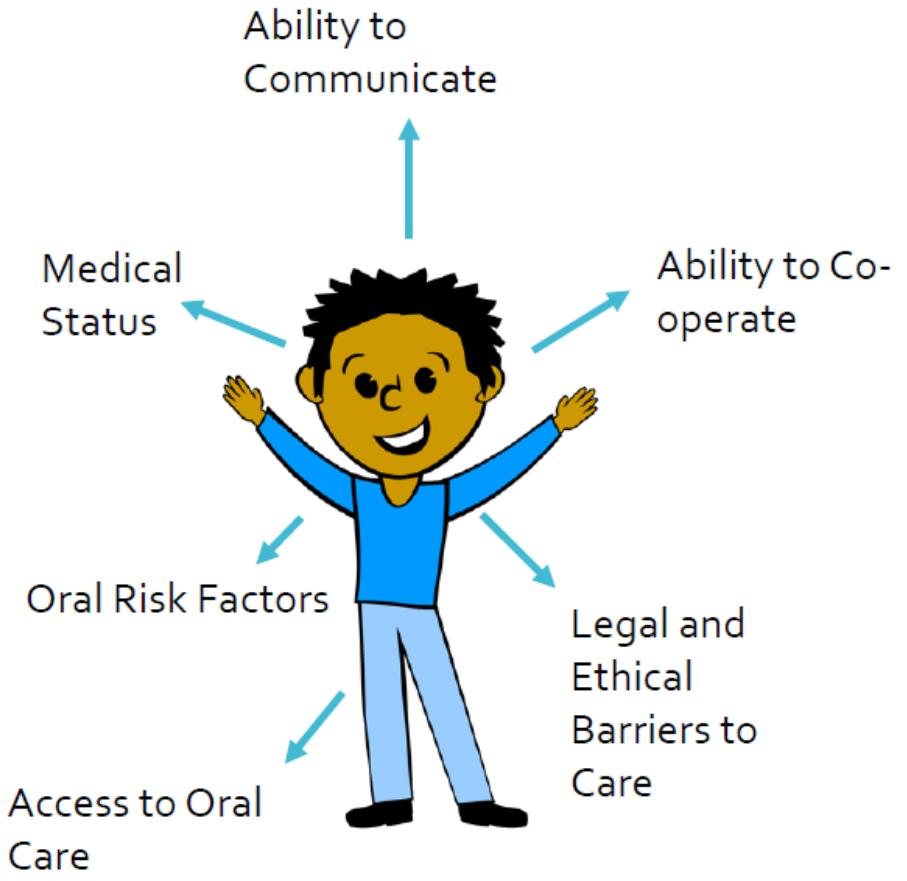


Case Mix

Case Mix was developed by the British Dental Association (BDA)

Response to the Department of Health's guidance 'Valuing People's Oral Health'

Developed in Primary Care for Special Care –further developed to measure Paediatric patients



BDA Case Mix Tool Scoring system

Used for each episode of care.

- **Narrative** for each criteria and scale points.
- Four point scoring scale:

  O, A, B, C

- **Measures patient complexity**

CASE MIX	O	A	B	C
Ability to communicate	0	2	4	8
Ability to co-operate	0	3	6	12
Medical status	0	2	6	12
Oral risk factors	0	3	6	12
Access to oral care	0	2	4	8
Legal and ethical barriers	0	2	4	8

1 - 0: No complexity.
2 - 1-9: Mild complexity.
3 - 10-19: Moderate complexity.
4 - 20-29: Severe complexity
5 - 30+: Extreme complexity.

Banded Total Weighted Score:

WHY USE CASE MIX?

- Commissioning special care services
- Performance management tool
- Ensure appropriate deployment of resources
- Assist in oral health needs of SCD patients

It can aid communication of the complexities involved in the individual patient case to other members of the dental team and can be utilised in establishing referral pathways (Bateman *et al*., 2010)

Not intended to reflect or give weight to the complexity of dentistry undertaken

Ability to communicate

Issues of communication between the dental team and the patient/ parent/ guardian/ carer while in the surgery

0	Free communication with adequate understanding between patient, parent, guardian, carer and dental team.	0
A	**Mild restriction** • Some difficulty in communication but can overcome • Patient / parent / guardian speaks English but not as first language • Patient/ parent/ guardian can communicate for themselves without intervention of 3rd party • Patient/ parent/ guardian has mild learning difficulty • Very young child with limited verbal communication	2
B	**Moderate restriction** • Non- verbal communication necessary • Child/ parent has autism or other communication impairments • Child/parent has moderate learning difficulty • Limited communication only possible	4
C	**Severe restriction** • No ability to communicate due to impairment • Multiple communication aids required • Interpreter/ 3rd party required to communicate	8

Ability to co-operate

Reflects circumstances where patient co-operation affects delivery of dental care
Patients may vary between appointments; average experience

0	Patient will accept all restorative care and simple extractions with LA +/- routine behavioural management techniques	0
A	**Some difficulty in co-operation** Full examination and/or simple treatment possible, but requiring additional support or behaviour management techniques	3
B	**Considerable difficulty in co-operation** • Limited examination only possible • Clinical holding required • Patient will accept limited restorative care with difficulty • Patient requires multiple acclimatisation visits to accept treatment	6
C	Patient requires general anaesthetic, sedation or other advanced management techniques to accept treatment	12

Medical Status

Reflects circumstances where modifications have to be made to the provision of dental care due to the MH

0	• Adequate medical history obtainable at appointment with no significant relevance to this course of treatment • No additional investigations required	0
A	**Some treatment modification required** • Medical history unable to be obtained at first appointment • Further information required in order to complete medical history	2
B	**Moderate impact of medical or psychiatric condition on provision of care** • Medical or psychiatric status complex or unstable, affecting the provision of treatment • Child in need	6
C	**Severe impact of medical condition on provision of care** • Multidisciplinary review required to treat • Multidisciplinary appointment for medical reasons	12

Oral risk factors

Reflects the specific risk factors which require a higher than average resource to be allocated to their care

0	**Minimal risk factors** • Stable oral environment; teeth brushed twice a day with fluoride paste • Can comply with all aspects of 'Delivering Better Oral Health' advice	**0**
A	**Moderate risk factors e.g.** • Can comply with most aspects of 'Delivering Better Oral Health' advice • Child unable to brush effectively themselves • Good Oral Hygiene hindered by malocclusion /manual dexterity • Course of treatment following a period of neglect	**3**
B	**Severe risk factors e.g.** • Extensive support to achieve some aspects of 'Delivering Better Oral Health' advice • Oral hygiene relies on 3rd party to maintain • Child uses non-fluoride toothpaste • Cariogenic diet resulting in uncontrolled caries • Molar Incisor Hypomineralisation with symptoms or post-eruptive breakdown • Altered salivation • Access to oral cavity severely restricted • Children with severe dental or craniofacial developmental abnormalities	**6**
C	**Extreme risk factors e.g.** • Unable to comply with any aspects of 'Delivering Better Oral Health' • Unable to brush effectively due to challenging behaviour or limited co-operation • High calorie supplementation • Regular sugar-containing medication • Severe xerostomia • PEG feeding • Immunocompromised	**12**

Access to oral care

Reflects complexities surrounding patient access to care at any point during the course of treatment

0	**Unrestricted** • Patient can access surgery without additional requirement • Child accompanied by a parent	0
A	**Moderately restricted** • Patient who fails to attend, or cancels at short notice, more than once in a course of treatment • Child who is not brought to an appointment more than once in a course of treatment • Patient requires support to access the surgery eg carer attends; administrative support	2
B	**Severely restricted** • Specialised equipment required to attend the surgery (eg ambulance, hoist, wheelchair tipper, slide board) • Child whose parent (or vulnerable adult whose carer...) repeatedly cancels, giving concern about possible disguised compliance	4
C	**Domiciliary care required***	8

*This criteria is intended **ONLY** for patients seen on a "domiciliary" basis in a hospital or nursing home. Do not use for operating theatre cases

Legal and ethical barriers

Considers consent and capacity

0	No legal or ethical issues affecting care; e.g. No problems with consent or parental responsibility.	0
A	**Some legal/ethical difficulties may arise** • Best interests' decision not requiring additional correspondence • Child in need	2
B	**Moderate legal/ethical difficulties may arise** • Fluctuating capacity to consent • Best interests' decision requires additional correspondence with carers/ relatives • Financial responsibility requires further clarification • Child who is subject to a care order • Child who is the subject of a child protection plan • Parental responsibility requires further clarification • Looked after child	4
C	**Severe legal/ethical difficulties** • Multi-professional consultation/ case conference required including but not limited to, child protection meeting • Referral to an IMCA • Safeguarding referral made	8

Case 1

64 year old female

MH: Two strokes 17 years ago, left sided weakness

Dysphasia – slurred speech

Dysphagia – can take thickened fluids, PEG fed, frequent PEG infections

Mitral valve replacement 5 years ago

Taking Warfarin – unstable and checked weekly

Relies on husband to drive to appointments

Frail, under care dietician and taking Ensure drinks

Brushes teeth twice daily with 1.1% sodium fluoride toothpaste and Corsodyl gel

CASE MIX	O	A	B	C
Ability to communicate	0	2	4	8
Ability to co-operate	0	3	6	12
Medical status	0	2	6	12
Oral risk factors	0	3	6	12
Access to oral care	0	2	4	8
Legal and ethical barriers	0	2	4	8

Case 1

A/0/B/C/A/0

Case Mix Score: 22

Category 4

CASE MIX	O	A	B	C
Ability to communicate	0	2	4	8
Ability to co-operate	0	3	6	12
Medical status	0	2	6	12
Oral risk factors	0	3	6	12
Access to oral care	0	2	4	8
Legal and ethical barriers	0	2	4	8

1 - 0: No complexity.
2 - 1-9: Mild complexity.
3 - 10-19: Moderate complexity.
4 - 20-29: Severe complexity
5 - 30+: Extreme complexity.

Case 2

Low support need autistic 17 year old

Does not make eye contact

Talks to Mum who acts as communicator

Hearing impairment – wears hearing aids, can lip read

Recall exam – good co-operation for exam

Brushes teeth once daily with fluoride toothpaste

Relies on Mum to bring to appointments

CASE MIX	O	A	B	C
Ability to communicate	0	2	4	8
Ability to co-operate	0	3	6	12
Medical status	0	2	6	12
Oral risk factors	0	3	6	12
Access to oral care	0	2	4	8
Legal and ethical barriers	0	2	4	8

Case 2

A/0/0/A/A/0

Case Mix Score: 7

Category 2

CASE MIX	O	A	B	C
Ability to communicate	0	2	4	8
Ability to co-operate	0	3	6	12
Medical status	0	2	6	12
Oral risk factors	0	3	6	12
Access to oral care	0	2	4	8
Legal and ethical barriers	0	2	4	8

1 - 0: No complexity.
2 - 1-9: Mild complexity.
3 - 10-19: Moderate complexity.
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5 - 30+: Extreme complexity.

Case 3

26 year old male

MH: High support need autism

Profound learning disability

Non speaking

Supported living with 24 hr support from carers

Wheelchair user – seen in own wheelchair

Recall exam – Very limited examination, attempted to use toothbrush for access. Relies on carers to brush teeth twice daily with 1.1% sodium fluoride toothpaste – variable co-operation

Relies on carers to brings to appointments

CASE MIX	O	A	B	C
Ability to communicate	0	2	4	8
Ability to co-operate	0	3	6	12
Medical status	0	2	6	12
Oral risk factors	0	3	6	12
Access to oral care	0	2	4	8
Legal and ethical barriers	0	2	4	8

Case 3

C/C/0/B/B/A

Case Mix Score: 32

Category 5

CASE MIX	O	A	B	C
Ability to communicate	0	2	4	8
Ability to co-operate	0	3	6	12
Medical status	0	2	6	12
Oral risk factors	0	3	6	12
Access to oral care	0	2	4	8
Legal and ethical barriers	0	2	4	8

1 - 0: No complexity.
2 - 1-9: Mild complexity.
3 - 10-19: Moderate complexity.
4 - 20-29: Severe complexity
5 - 30+: Extreme complexity.

Case 4

- 40 year old male
- MH: Noonan's Syndrome
- Deaf – requires BSL interpreter or written communication
- Platelet defect – liaison with haematology requires tranexamic acid prior and post op dental procedures
- Accepts treatment under LA
- Planned for scaling and filling under LA
- Brushes teeth once daily
- 2 new carious lesions since last recall
- Lives alone – self transport to appointments

CASE MIX	O	A	B	C
Ability to communicate	0	2	4	8
Ability to co-operate	0	3	6	12
Medical status	0	2	6	12
Oral risk factors	0	3	6	12
Access to oral care	0	2	4	8
Legal and ethical barriers	0	2	4	8

Case 4

B/0/B/A/0/0

Case Mix Score: 13

Category 3

CASE MIX	O	A	B	C
Ability to communicate	0	2	4	8
Ability to co-operate	0	3	6	12
Medical status	0	2	6	12
Oral risk factors	0	3	6	12
Access to oral care	0	2	4	8
Legal and ethical barriers	0	2	4	8

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4 - 20-29: Severe complexity
5 - 30+: Extreme complexity.

NHS England – Guide for commissioning services – Special Care Dentistry 2015

Casemix category	Level 2 care: Dentist with enhanced skills or experience	Level 3 care: Registered Specialist/ Consultant
Communication	Significant communication difficulties due to multi-sensory or cognitive impairment	No verbal communication ability due to severe cognitive impairment
Co-operation	Presents with a disability, psychological or mental health state that means: • only limited examination is possible • significant treatment interruption due to inability to co-operate, inability to tolerate procedure or inappropriate behaviour resulting in only a limited examination May require: • Advanced anxiety and behaviour modification techniques, e.g. progressive desensitisation, Cognitive Behavioural Therapy • Conscious sedation for moderate phobia / gagging, or concomitant disabling/ medical / mental health condition	Presents with severe disability or mental health state that prevents them from co-operating with dental examination and/or treatment. May require: 1. Specialist experience of managing combative, agitated or inappropriate behaviour in patient at risk of harm to self or others 2. Basic/Advanced sedation techniques dependant of level of co-operation, anxiety and treatment required 3. Assessment of patient requiring dental treatment under GA 4. Significant clinical holding involving Level 2 or 3 holds / multidisciplinary working
	• Clinical holding of patient should only be undertaken following risk assessment and by a dental team with appropriate training in clinical holding [3]	

NHS England – Guide for commissioning services – Special Care Dentistry 2015

Medical	ASA 3 moderately controlled medical condition(s) Progressive degenerative medical/ disabling condition: intermediate stage where specialised service of risk assessment is required • Management under specialist supervision	ASA 3 unstable and ASA 4 medical condition i.e. significant risk of medical emergency Progressive degenerative medical / disabling condition: advanced stage May require: • multifactorial / multispecialty medical risk assessment • treatment in medically supported hospital setting • use of conscious sedation in ASA III/IV conditions • shared medical care e.g. haematology, radiology, oncology, cardiology, respiratory medicine
Access	Requires NHS transport to access dental surgery and/or special equipment to transfer to dental chair (manual handling risk assessment, hoist)	Patients who require secondary care facilities for access
Oral risk	Oral hygiene requires support of third party	Access to oral cavity for dental treatment severely restricted by major positioning difficulties, inability to open mouth, or dysphagia problems Patient unable to tolerate home oral care provided by 3rd party Requires multi-disciplinary management of oral care with high risk factors for oral disease
Legal and ethical	Best interests require 2nd clinical opinion Doubtful or fluctuating capacity to consent, clinician required to make best interest decision and consult/ correspond to do so	Patients requiring a Deprivation of Liberty standard or a court decision regarding their oral care. Clinician required to make a non-intervention decision where there is extreme difficulty in providing care and it is not in the patients best

Access

Can the patient get to the building?

The building	Accessible premises Transport e.g. Taxi, Ambulance
Dental chair	May relay on support/escort for appointments
The Mouth	Unable to access clinic Safety, behavioural concerns

Access

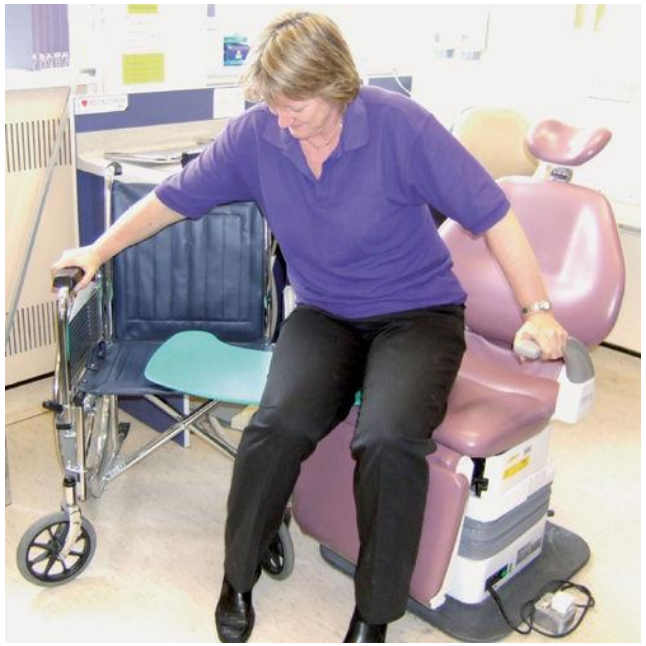
The building

Dental chair

The Mouth

Can the patient get into the dental chair?

Accessible premises
Manual handling aids e.g banana board
Brake leg chair
Sara steady
Hoist
Own adapted wheelchair
Wheelchair platform
Bariatric services (>23 stone)
Support pillows
Mobile carts, suction, dental chair



Banana Board

Sara Steady

Access

The building

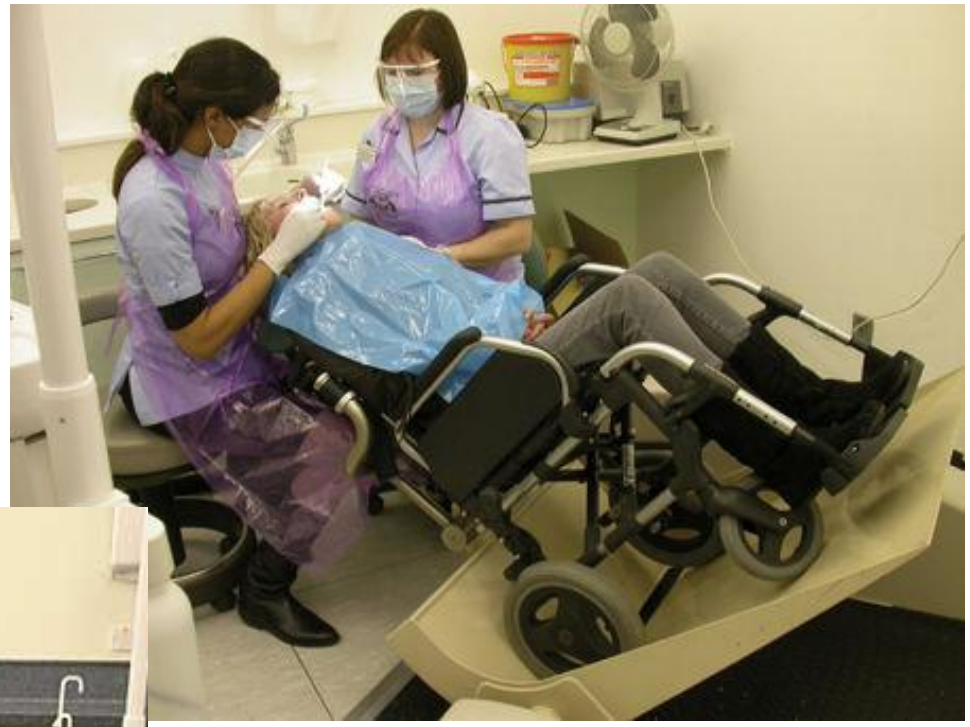
Dental chair

The Mouth

Examples: Cerebral palsy, Multiple Sclerosis, Stroke, Huntington's, Parkinson's, acquired brain injury, profound learning and physical disability, kyphosis (curvature of the spine), advanced dementia, physical disability

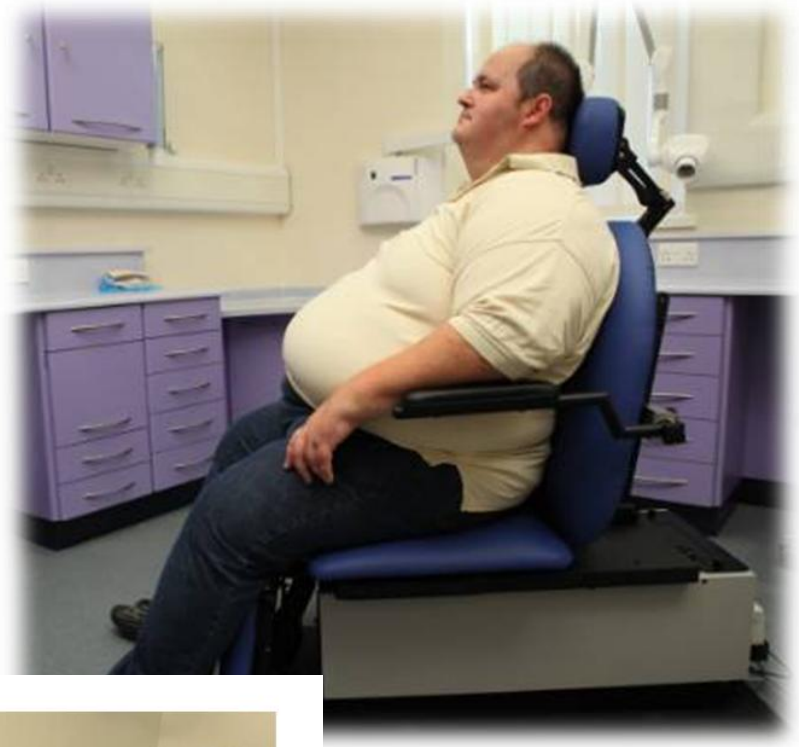
Wheelchair Tipper

- Check safe working load
- Manual handling risk assessment
- Training
- Not suitable all chairs




DESIGN
SPECIFIC

Bariatric facilities



Safe working load: (SWL) Can be up to 60-70 stone

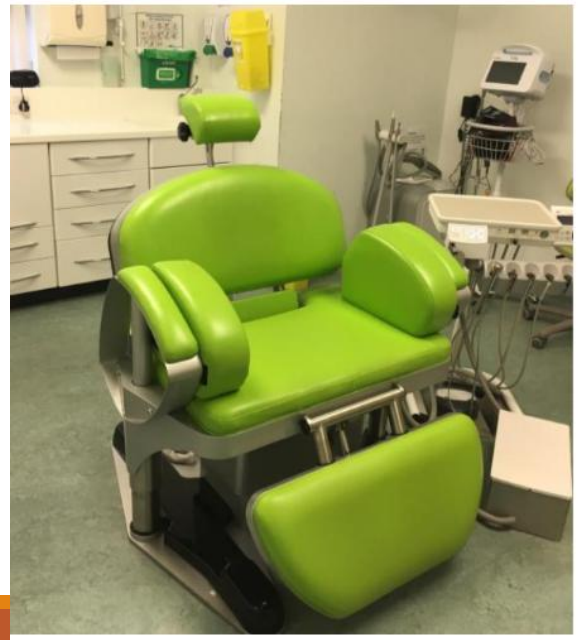
Interim chair usually up to 28 stone SWL

Wider seat

Brake leg design

Manual handling risk assessment

Training



Bariatric bench – 42 stone (300kg)

Reverse Trendelenburg and Trendelenburg

THE OXFORD HELP®

Head Elevating Laryngoscopy Pillow

Bariatric Facilities

NOT JUST THE CHAIR

Needs to be considered for all aspects of patient journey

- Parking
- Access to the building
- Waiting room and escort chairs
- Toilets
- Medical emergencies – larger NIBP cuff, venous access
- Hoist that can take up to the same safe working load
- Scales
- Staff education and training

Manual Handling

Risk Assessment

1. Identify Hazards
2. Decide who might be harmed
3. Evaluate the risks and decide on precautions
4. Document findings
5. Review and update

LOW RISK	1-3
MODERATE RISK	4-6
HIGH RISK	8-12
VERY HIGH RISK	15-25

LIKELIHOOD SCORE

a) Time Frequency Descriptor

LIKELIHOOD SCORE	1	2	3	4	5
DESCRIPTOR	RARE	UNLIKELY	POSSIBLE	LIKELY	VERY LIKELY
Frequency How often might it/ does it happen	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily

b) Probability Descriptor

LIKELIHOOD SCORE	1	2	3	4	5
DESCRIPTOR	RARE	UNLIKELY	POSSIBLE	LIKELY	VERY LIKELY
Probability Will it happen or not?	Less than 5% chance	5 – 25% chance	25 – 50% chance	50 – 75% chance	75 – 100% chance

RISK SCORE

LIKELIHOOD SCORE	1	2	3	4	5
DESCRIPTOR	NEGLIGIBLE	MINOR	MODERATE	MAJOR	CATASTROPHIC
5 Very Likely	5	10	15	20	25
4 Likely	4	8	12	16	20
3 Possible	3	6	9	12	15
2 Unlikely	2	4	6	8	10
1 Rare	1	2	3	4	5

General risk assessment template

Brief Description of activity, location or equipment: The set up and use of the wheelchair/bariatric bench
Description: Accessory to the compact wheelchair platform to accommodate mobile bariatric patients. With the compact platform in the lowered position the bariatric bench can be wheeled onto the platform and is held securely. The patient then sits on the bench and after the headrest and backrest are adjusted the bench can be reclined and the patient can receive treatment. The bench can be removed from the platform to allow it to become a mobile compact wheelchair platform.

Description of Hazards	Persons Affected by the Work Activity and How	Existing Controls	Likelihood	Severity / Consequence	**Risk Rating**

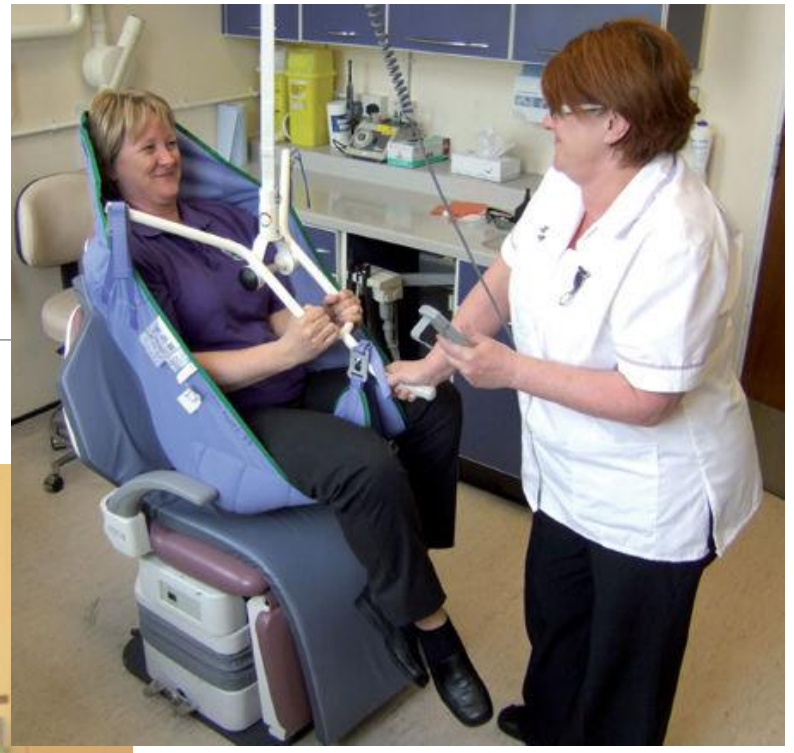
KEY TO RISK RATING: Likelihood x Severity/Consequence = Risk Rating

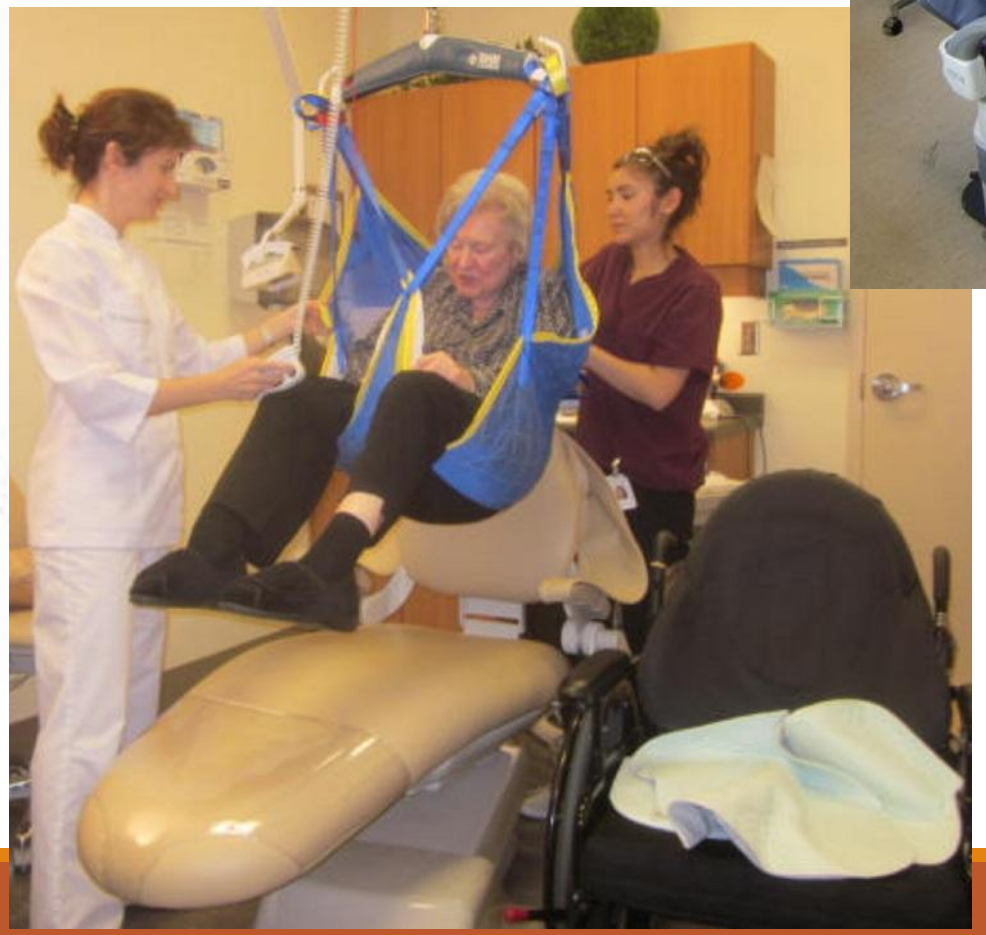
Likelihood	Severity / Consequence	Risk Rating
1 Rare	1 Insignificant	**Low Risk (Green)**
2 Unlikely	2 Minor	**Medium Risk (Yellow)**
3 Possible	3 Moderate	**High Risk (Amber)**
4 Likely	4 Major	**Extreme Risk (Red)**
5 Almost Certain	5 Catastrophic	

General risk assessment example

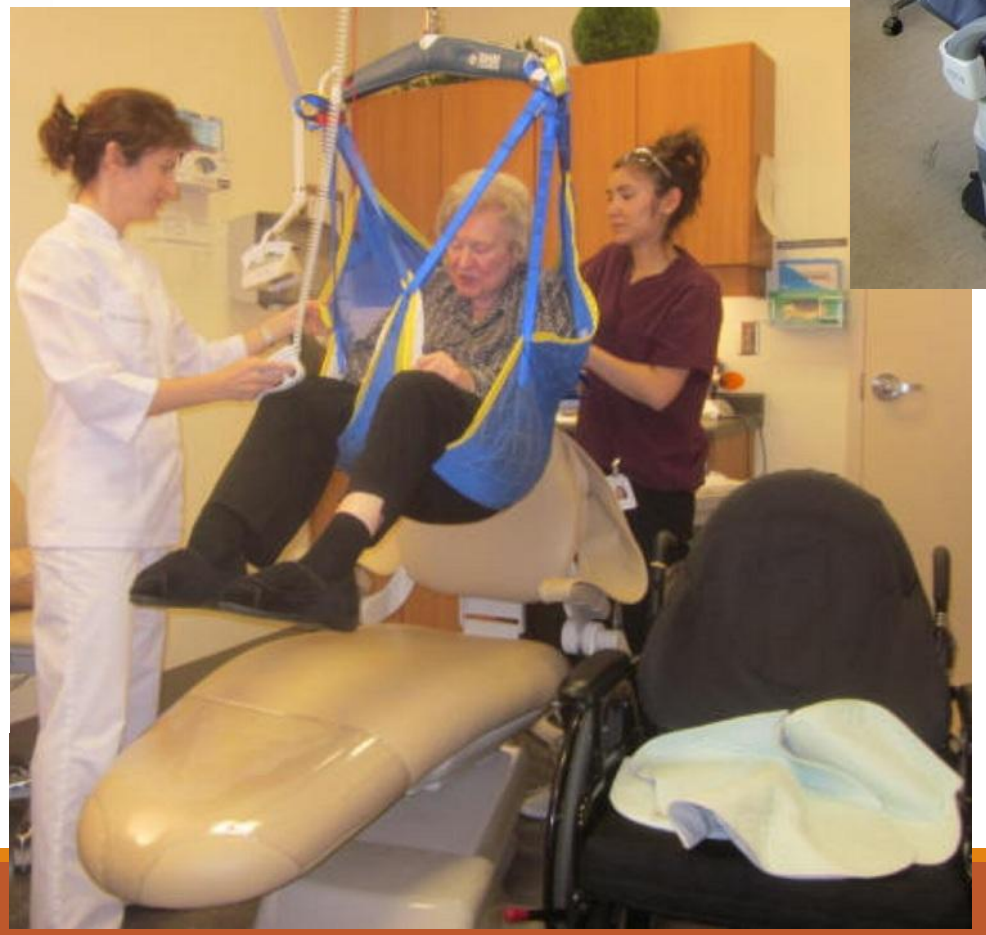
Description of Hazards	Persons Affected by the Work Activity and How	Existing Controls	Likelihood	Severity / Consequence	**Risk Rating**
Hazards by number – outling the stages of the process from set up to finishing e.g. Patient weight	Dental team but can also include wider team – contractors, domestic staff e.g. Dentist Dental nurse Hygienist Student Patient	e.g. Safe working limit 300kg / 42 stone. Max patient width 800m. Patients over SWL or width should not use. Trained staff Bariatric scales	How hazard may happens	Probability hazard will happen or not	

Patients own sling
Disposable sling with clips





Sling check at every hoisting episode
No consenous on single use slings (if kept same patient up to 6 months)



Activity C31: Overhead Hoisting - inserting a transfer sling while person sitting – loop attachments

SECTION D: PATIENT/CLIENT MOVING AND HANDLING PLAN	V2 31/03/2014
NAME:	DOB:

	Details of method and equipment
 	**Inspect sling and equipment for signs of wear and tear and report any defects immediately (If dangerous do not use).** • Position person beneath hoist track and ensure brakes of the chair are on. • Encourage person to put their hands on the arms of the chair and lean forward. • Slide sling down person's back and position lower edge of sling to the base of the spine (tailbone). • Carer kneels in front of person, grasps the end of one leg piece of the sling and gently pulls it forward along the side of the leg. Repeat for the other leg • Ensure the sling is round edge of buttocks. • Carer raises the person's foot on to carer's thigh. Place the leg piece of the sling under raised thigh and bring up between legs. Repeat for other leg. • Cross leg pieces, one through the other. • Position the spreader bar of the hoist in front of the person. • Attach the shoulder straps (on the _____* loop), the side straps (on the _____* loop) and the leg straps on the _____* loop. • Before raising person in the hoist, always ensure the sling is properly attached to the spreader bar. • Steady the person to prevent swinging while transfer in progress.

SIGNATURE:	DATE:

Check risk assessment ensure no changes

Patient weight
Size of sling
Type sling
Sling inserted vs need to insert in clinic
Sling check
Ask patient, family, carers on how usually hoist
- **Short arms long legs, document in notes**

- **Evacuation consideration**

Access

The building

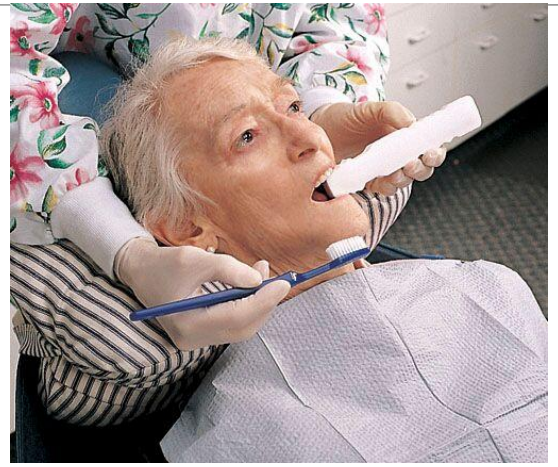
Dental chair

The Mouth

Can you examine the patient or carry out dental treatment?

- Limited opening e.g trismus, Scleroderma, post radiotherapy or chemotherapy, facial muscle spasms
- Excess soft tissue e.g obese patients
- Xerostomia may cause uncomfortable mouth e.g post radiotherapy, Sjogren's syndrome, poly pharmacy
- Oral hypersensitivity eg. Acquired brain injury, Autism conditions
- Movement disorders
- Pronounced gag reflex
- Anxiety and fear
- Psychiatric and behavioural issues
- Lack of understanding e.g Learning disability, acquired brain injury

Aids for access



Open wide
Available at:
dentocare.co.u
k

Finger guard
Available at:
dentocare.co.uk

Mouth prop
Available at:
Trycare.co.uk

Therabite
Available at:
Healthproductsforyou.c
om

Teepa Snow's Hand Under Hand Technique

Patients living with dementia but can be successful with other patient groups e.g. learning disability

OVERLAP WITH COMMUNICATION AND CO-OPERATION

How to Help a Person Living with Dementia Brush their Teeth - with Teepa Snow

Link to video

https://www.youtube.com/watch?v=6gLrH8mioCw

Desensitisation procedure

1. Ensure patient is sitting upright with optimal positioning for a stable base. You may need to give extra support with pillows etc.
2. Explain what you are going to be doing for each step. E.g. "I am going to stroke your cheek now". Try to use a calm, reassuring voice.
3. In order to gradually get accustomed to touch, start with the hands. Touch the person's hands firmly.
4. Then touch the top of the arms, again firmly.
5. Touch the shoulders firmly with both hands.
6. Touch the top of the head with both hands.
7. Support the jaw from the front with one hand. Maintain this contact throughout the oral care procedure, as this will give stability.
8. Press firmly above upper lip before you introduce the toothbrush in the mouth.
9. Press firmly below lower lip before you introduce the toothbrush in the mouth at the lower gums.
10. If patient shows hypersensitivity at any stage, stop, go back to the previous step and continue. This technique is designed to build tolerance and should not be rushed.

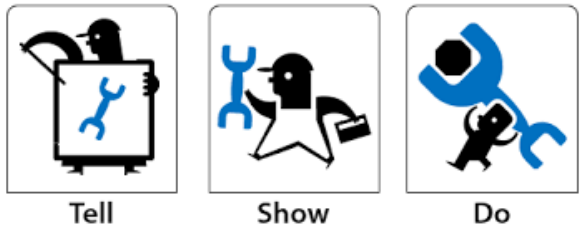
Co-operation challenges

- Dental anxiety and phobia
- Learning disability
- Autism Spectrum Conditions
- Sensory impairments
- Dementia
- Movement disorders
- Psychiatric illness
- Hearing and visual impairments

Behaviour management

BUILDING A RAPPORT WITH THE PATIENT IS KEY

Acclimatisation



Modelling

Keep instruments hidden until needed

For sensory overload - sunglasses, ear defenders, music

Positive reinforcement

Use of the WAND
Link : https://www.dentalsky.com/wand_dental

Co-operation

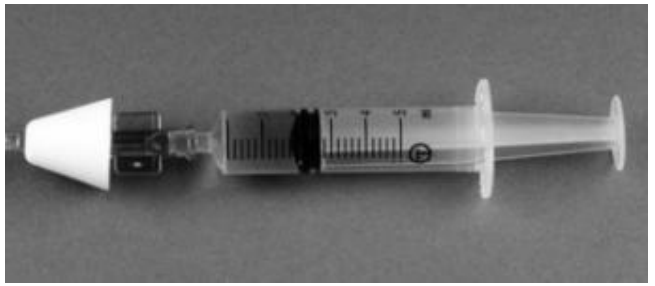
May require referral to CDS or HDS

Conscious sedation
-Inhalation
-Intravenous
-Oral
-Intranasal

General Anaesthetic

Positive Behavioural management

Used as premedication
Can be given as buccal, oral or intranasal using a MAD device (Mucosal atomisation device) below



Legal and Ethical Considerations

Capacity and consent:

All patients should be supported to make their own decisions regarding dental health

Informed consent is only valid if a patient has capacity

- Ability for a person to make their own decisions

- Time and task specific

If disturbance to the brain/mind - may affect decision making

Safeguarding Vulnerable Adults

Confidentiality

OBTAINING KEY INFORMATION

Social History

Living arrangements

Relationships

Who comes to appointments

Transport to appointments

Next of Kin – family or friends

Key worker or carer

Other healthcare professionals

Medical Status

What do you need to know?

- Up-to-date full medical history
- Stability of medical conditions
- Current medications
- Allergy Status

Who can you ask?

- Patient or Carers/Family
- GP – contact via telephone, letter or email to obtain a medical summary.
- Specialists – if there are specific queries.

Medical complexity

Co- morbidities

Polypharmacy

Unstable disease e.g angina, epilepsy, diabetes, coronary heart disease, respiratory disease

Progressive neurological degenerative medical conditions

Type 1 allergies e.g latex

Bleeding disorders e.g Inherited, acquired

- Dental treatment prior and during:
- Cardiac surgery e.g valve replacement
- Oncology treatment e.g surgery, radiotherapy, chemotherapy, bone marrow transplant, intravenous bisphosphonates
- Organ transplant, immunotherapy

Liaison with appropriate medical healthcare professionals is vital to ensure safe delivery of treatment

There are many potential factors that can increase the risk of oral disease, including:

- Poor manual dexterity
- Limited mouth opening
- Xerostomia
- Reliance on a 3rd party to complete oral hygiene
- Lack of motivation
- PEG-feeding
- High calorie supplementation
- Lack of co-operation

Prevention is key!

Oral Risk Factors

Caries risk assessment

- Oral hygiene practices
- Involvement of family, carers

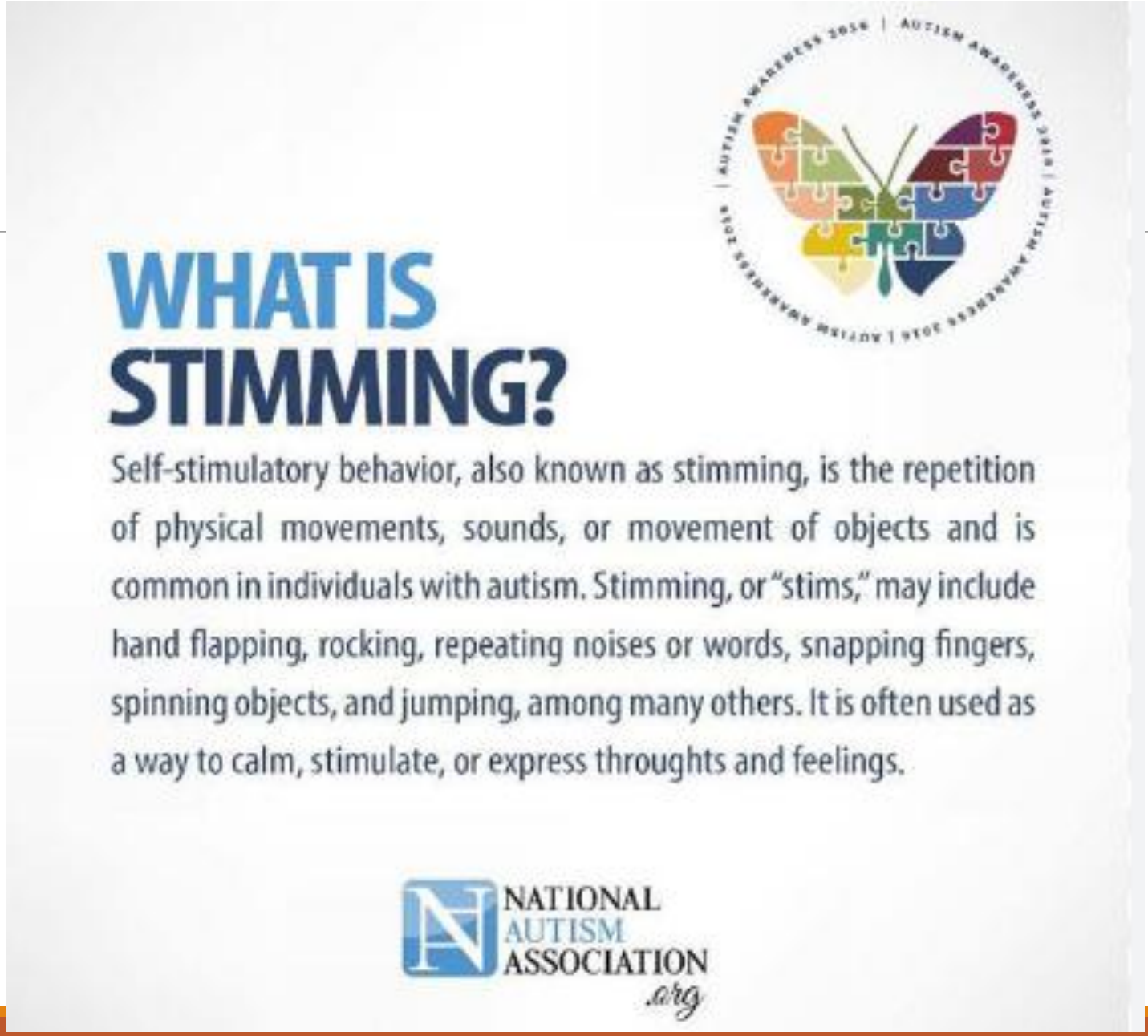
Independent vs assisted

Diet

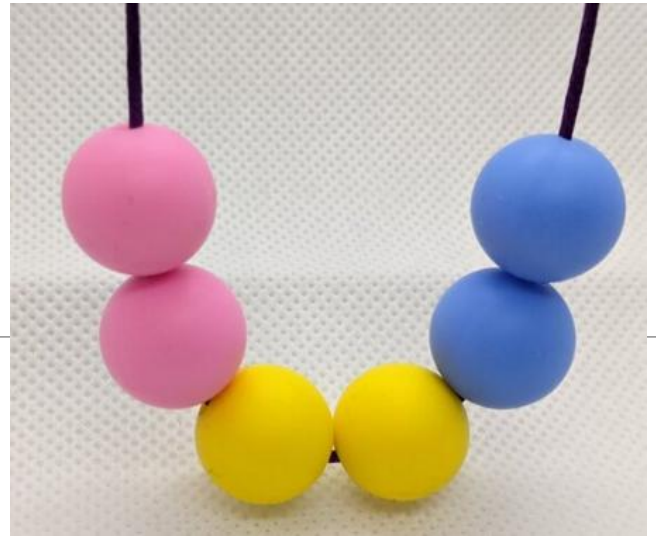
- Conditions that affect nutritional intake

E.g. Cerebral palsy, Prader Willi Syndrome

- Autistic conditions – rigid ritualistic diets
- Brides / rewards
- Pica
- Socioeconomic status


WHAT IS
STIMMING?
Self-stimulatory behavior, also known as stimming, is the repetition of physical movements, sounds, or movement of objects and is common in individuals with autism. Stimming, or "stims," may include hand flapping, rocking, repeating noises or words, snapping fingers, spinning objects, and jumping, among many others. It is often used as a way to calm, stimulate, or express throughts and feelings.
NATIONAL
AUTISM
ASSOCIATION
.org


Therapy Putty
Therapy Putty
Therapy Putty
Therapy Putty
SPIKEY




HAPPY TO TALK
LEAVE ME ALONE

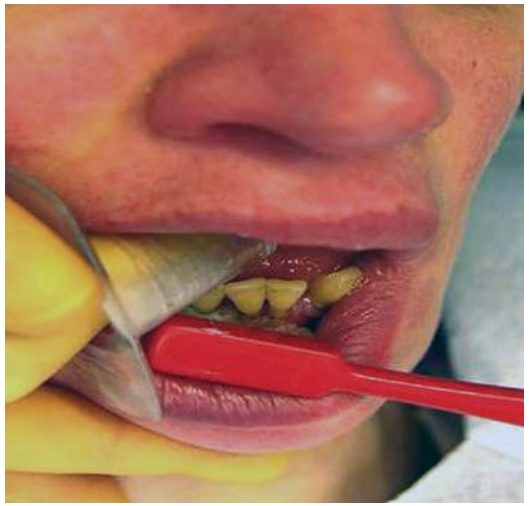
Mouth care adaptations

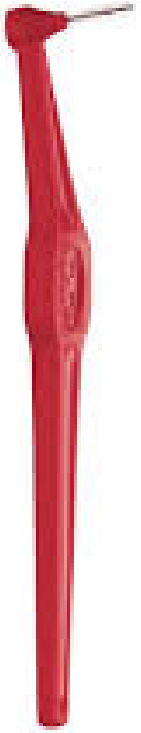
Aids and adaptations

- Modified tooth brush handles
- Powered toothbrush
- Modified brush heads

–Collis curve

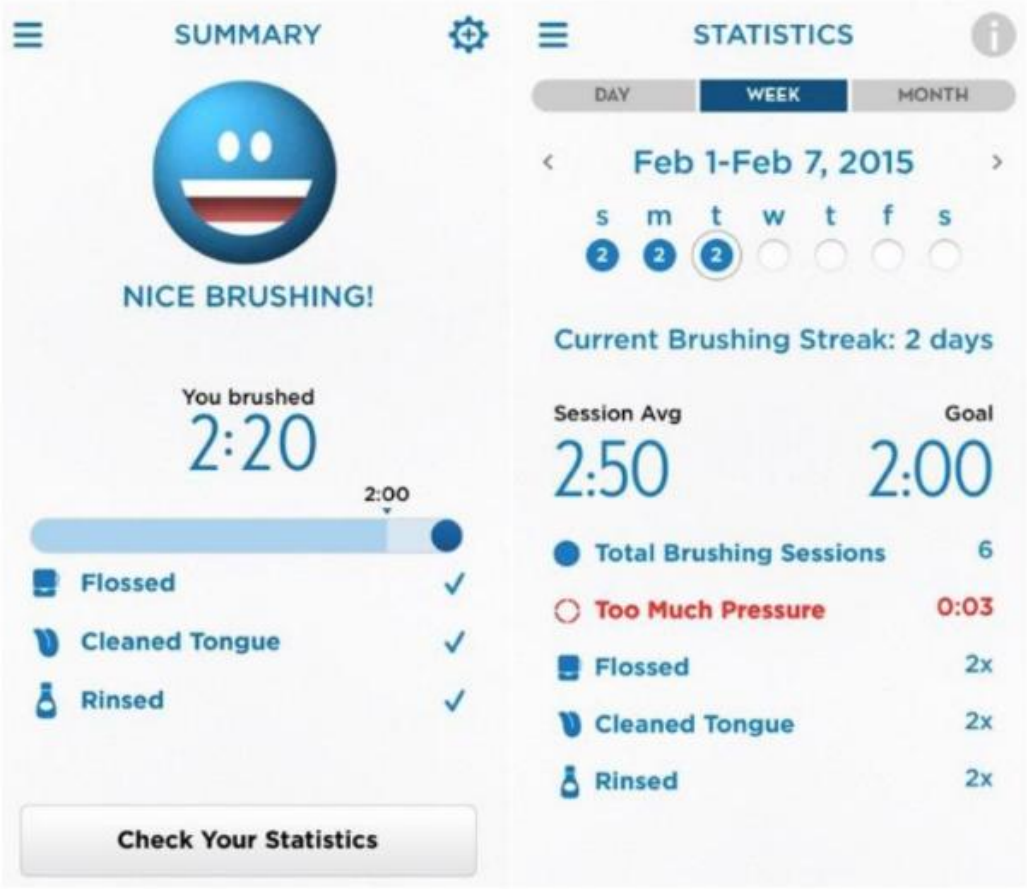
–Superbrush



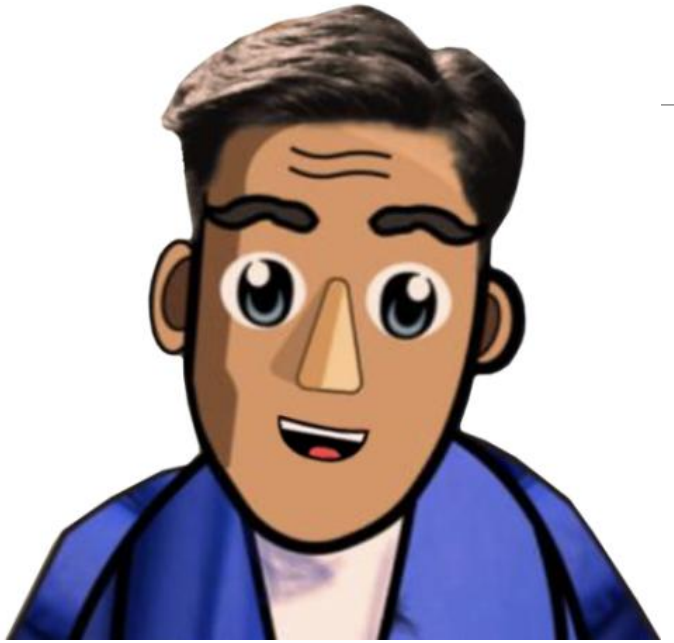



MOPMS

- Egg timers
- Watch alarms
- Phone alarms
- Apps
- Daily routine
- Song or music of required length



Brushing
Better
Together



First choose which toothbrush you use

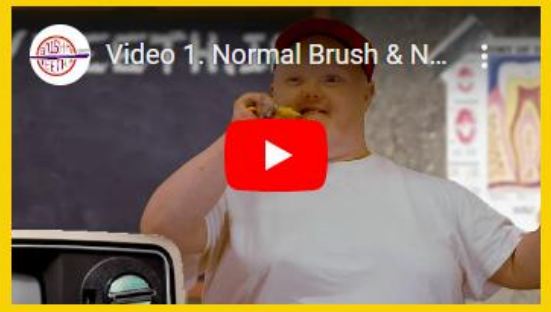
Normal toothbrush

Electric toothbrush

Special toothbrush

1

I brush my own teeth



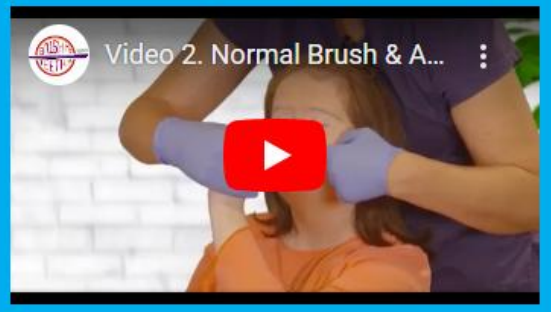
Downloads

Download Brushing Activity

Download Mouth Care Plan

2

I need a little help



Downloads

Download Brushing Activity

Download Mouth Care Plan

3

I need a lot of help

Downloads

Download Brushing Activity

Download Mouth Care Plan

Nutritional Supplements = high sugar

Average Contents	Unit	per 125ml bottle	per 100ml
Energy	kcal	300	240
Protein	g	12.0	9.6
Carbohydrate	g	37.1	29.7
Sugars	g	18.8	15.0
Fat	g	11.6	9.3
Saturated Fat	g	1.1	0.9
Fibre	g	0.0	0.0

https://www.nutriciahcp.com/adult/products/Fortisip_Compact/

Fortisip Compact
Sugars: 18.75g

Fortisip Bottle
Sugars: 13.4g

Fortisip Yoghurt
Sugars: 21.6g

Nutritional Supplements = high sugar

Fortisip Extra
Sugars: 18.0g

Fortisip Multi Fibre
Sugars: 14.0g

Fortisip Compact
Sugars: 18.75g

Fortisip Bottle
Sugars: 13.4g

Fortisip Yoghurt
Sugars: 21.6g

- Unable to stop with dietary advice
- Encouraged not to be sipped throughout the day
- May not be on medication list

https://www.nutriciahcp.com/adult/products/Fortisip_Compact/


Colgate
Duraphat® 5000 ppm Fluoride Toothpaste
Fluoride
1 g of toothpaste contains 5 mg Fluoride (as Sodium Fluoride),
corresponding to 5000 ppm Fluoride.
51g


CORSODYL
1% W/W DENTAL GEL


Nurse
Unflavoured
Toothpaste


Colgate
Duraphat®
Sodium fluoride


Oralieve®
DRY MOUTH RELIEF
Moisturising
Mouth Gel


Oralieve
Moisturising
Mouth Spray


Profluorid
Varnish
10 ml

What is dysphagia?

Difficulty in swallowing safely or effectively

Impaired or uncomfortable transit of food or liquids, including saliva, from the oral cavity into the oesophagus

A difficulty can occur at any stage of the eating, drinking and swallowing process

(SIG, 2014)

Types of dysphagia

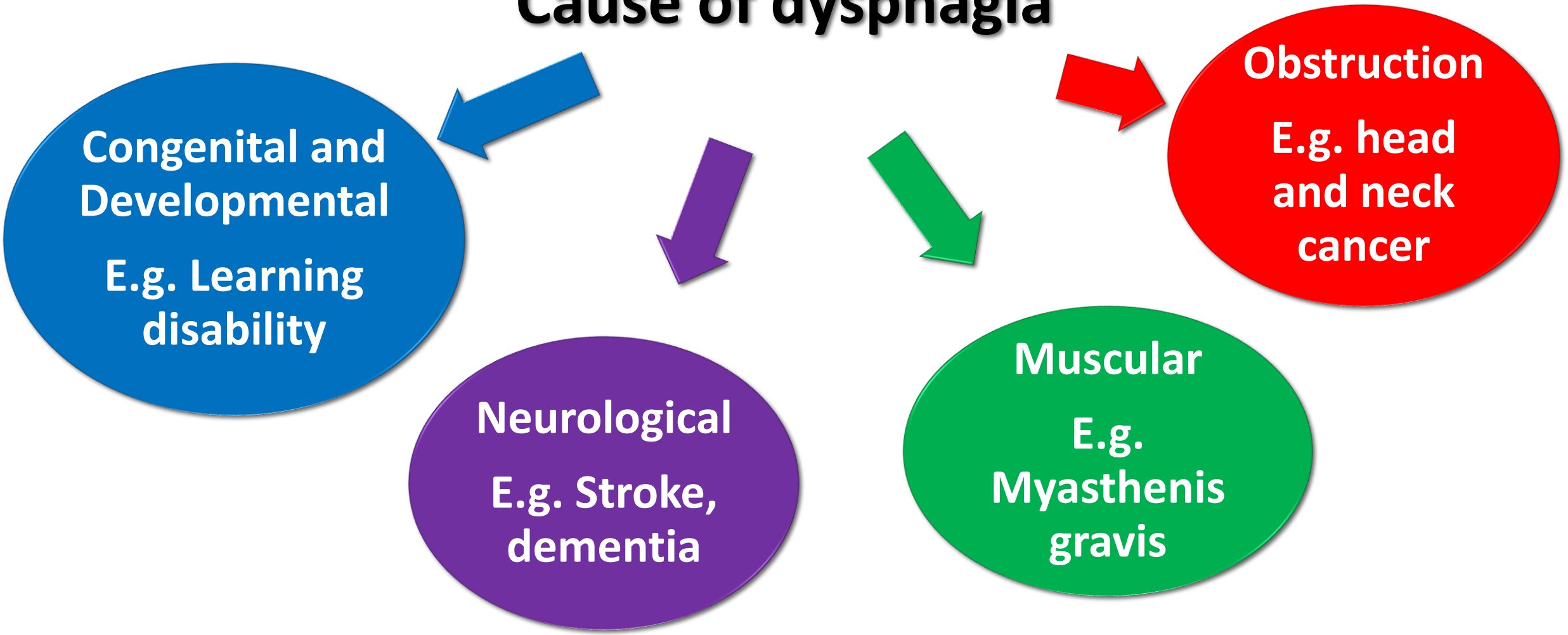
Oropharyngeal (High) – problem with initiating swallow due to problems in mouth or pharynx

Oesophageal (Low) – difficultly in passing food and liquids through oesophagus

Functional – sensation of solids and/or liquids sticking, lodging or uncomfortable passage through the oesophagus. No structural or organic cause.

(Nicely *et al.,* 2014; RCSLT 2014; SIG, 2014)

Cause of dysphagia



(SIG, 2014)

Common Oral Problems

Poor oral clearance or pouching of food

Greater accumulation of plaque and calculus

Increased susceptibility to xerostomia

Aspiration risk during dental treatment

Increased caries risk in those on nutritional supplementation and thickeners

Anxiety during mouth care and dental treatment

Recognising Signs of Dysphagia

Inability to control saliva – drooling

Difficulty initiating a swallow

Coughing

Choking

Gurgling or wet voice after swallowing

Nasal regurgitation

History of frequent episodes of pneumonia

Unexplained weight loss

IDDSI

International Dysphagia Diet Standardisation Initiative

www.iddsi.org

NEW IDDSI GUIDELINES*
Nutilis Clear: Mixing Instructions

Level 1: Slightly thick		
1 level scoop of Nutilis Clear in 200ml drink	x 1	
Level 2: Mildly thick		
2 level scoops of Nutilis Clear in 200ml drink	x 2	
Level 3: Moderately thick		
3 level scoops of Nutilis Clear in 200ml drink	x 3	
Level 4: Extremely thick		
7 level scoops of Nutilis Clear in 200ml drink	x 7	

Figure 4: Management of dysphagia [1]

Dental treatment

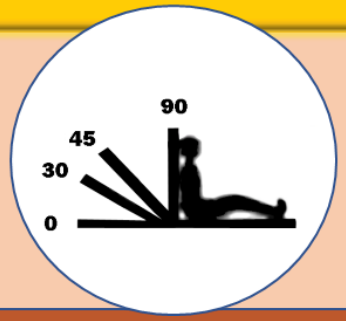
Careful body positioning:
Sitting upright
If supine raise head to 30-45 degrees or tilt to one side [1, 6]

Suction any residual food, debris or secretions [6]

Frequent breaks [1, 7]

Avoid use of fast hand piece and ultrasonic scaler [1, 7]

Use high volume suction [1, 7]



Prevention

Brush teeth, gingiva and tongue twice daily [1, 8]

Patient in chin-tuck position [1]

Use low foaming anti-tartar fluoride toothpaste [1]

Apply chlorhexidine digluconate gel or spray twice daily [1,8, 9]

Do NOT use mouthwash

Apply water based lip moisturiser regularly [1]

Long term management

Regular dental appointments

Consider referral to Community Dental Service (CDS)/ Special Care Dentistry

Educating families and carers on the importance of good oral health [10]

Prescribe high fluoride toothpaste and varnish application, if indicated [1, 11]

Mouthcare

Good OH to reduce bacterial load – aspiration pneumonia

Aspirating toothbrush

Non-foaming toothpaste

CHX gel / spray

No mouthrinses

Meticulous denture hygiene

Low or Non-Foaming Toothpastes

Duraphat 5000ppm contains less SLS (low-foaming) than Duraphat 2800ppm

Communication

Patient groups affected by communication difficulties:

Learning disability

Autism Spectrum Disorder

Hearing and visual impairments

Dementia

Stroke survivors

Cerebral palsy

- Neurological impairments
- Dental anxiety/phobia
- Psychiatric illness

(Dougall and Fiske, 2008b)

Reasonable Adjustments

- Find out how the person prefers to communicate and receive information
- Provide and interpreter
- Seek advice from or refer to speech and language therapists
- Extend appointment times
- Written information in accessible format of their choice
- Discuss with family, friends, carers if appropriate
- Use verbal and non verbal communication aids
- Careful of jokes …. ‘Jump into the dental chair’

VERBAL

SPEAK TO THE PATIENT at a level they understand

LISTEN to patient/carers

Simple language

Positive language

Ask open ended questions

Check understanding

Give adequate time

(Fiske *et al.*, 2006; BSDH, 2012)

"When I had to go to the hospital the doctors would usually speak to my mum rather than speak to me. So I didn't bring her to the hospital anymore. Finally they started to recognise I'm the one, I need to understand, not my mum."

Mencap, 2008

VERBAL

SPEAK TO THE PATIENT at a level they understand

LISTEN to patient/carers

Simple language

Positive language

Ask open ended questions

Check understanding

Give adequate time

NON VERBAL

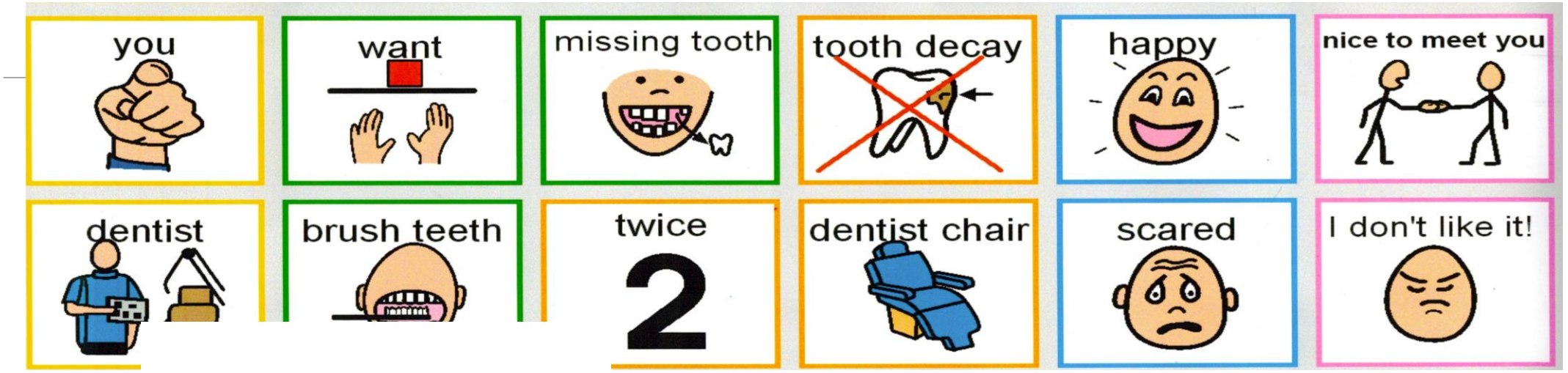
- Hand gestures and facial expressions
- Switch signals
- Photographs, objects
- Pictures e.g. PECS

- British Sign Language, Makaton
- Easy read leaflets

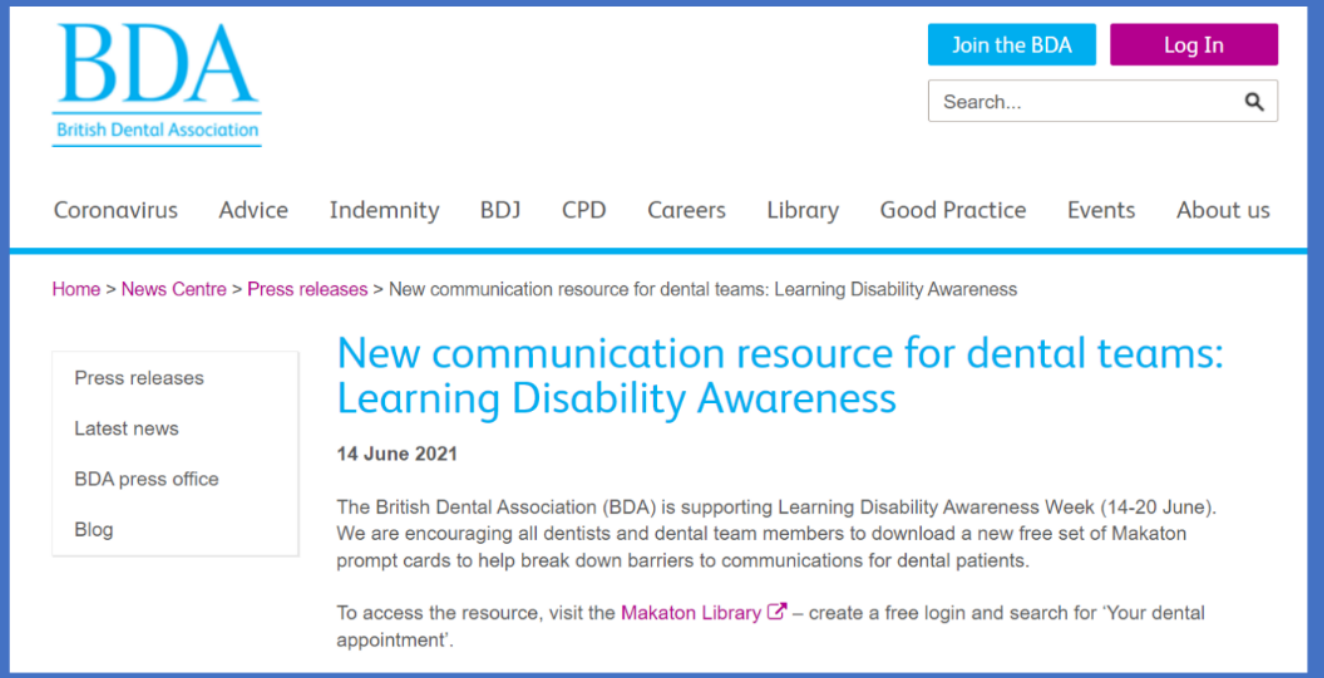
- Braille or Moon
- Augmentative and alternative communication devices (ACC) e.g communication boards

Picture Exchange System (PECS)

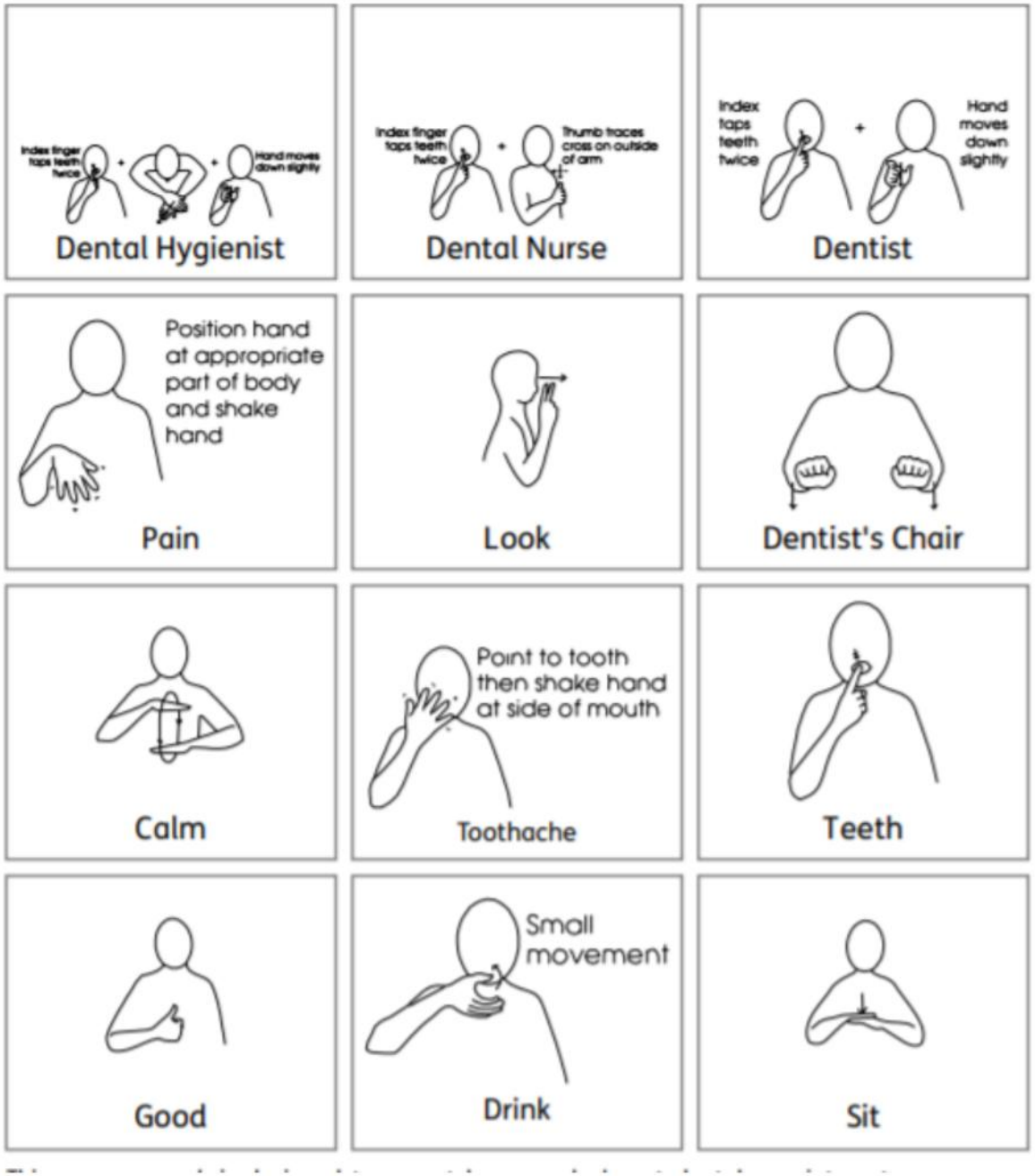
Picture Exchange System (PECS)



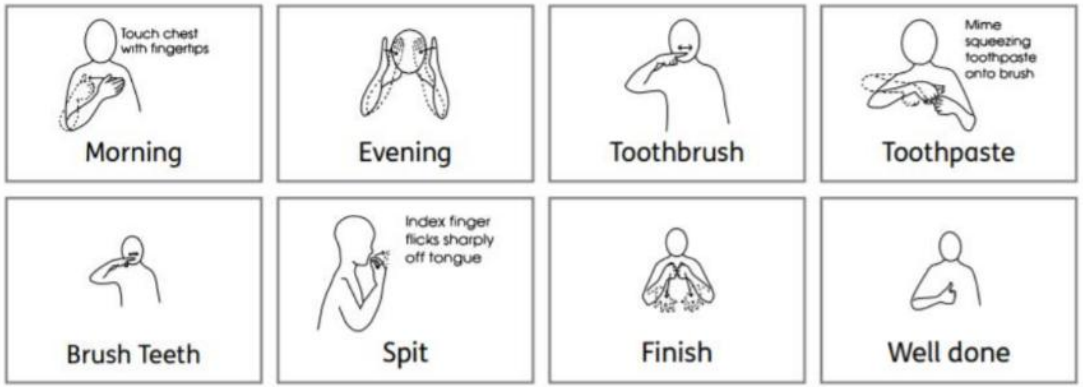
Makaton

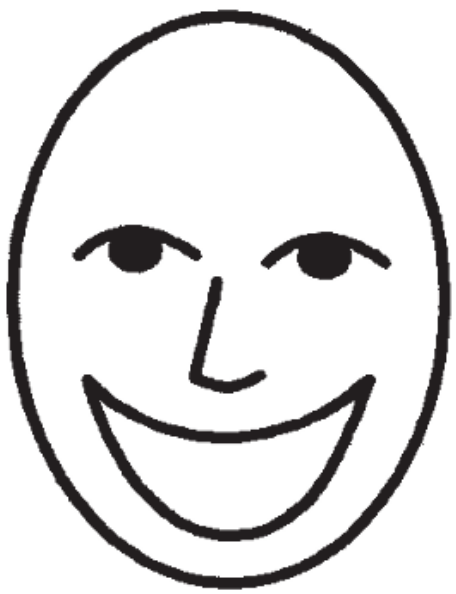


https://bda.org/news-centre/press-releases/Pages/New-communication-resource-for-dental-teams-Learning-Disability-Awareness.aspx

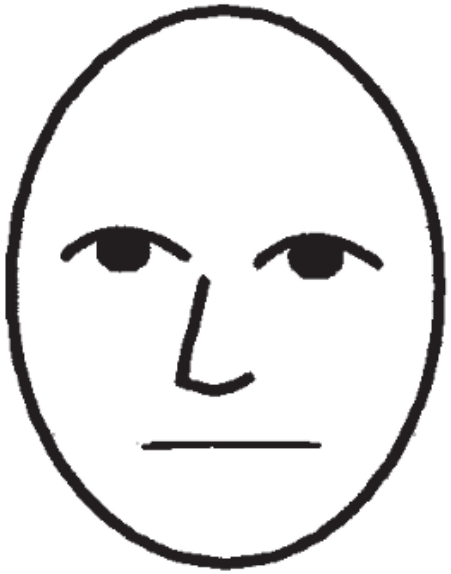

Dental Hygienist
Dental Nurse
Dentist
Position hand at appropriate part of body and shake hand
Pain
Look
Dentist's Chair
Calm
Point to tooth then shake hand at side of mouth
Toothache
Teeth
Good
Small movement
Drink
Sit


Dentist
Dental Nurse
Dental Hygienist
Dentist's Chair
Look
Pain
Teeth
Toothache
Calm
Sit
Drink
Good

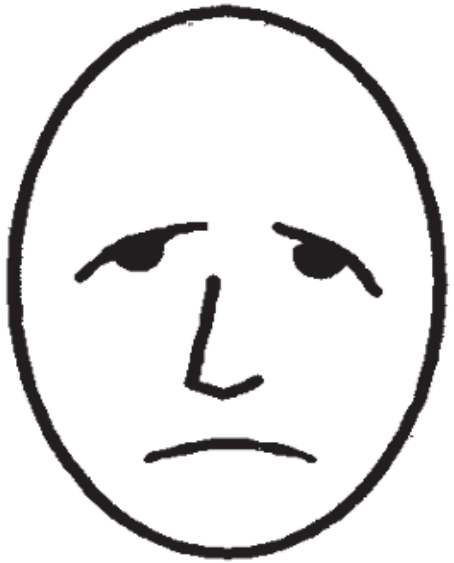

Touch chest with fingertips
Morning
Evening
Toothbrush
Mime squeezing toothpaste onto brush
Toothpaste
Brush Teeth
Index finger flicks sharply off tongue
Spit
Finish
Well done



Happy



OK



In Pain

Bad pain

WHAT HAPPENS?

If needed, your tooth will be made numb.

The decay is removed with a special tool. You may feel some vibration and it will sound a bit noisy.

Any water or bits in your mouth will be cleared away through a tube held by the Dental Nurse.

A filling is chosen to fill the hole. White fillings need to be set with a strong light.

The filling is then smoothed and shaped so it is comfortable when you bite.

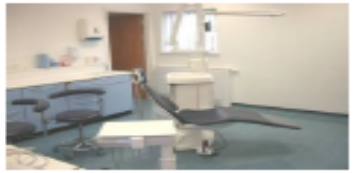
Easy read leaflets

At least size 16 font

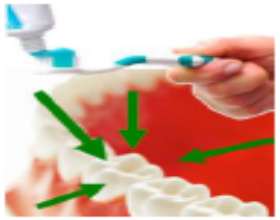
Picture and short sentence

The Healthy Mouth Guide

It is easy to have a healthy mouth – just follow the good mouth guide below



Have regular check-ups at the Dentist.



Brush all surfaces of your teeth and gums with a toothbrush and Fluoride toothpaste twice daily.

Sugar causes decay. Sugar is in lots of food and drink.

Have sugary food and drink at meal-times only.

Avoid smoking and drinking too much for a healthy mouth.

Non verbal indicators of pain

- Change in behaviour
- Challenging behaviour
- Change in eating patterns – refusing food
- Sleep disturbance
- Refusing oral hygiene
- Holding/hitting their face
- Fingers in their mouth
- Not wearing previously worn dentures

Challenges – is it dental pain?

Pain diary

Time of day pain occurs how long does it last

Do analgesics or anything else help?

Avoids foods, drinks, hot, cold

Disturbed sleep

Refusal to brush teeth when they did previously

Leaving out dentures

Crying, shouting, hitting face – how often

Clenching/bruxism

Exam by dental team to rule out dental problems

Percussion/swelling/ulcer

Adequate analgesics

Keep eye on swelling/ temp changes

Antibiotics only if systemic symptoms/ immunocompromised

Soft diet – avoid hot/cold?

Review

Abbey pain scale

Q1.	**Vocalisation** **eg. whimpering, groaning, crying** *Absent 0 Mild 1 Moderate 2 Severe 3*	Q1	
Q2.	**Facial expression** **eg: looking tense, frowning grimacing, looking frightened** *Absent 0 Mild 1 Moderate 2 Severe 3*	Q2	
Q3.	**Change in body language** **eg: fidgeting, rocking, guarding part of body, withdrawn** *Absent 0 Mild 1 Moderate 2 Severe 3*	Q3	
Q4.	**Behavioural Change** **eg: increased confusion, refusing to eat, alteration in usual patterns** *Absent 0 Mild 1 Moderate 2 Severe 3*	Q4	
Q5.	**Physiological change** **eg: temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor** *Absent 0 Mild 1 Moderate 2 Severe 3*	Q5	
Q6.	**Physical changes** **eg: skin tears, pressure areas, arthritis, contractures, previous injuries.** *Absent 0 Mild 1 Moderate 2 Severe 3*	Q6	

Total Pain Score

0 – 2	3 – 7	8 – 13	14+
No pain	Mild	Moderate	Severe

Chronic	Acute	Acute on Chronic

Abbey, J; De Bellis, A; Piller, N; Esterman, A; Giles, L; Parker, D and Lowcay, B.
Funded by the JH & JD Gunn Medical Research Foundation 1998 – 2002

Orofacial Pain Scale in Non Verbal Individuals (OPS-NVI)

Category	Behaviour
Facial Activities	Frowning Narrowing or closing eyes Raising upper lip Opened mouth Tightened lips
Body movements	Resisting care Guarding Rubbing Restlessness
Vocalisations	Using offensive words Using pain related words Screaming/shouting Groaning
Specific	Restricting jaw movements Refusing prosthetics Drooling

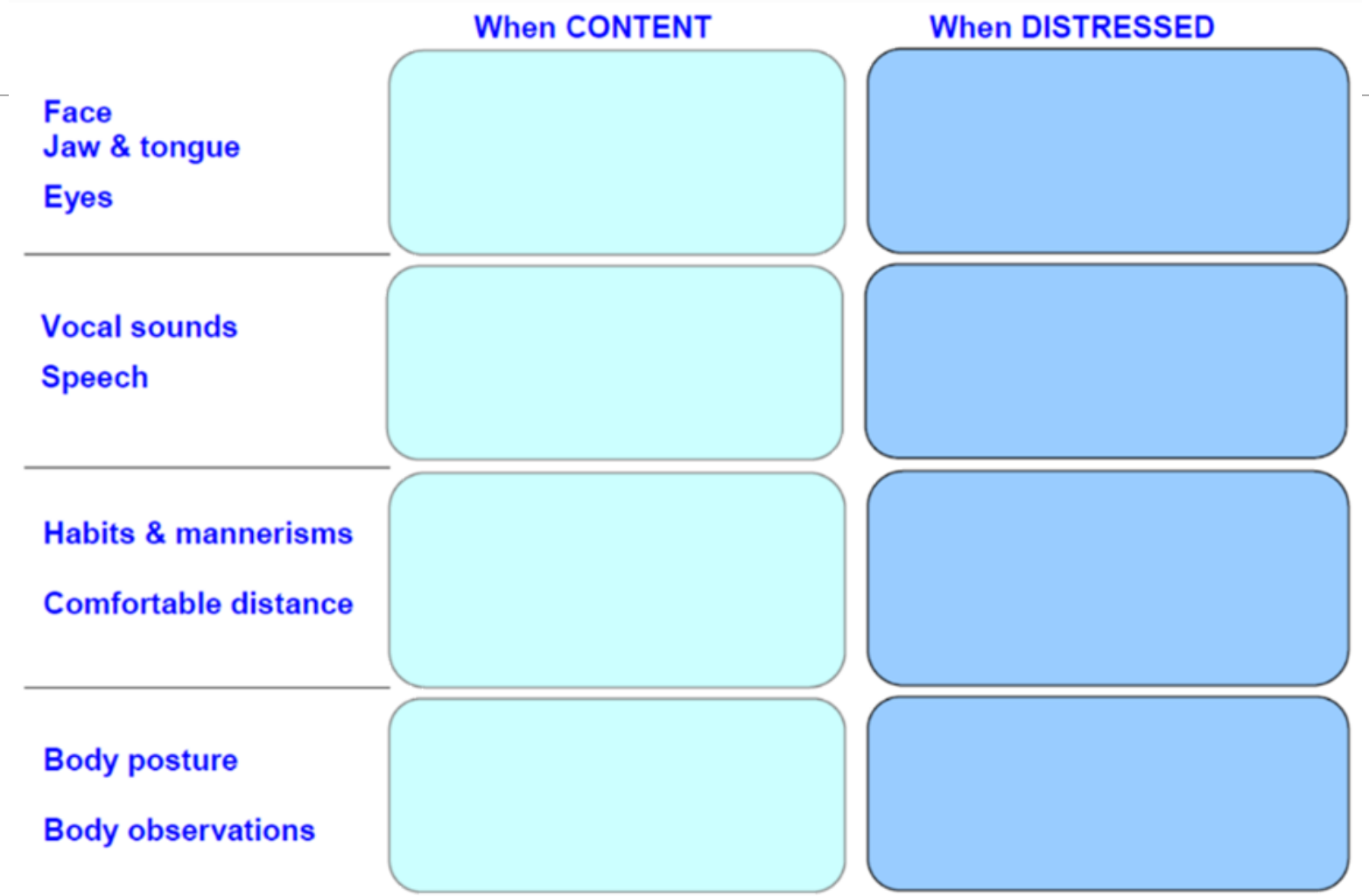
Distress Assessment – Distat

Pain and distress are different

Disability Distress Awareness Tool

- Non speaking patients
- Distress may be mistaken for signs of pain
- Everyone has unique ‘vocab’ of distress
- Baseline to assess distress
- NOT scoring document
- Makes intuition tangible
- Helps work out if pain or something else

Title


When CONTENT
When DISTRESSED
Face
Jaw & tongue
Eyes
Vocal sounds
Speech
Habits & mannerisms
Comfortable distance
Body posture
Body observations

This is my Hospital Passport

NHS

For people with learning disabilities coming into hospital

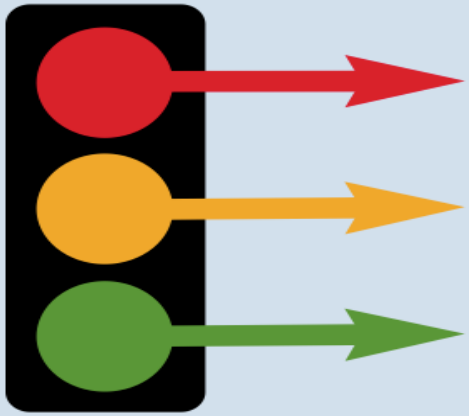
My name is:

If I have to go to hospital this book needs to go with me, it gives hospital staff important information about me.

It needs to hang on the end of my bed and a copy should be put in my notes.

This passport belongs to me. Please return it when I am discharged.

Nursing and medical staff please look at my passport before you do any interventions with me.



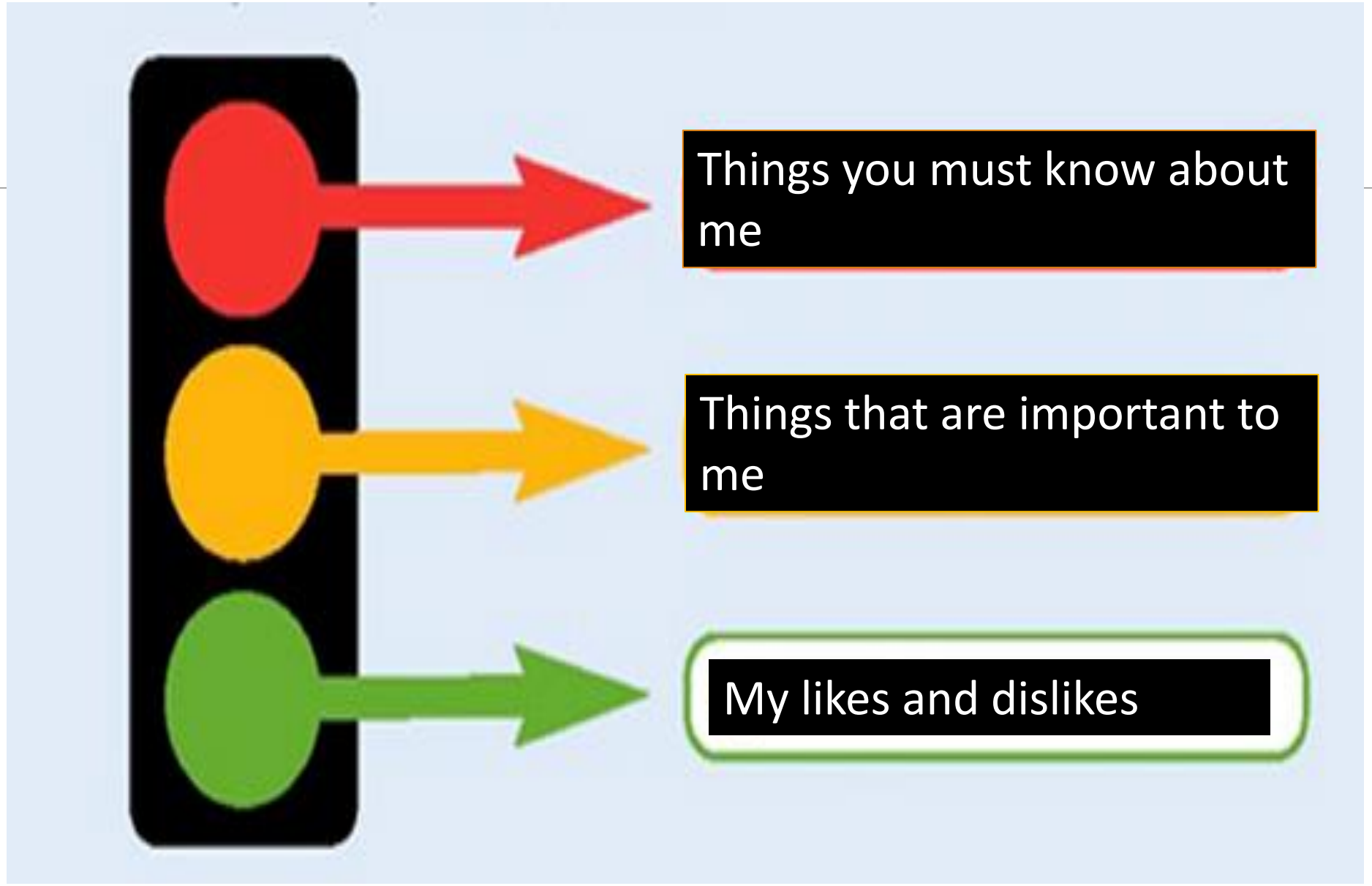
Things you must know about me

Things that are important to me

My likes and dislikes

Epsom and St Helier University Hospitals NHS Trust
Kingston Hospital NHS Trust
Mayday Healthcare NHS Trust
St George's Healthcare NHS Trust
Foundation of Nursing Studies

Croydon Community Learning Disability Team
Kingston Community Learning Disability Team
Merton Team for People with Learning Disabilities
Richmond Specialist Healthcare Team (Learning Disabilities)
Sutton Learning Disabilities Team
Wandsworth Community Learning Disability Team


Things you must know about me
Things that are important to me
My likes and dislikes

Appointment preparation tips

- **Person centered**
- Dental team training including the receptionist
- Pre appointment telephone call
- Desensitisation appointment – exam in a chair
- Use of a flag on person's records so that all staff are aware of the person's LD or ASD
- Additional time for appointment and preferred time of day for the person
- Minimise wait times

- Social stories, visual schedules, easy read leaflets
- Assistive communication devices, Picture exchange system
- Individualised hospital passport

Behaviour that Challenges

- Children and adults with learning disabilities may display behaviours that poses a challenge to others and/or puts their safety or others at risk.
- Challenging behaviours can include:
  - Aggression (e.g. hitting)
  - Self-injury (e.g. head banging)
  - Destruction (e.g. throwing)
  - Pica
  - Sexually Inappropriate behaviours

The Challenging Behaviour Foundation

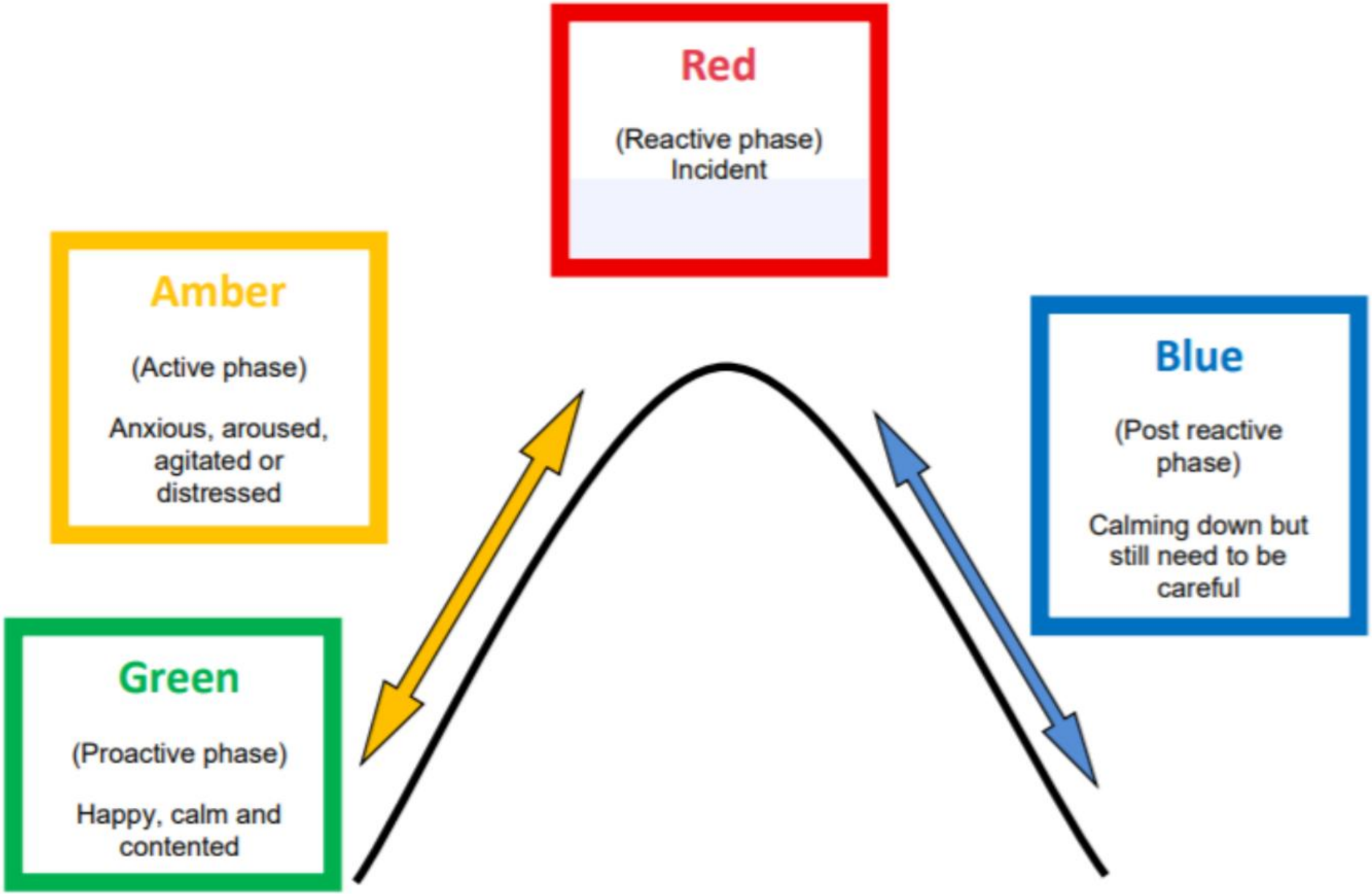


Figure 1: Arousal curve showing different stages of behaviour

Positive Behaviour Support Plan - Triggers

- Being aware of the potential triggers for challenging behaviours can be the first step in reducing the behaviours.
- Knowing the triggers for the person you care for can help you to put things in place to reduce their anxiety.
- Common triggers:
  - Being asked to do something or told to stop doing something
  - A particular individual or activity
  - Entering a noisy, hot, crowded place
  - Boredom, not being spoken to or involved
  - Not understanding what you are being asked to do

Positive Behaviour Support Plan

Some examples of reactive strategies include:

- Distraction and redirection (e.g. a guided walk to remove the person from the room to keep them and others safe)
- Use low arousal approaches – talk in a calm, monotone voice
- Restrictive interventions (such as physical restraint and medication) should be a last resort.

Some examples of proactive strategies include:

- Opportunity to use communication the person prefers.
- Individualised communication plan
- Keep routine
- Provide choice but not an excessive amount (maybe 2 or 3)
- Praise and reward positive behaviours

Example PBS plan

My difficult situation

Car journeys, especially when:

- We have to stop at a red light
- We get stuck in traffic
- We take an unfamiliar route
- I misunderstand where we are going
- I don't know where we're going

Behaviour I might display

Early warning signs:

- Tense mouth
- Face looks tense
- I will ignore you if you try to talk to me
- I will start to rock back and forward

If the early warning signs are not noticed I may:

- Rock back and forward violently
- Try to get out of my seat
- Bang my head against the windows
- Try to pull the drivers hair, pull at their clothes, or anything else I can reach
- Try to kick the driver
- Scream and shout at the top of my voice
- Throw anything that is within reach in the car

What you can do to avoid this difficult situation

- Make sure I know exactly where we are going and remind me throughout the journey
- Give me a picture/symbol card of where we are going so I can hold on to this to remind myself throughout the journey
- Slowly talk me through what will happen on the route… "first we will go past the cinema…"
- Take familiar routes whenever possible
- If we have to go on an unfamiliar road, warn me beforehand
- Provide a running commentary of the journey, e.g., if we're coming up to a red light, say "red for stop", or if we're approaching a queue of traffic say "we're going to stop behind this car"

- If something happens to alter the route talk me through this too
- Play my favourite music to distract me

What can you do if I display challenging behaviour

When I am showing early warning signs:

- Remind me where we are going
- Make sure I have hold of my picture card to remind me where we're going
- Play my favourite music to try and distract me
- Tell me about the fun things we are going to do when we get to our destination

If the situation has escalated:

- Talk in a calm voice
- Don't use too many words
- If you can work out where I think we are going (that is distressing me), tell me where we are really going
- If I am trying to pull your hair/pull at your clothes, say "sit on your hands"
- If I am banging my head on the window or getting very distressed, find a safe place to stop, help me out of the car
- Do not continue the journey until I can sit calmly

Afterwards:

- Continue the journey, calmly talking me through what is happening

Clinical Holding

‘Use of physical holds (clinical holding), to assist or support a patient to receive clinical dental care or treatment in situations where their behaviour may limit of the dental team to effectively deliver treatment or where the patient’s behaviour may present a safety risk to themselves, members of the dental team or other accompanying persons’

Least Restrictive option first
Needs to be risk assessed
May be included as part of reactive strategies in PBS plan

British Society for Disability and Oral Health

Unlocking Barriers to Care

Guidelines for

‘Clinical Holding’ Skills for Dental Services

for people unable to comply with routine oral health care

June 2009

For patients with:

- Learning disabilities and/or autistic spectrum conditions
- Dementia
- Mental ill health
- Degenerative conditions eg Huntingdon’s disease and Multiple Sclerosis
- Involuntary movements or no ability to control their movements eg Cerebral Palsy or Parkinson’s disease
- Severely anxious patients
- Some patients with specific medical conditions eg Stroke, brain tumour or an acquired brain injury

When may clinical holding be indicated?

Patient with capacity:

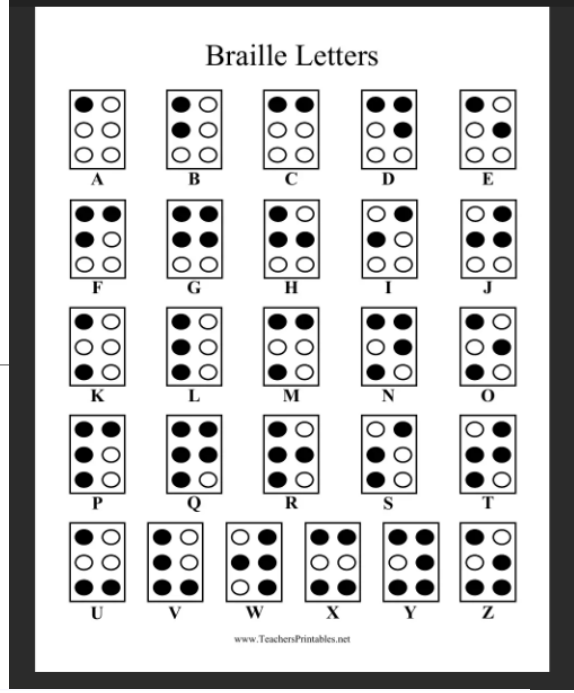
- Informed consent
- Dental anxiety, movement disorders, physical disability

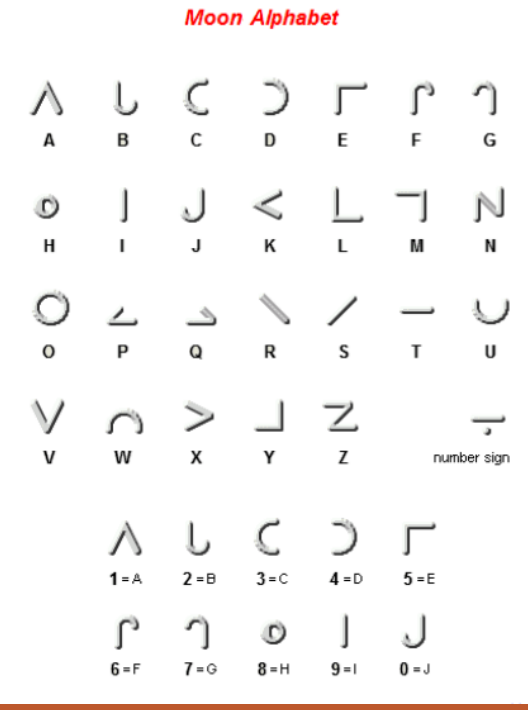
Lacks capacity:

- Clinical holding as part of best interest decision following Mental Capacity Act principles
- Completed risk assessment
- Least restrictive hold for limited amount of time
- Debrief and documentation
- Unplanned emergencies – risk to themselves and others

Sight impairment

- Braille
- Moon
- Large Print (16 point+) and Giant Print (18 point +)
- Computers and Screen readers
- Magnifiers
- Apps





Dos and Don’ts

DO’s	DONT’s
DO identify yourself by name, and your job/staff position	**DON’T** touch the person without consent, and never grab, push or pull the person in any way.
DO offer assistance by offering your arm to hold – Sighted guide	**DON’T** raise your voice.
DO address the person by their name each time you speak to them specifically in a group situation.	**DON’T** censor your language. **DON’T** avoid words like “look” and “see”
DO verbalise your responses and actions. Avoid using nods, head shakes and hand gestures without equivalent verbal cues in conversation.	**DON’T** move furniture or other objects without consulting or telling the person, and never interfere with their personal items.
DO apologise if an interaction goes badly and ask the individual how you can help to make the next one go better.	**DON’T** make faces or gestures to yourself or others while talking with the person.
Tell-Feel-**DO**	**DON’T** shining the dental light in eyes

https://wechope.org/resources/how-to-communicate-with-people-who-are-blind-or-vision-impaired-part-1/

Hearing Impairment Terms

Hearing Impairment

- Acquired hearing loss may be mild, moderate or severe
- Deafened people who were born with hearing and have suddenly become severely or profoundly deaf after learning speech
- People born with profound hearing loss

Deaf British Sign Language User

- use BSL to communicate (English not their first language)
- May have difficult with reading and understanding spoken or written English

- **deaf** – A person who identifies as being deaf (lowercase d) indicates significant hearing impairments

- **Deaf** – A person identifies as being culturally Deaf and belonging to the Deaf community. Most Deaf people are sign language users who have been deaf all their lives. Limited ability to write or speak English.

Reasonable adjustments

This symbol is used to indicate that an induction loop system is available

Makaton

Relay UK

Helping people with hearing and speech difficulties communicate with anyone over the phone, using the national relay service.

https://www.relayuk.bt.com

Dysarthria

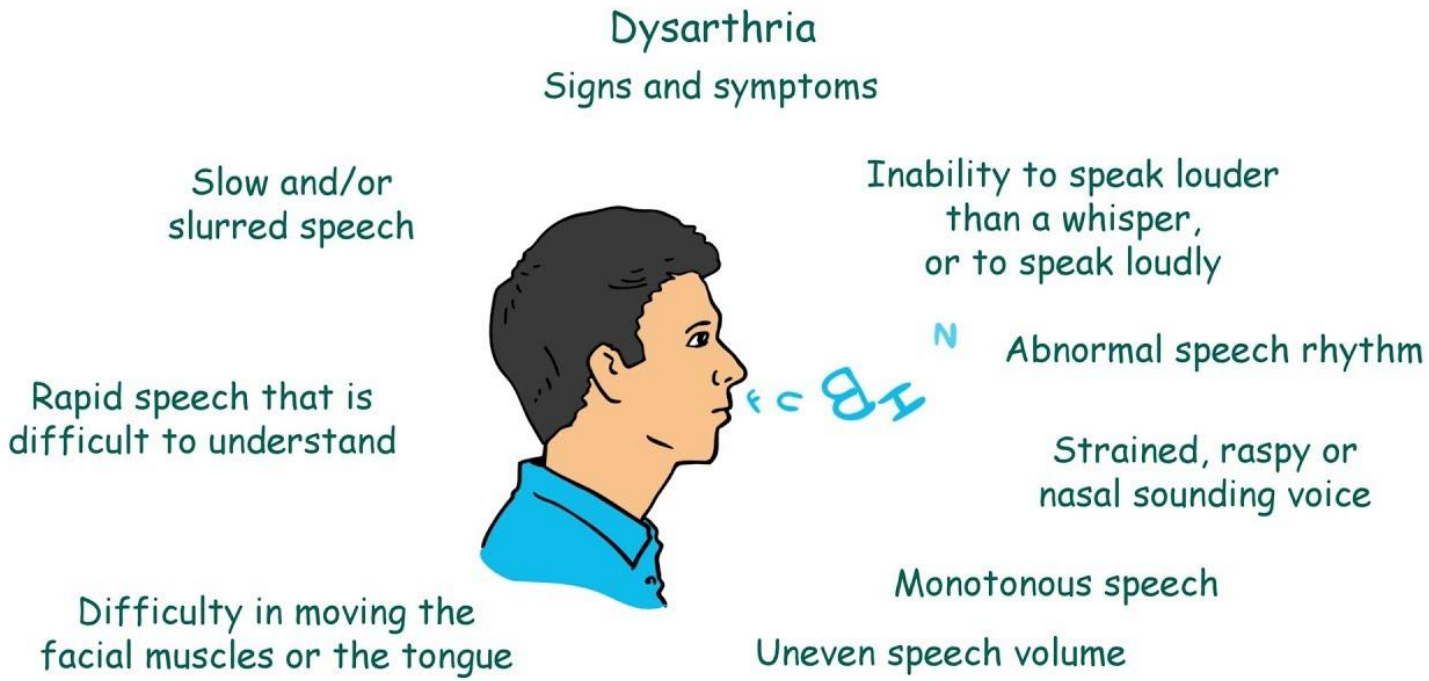
Speech is employed correctly but articulation is faulty because of neuromuscular problems

Affect articulation of consonants

Slurring of speech

Video: https://www.stroke4carers.org/?tag=dysarthria

E.g. conditions:
Stroke, multiple sclerosis, parkinsons, brain injury, cerebral palsy, muscular dysphtrophy



Aphasia

Associated conditions: Stroke, brain injury

Acquired communication impairment resulting from damage to portions of the brain responsible for speech.

Broca's aphasia – damage to the frontal lobe of the brain, speech output is severely reduced, 4 words usually, understanding ok.

Wernicke's aphasia –temporal lobe may result in a fluent aphasia. Affected individuals may speak in long sentences that have no meaning, add unnecessary words and even create new 'words', understanding affected

Anomic aphasia - where people can understand speech well but are left with a persistent inability to supply words for the things that they want to talk about. Worse when anxious

Communication Tips

Stay calm when talking.

Normal voice, slower speed than usual.

Maintain a natural conversation manner appropriate for an adult

Use short, uncomplicated sentences and do not change the conversation too quickly

Avoid open questions. Close questions “yes” or “no” answer better

Avoid finishing a person’s sentence or correcting errors in their language

Do not pretend to understand

Minimal distraction e.g. background radio or television noise

Be open to different ways of getting and sending messages e.g. drawing, diagrams

Non-verbal communication (AAC)

Speech and language therapists

(Orchardson, 2012)

All Augmentative and Alternative Communication (AAC requires):

1. **Voluntary control over any movement** – head, arm, foot, fingers, eyes – to be able to choose an 'option'

2. Ability to **see** or **hear** the 'options' (symbols, pictures, spoken words, written words, letters)

3. Ability to **understand what the 'options' represent**

High Tech vs Low Tech

Low tech:

Paper based

Other equipment that is non-programmable

E.g. Pointing, communication boards, pen paper,

High tech:

Programmable computer based software

Often includes a synthetic voice

Individuals with degenerative conditions can ‘bank’ their own voice to create a synthetic voice that sounds more like them

Pointing

Yes ✓

No X

LOW TECH

Go Talker

Big Mack – playback

Talking photo album

Aids for touch screen

Hold the frame so you can see each other through the hole in the middle. Have 'yes' on your left and 'no' on your right, the same as you would for your hands.

Jon will point with his eyes to a group of letters.

He will then point with his eyes to a colour.

That group + green = S

Combine the group of letters with the colour he chose to find out what letter he wants - check this with him (he will look at 'yes' or 'no'). If he looks at no, start again.

HIGH TECH


Nice to meet you


History 2
Hello! How a..
Yes
Hello! How are you
going
saying
sure
talking
a
Smart word prediction to reduce typing effort

Communication - People living with dementia

- Address patient by their preferred name
- Approach the patient from the front
- Maintain eye contact
- Time for patients to process information
- Use familiar words and terms
- One question at a time
- Reassuring touch
- Sensitive to non-verbal communication in later stage

This is me®

This leaflet will help you support me in an unfamiliar place.

My full name is

Please attach a favourite photo of yourself here.

You can also attach a recent photo of yourself on the next page.

- See the notes on **page 4** to help you complete **This is me**, including examples of the kind of information to include.
- Keep this leaflet with you and put it in a suitable place so that all the people caring for you can see and refer to it easily.

In partnership with

Royal College of Nursing

Alzheimer's Society
United Against Dementia

About me

(See the notes on **page 4** for ideas about the kind of information to include)

Name I like to be called

Where I live (area not the full address)

The carers/people who know me best

I would like you to know

My personal history, family and friends, pets and any treasured possessions

My background

(See the notes on **page 4** for ideas about the kind of information to include)

My cultural, religious and spiritual background

My interests, jobs and achievements

Favourite places I have lived and visited

My habits and routines

(See the notes on **page 4** for ideas about the kind of information to include)

The following routines are important to me

Things I like to do for myself

Things I might want help with

Things that may worry or upset me

What makes me feel better if I am anxious or upset

My communication and mobility

(See the notes on **page 4** for ideas about the kind of information to include)

My hearing and eyesight

How we can communicate

My mobility

What not to say to a person with dementia

Don't Say	Instead Try
"Remember when…?"	"I remember when…."
"I've just told you that"	Be patient. It's important for a person with dementia to feel they're being listened to and understood.
"What did you do this morning…."	"Do you want a tea or coffee" Closed questions/2-3 options
"Do you recognise me?"	"Hello….my name is…."
" today we are going to check you teeth, then take some xrays and then some cleaning and then we will book another appointment…"	Short, Simple sentences Avoid talking in loud environments Wait until you have the person's full attention.
"love, honey, dear"	Use preferred name as often as appropriate. This helps keep their dignity intact and aid concentrations.

Dementia- Friendly Environment

Dementia Friendly Dentistry – Practical Considerations	
People	• Use of ‘This is Me’ • Assistance completing medical history • Dementia training for all staff. • Ask patients/carers what would make visits easier.
Processes	• Continuity of care. • Familiarisation visits. • Flexible appointments • Signpost patients to dementia services.
Place	• Simple, clutter-free layout. • Dementia friendly signs (yellow background, black text). • Dementia friendly clocks (display time, day and date). • Background noise kept to a minimum. • Wheelchair accessible and disabled parking.

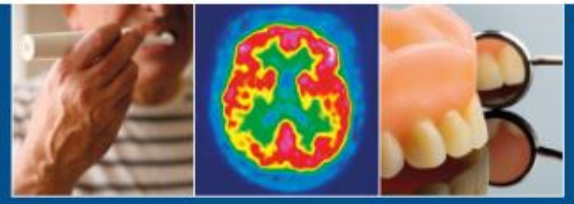

Toilet


MAY
2
MON


SATURDAY
MORNING
6:08 A.M.
10, SEPTEMBER 2016
Svinz


Way Out

College *of* General Dentistry



Dementia-Friendly Dentistry

Good Practice Guidelines

25 YEARS OF PROMOTING EXCELLENCE IN DENTISTRY

FGDP (UK) ADVANCING DENTAL CARE

Forget me not – the role of the general dental practitioner in dementia awareness

G. McNamara,[1] J. Millwood,*[2] Y. M. Rooney[3] and K. Bennett[4]

BRITISH DENTAL JOURNAL VOLUME 217 NO. 5 SEP 12 2014

Dementia Friends

An Alzheimer's Society initiative

https://www.dementiafriends.org.uk

Choose how you would prefer to join

Video

Watch a short video about dementia to become a Dementia Friend

- Quick and easy (5 minutes)
- Hear from people living with dementia and learn how you can help

Watch video

Information Session

Attend an in-person or virtual Information Session run by one of our volunteer Ambassadors.

- More in-depth (45 minutes)
- Attend a friendly and interactive Session or join from the comfort of your home.

Find your Information Session

Mental Health Risk Assessment

Important risks to identify

Violence
Neglect
Suicide

The distressed patient

Use short simple language and calm tone of voice

Acknowledge what the person is feeling ‘I can understand you are distressed/angry/upset’

Have a calm open posture, do not mirror aggression

Expression of delusions – Acknowledge but do not support, pretend to agree, dismiss or argue. ‘I can understand that these ideas must be very distressing to you’ .

Recognise verbal and non verbal cues invasion of body space, pacing, hitting objects, raised voice, verbal abuse, odd or bizarre interactions

De-escalation strategies - try to get the person to sit down, sit at same level as them, ‘How can we help you together’ ‘How can I help you because I want to help’ – continue to acknowledge their feelings

Ensure safe exit, do not leave the patient alone, do not leave staff alone

Risk assess the situation continuously

- **Get help – Contact Community Mental Health Team, GP, crisis team, carers, friends, family.**
- **Violence or threatening call the police ‘We have a vulnerable adult who is causing concern and who needs to be taken to a place of safety’**

Case example : Tearful at end of appointment and crying

Management:

Calm open communication to allow discussion reasons for distress and undertake risk assessment

Listened to concerns

Identification of support available

Asked ‘Do you feel safe?’ – Direct questions about intentions

Asked what support she wanted

Allowed patient to leave

Contact with CMHT – CPN and GP to inform

Follow up

What if the patient disclosed suicidal thoughts?

Duty of care as healthcare professional

Who are you going to call?

Must not leave the patient until speak to mental health team or appropriate support

- CMHT e.g. CPN
- GP

- Out of hours GP
- Crisis team
- Police

Mental Health First Aid

Lighthouse

HSC Public Health Agency

PHA - Welcome - PHA Mental Health First Aid Framework

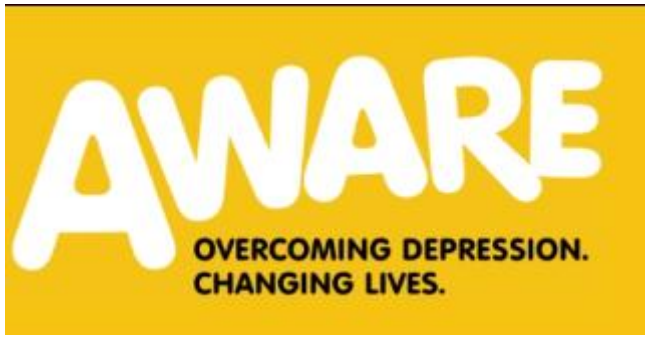
AWARE
OVERCOMING DEPRESSION.
CHANGING LIVES.

St John Ambulance Northern Ireland

action mental health

Mental Health First Aid

PHA - Welcome - PHA Mental Health First Aid Framework



Please contact your local Training Provider for details on course dates and locations. Contact information is contained in the directory linked to your Trust area:

Western area: Training directory April - September 25

Southern area: https://hcsnisoutherntrust.pagetiger.com/pwb-training-directory-april-to-sept-2024/1

South Eastern Area: Training directory 25

Northern Area: https://northerntrust-hscni.pagetiger.com/mental-healthnt

Belfast Area: Training directory 25/26

Communication: Aphasia, Dysarthria, Apraxia

Link to video
https://www.youtube.com/watch?v=zjkgSCIXo3k

(Orchardson, 2012)

Aphasia

Acquired language disorder (brain damage) .

Difficulty in producing or comprehending spoken or written language.

Third of stroke survivors experience some level of aphasia.

44% of stroke survivors experiences severe anxiety as a result of their aphasia (Morris *et al.* 2017).

Aphasia effects each person differently.

Dependant on the degree and location of the damage to the brain.

It is important to recognise and understand the type of aphasia one has, how it effect their communication and adapt techniques accordingly.

Assistance from speech and language therapists.

Special Care Dentistry Treatment Planning

Flexible

Least invasive / low risk option first

Always re – visit treatment modality choice

Individualised

Emphasis on prevention

Holistic

Dependent on urgency of treatment

Case example 1

34 year old

Moderate learning disability

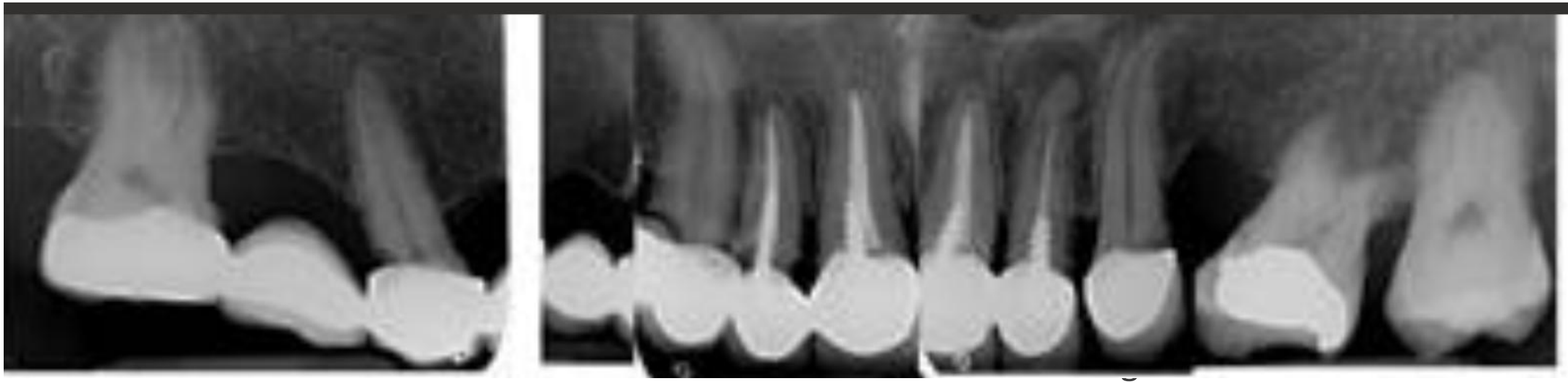
Arabic language

IVS previously

Behaviour management

Special Care Dentistry Treatment Planning

Case example 1



Case example 2

PMH: Angina

Hypertension

Type 2 diabetes mellitus

Learning disability

Obstructive sleep apnoea CPAP at night

Left adrenalectomy pheochromocytoma

Asthma

Reflux

Gout

Klinefelter syndrome (XXY)

Risk assessment:

Stability angina

Functional status of patient

Social history: supported living residence

Sister NOK calls to house 1-2 times per week

Smokes 40 cigarettes daily since was 18 years old

Alcohol not currently

Dental history

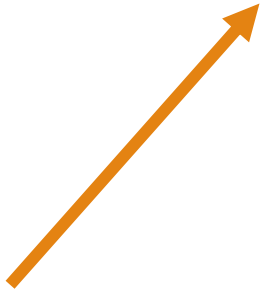
Referred for treatment under IV sedation as routine due to dental anxiety

Had extraction under LA OS previously

First appointment rearranged due to tightness

No issues with extraction under LA

Seen as a recall in CDS



Episode chest pain
ABCDE approach - gave 2 sprays GTN from emergency drug kit sublingual
Airway patent
SPO2 93 - 94 so oxygen 15L / min 100% placed non rebreathe mask
Resp rate 18
BP 106/52 HR 55
SP02 99 on oxygen
Cap refill normal 2
Chest pain resolved and continued to monitor

MDT SCD assessment

Previous HDU admission post op

ASA: 3

Recent Risk Scores:

Clinical Frailty Scale: 3 (28/8/2024 13:47)
Exercise Tolerance Assessment: Moderate (28/8/2024 13:47)

Clinical Frailty Scale: 3 (28/8/2024 13:47)

BMI 37

Likely stable angina exacerbated by dental anxiety

Treatment options

1. LA in CDS
2. LA monitoring DPU
3. IHS in CDS
4. IVS in DPU
5. GA in DPU

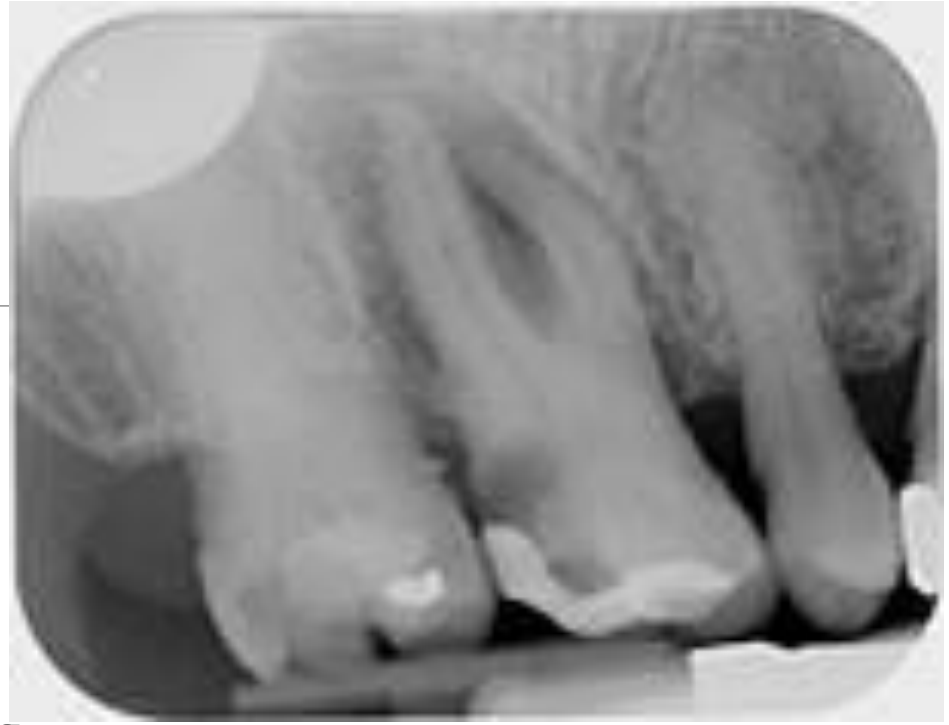
Case 2 example

Saw in CDS yesterday

Pain and swelling associated UR67

Had GTN spray with him

Emergency equipment available



Diazepam for anxiety
Carer knew him well
Familiarisation
Staff awareness

Deep breathing

Hand holding

Distraction

Adequate LA

Local haemostatic measures used

Case example 3 – to treat or not to treat

97-year-old - referred from CDS IVS suspect dental pain

PMH: Dementia likely Alzheimer's

Atrial fibrillation

CKD stage 4

History of falls

Left NOF fracture 2017

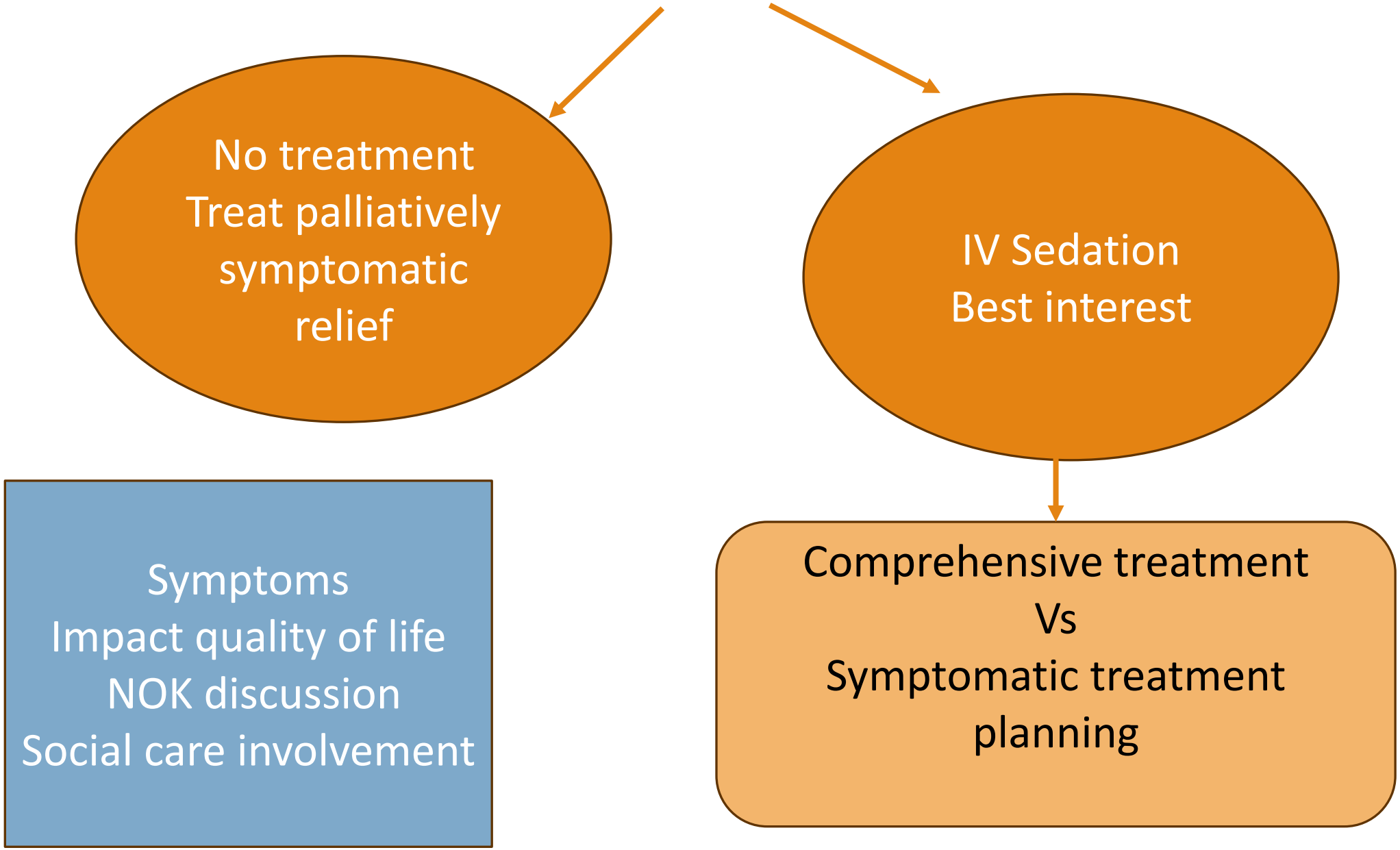
Wheelchair user – can transfer with assistance

Care home resident

Little information from carer

Limited dental exam
Anaesthetic assessment
ASA 4
41 kg
Limited pre-operative exam
Further information needed

Risks and benefits
Best interest decision


No treatment
Treat palliatively
symptomatic
relief
IV Sedation
Best interest
Symptoms
Impact quality of life
NOK discussion
Social care involvement
Comprehensive treatment
Vs
Symptomatic treatment
planning

Case example 4

16 year old

MH: ASD, mild learning disability, ADHD

Previously treatment under GA at 8 years old

Urgent appointment - Fractured UL1

Self injurious behaviour, diazepam,regular pain relief

Repeating ‘FIX IT’ and pointing to tooth

ART, communication ipad, acclimitisation, urgent referral SCD

Review colleague restoration with composite

Listed for GA EUA, radiographs, AOT

Patient management

Holistic - Appointments catered to individual

Taking into account wishes of patient and family/carers

Multidisciplinary team approach

Dental treatment should be appropriate for individual

Prevention is vital

Any Questions?

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