Domiciliary dentistry during and after the COVID-19 pandemic

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The impact

The main impact of COVID-19 on domiciliary services depended largely on where you were living at the time. Some areas continued to provide care on a domiciliary basis if the patient met the criteria for urgent dental care. Other areas, where salaried services became urgent dental centres and those where domiciliary services are provided by the General Dental Service, people confined to home only had access to the 3 A's (advice, analgesics and antibiotics) plus the additional challenge of obtaining an urgent prescription. Table 1 illustrates the impact using the returns submitted to the BSA in England and Wales during the height of the pandemic last year and the effect on the total numbers of courses of treatment including domiciliary care in 2020. This totalled less than half of the number of returns submitted in previous years. Meanwhile, the latest figures for 2021 remain low. Because full courses of treatment were halted, people confined to home have been waiting a considerable time for treatment, even dentures.

Assessing the risk

At the same time, patients who meet the criteria for domiciliary care were often in the 'shielding' group (now renamed clinically extremely vulnerable) or were over 70 and advised to shield. Visiting these patients at home was a process of weighing up the risks and benefits of going into their property and quite a responsibility for the dental team.

The Standard Operating Procedure issued by the Office of the Chief Dental Officer of England stated:

'Where domiciliary visits are necessary, these should be appropriately risk assessed and managed. Where patients are shielded or at increased risk, these visits should be organised in line with the principles of local protocols for these groups.'[1]

Local SOPs

It wasn't easy for those of us responsible for writing these protocols. Car sharing was discouraged, so we drove with open windows and wearing masks. Where and at which point should we don and doff the PPE? If donning PPE outside what happens if it rains/snows etc? Was it OK to keep the same scrubs on between patients? What happens if a COVID-19 positive patient needs urgent care? How do we deal with clinical waste?

Members of The British Society Of Gerodontology shared policies and procedures in order to develop protocols to work safely in patients' homes. The one saving grace at this time derived from the fact that domiciliary restorative kits are bulky and time consuming to set up and with portable suction being less than ideal, most domiciliary care is minimally invasive and does not involve aerosol generating procedures (AGP). Rechargeable electric handpieces are easy to set up, light and compact, so we omitted precautions for an AGP procedure in our protocol!

Planning and checking in

One of the key elements of domiciliary dental care is planning the visit and this now required a few additional stages. Remote check-ins prior to the visit provided an opportunity to establish where the dental team would be seeing the patient, who would be present; keeping others to a minimum where possible. An unoccupied room with a sink was identified for donning and doffing PPE. It was also necessary to request a clean, empty table in the patient's room with the windows open, if possible, for ventilation. We telephoned ahead with our arrival time to minimise inconvenience. Such planning was easily done by a dental nurse team.

As in other healthcare settings, virtual consultations helped when the risk of visiting has outweighed the benefits and the Sheffield Check-in[2] procedure has proved invaluable. This has wide application and meets the requirements for the 'remote point of contact' as described in the OCDO England's 'Transition to Recovery' SOP.[3]

Information gathering

A virtual consultation can reduce face to face time for information gathering prior to the appointment, particularly with regard to medical history. Some of the questions on the domiciliary risk assessment were adapted to include the COVID-19risk assessment questions.[4]

In Wales, a 'Care Home Thermometer' was developed along with a risk assessment to optimise safety when attending a care home. It was based on a scale 1 to 4 where 4 meant that there were many cases of COVID-19 in the care home and that the risk of transmission was high. If the domiciliary visit was deemed too risky for a face to face assessment, a rudimentary clinical examination may have been possible using platforms such as 'Attend Anywhere' with a suitable device such as an *iPad*, tablet or phone, for which we are often reliant on a carer or family member to provide and/or operate.

Care home residents

We are all aware that care homes had to lockdown severely in order to protect their residents and in the process were denied face-to-face contact with families and friends who often provide a great deal of informal support within care homes with personal care and feeding.

These support groups are often the ones who will alert dental services if they detect a problem with their relative or friend as they know them well and can identify a behavioural change or reaction that may be a sign of oral discomfort. These are the people who often ensure the resident is wearing their dentures and caring for their teeth. People in their own homes, may not have been able to welcome family or friends into their home at mealtimes and have found themselves eating alone. Perhaps they don't enjoy their food as much or make unhealthy food choices.

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A Danish study of people over 80 living in the community, concluded that social relationships are related to the oral health status of old-old individuals and those who were continuously dissatisfied with the frequency of social interaction showed poorer oral health.[5] Those who are dependent for oral care may have been reliant on carers who, at first, were not provided with correct PPE and there were mixed messages about risks of brushing, using electric toothbrushes etc. so may not have had support with mouth care.

Infection prevention and control

As lockdown eased, care homes have started to welcome back domiciliary teams. Some requested that lateral flow tests were performed whilst sitting in the car outside the home which was time consuming and quite cold over the winter months but most are now more trusting and accept the twice weekly results that we administer ourselves. As well as the fact that we are now fully vaccinated.

Another challenge is that we have little or no control over our working environment. There is an increased need for Infection prevention and control. I don't think we, as a dental team, have previously considered we may be a risk to an older person confined to home. So, wiping all our touch points is just as important in someone's home as it is in the surgery.

As the weather gets warmer, we may consider a domiciliary visit *'en plein air'*. I did do one of these many years ago when I arrived at a home and the patient was sitting in a very accessible high backed chair in her garden with good light and a rather yappy dog by her side, We talked for a while and as it was such a lovely afternoon and not wanting to go through the very lengthy process of helping her move inside and the dog seemed to accept us in the garden, which was very private and not overlooked, proceeded to examine her and did my first outside domiciliary visit. Something that could be considered if the risks outweigh the benefits of an inside visit. This might also resolve another challenge which we faced last summer when the heat inside peoples homes was exaggerated by wearing PPE.

Transition to recovery

As a clinician providing domiciliary treatment last year, it was sometimes difficult to make decisions in the best interests of the patient by involving relatives or advocates in a shared decision-making approach. We are looking forward to being able to do that again as the pandemic is controlled.

Table 1 Dental insight. 21.05.21 – nhsbsa. Data on file. Domiciliary visits in England and Wales 2020-21

Calendar Year					Month	Forms with Domiciliary Services			
2018		2019		2020		England	Wales	2021	
								England	Wales
England	Wales	England	Wales	Impact of Covid-19	Jan	4,176	406	1,364	87
					Feb	5,011	474	2,003	80
					March	5,810	360	2,375	70
					April	1,166	76	1,606	33
					May	477	81		
					June	255	182		
					July	371	9		
					August	734	7		
					Sept	1,056	27		
					Oct	1,259	11		
					Nov	1,828	63		
					Dec	1,048	57		
60,619	**2181**	**59,329**	**3679**			**23,191**	**1,752**		

One patient in her 80s, required domiciliary care from a colleague in Dorset. She had survived COVID-19 but left hospital without her full upper denture that was fitted when she was fifteen years old. Such episodes create additional pressure for domiciliary services which are already struggling to resume with the courses of treatment that were discontinued over a year ago.

Commissioning and care pathways

The salaried dental services currently provide most of the domiciliary treatment in the UK. But. there is now a greater need to consider flexible commissioning, to work in partnership with other primary care practitioners – for example, the ROCS project in Sheffield where Local GDS work in partnership with the CDS to provide prevention and dental treatment in care homes.[6] Similarly, the Scottish Oral health Improvement Plan, January 2018[7] involves accredited GDPs providing domiciliary care.

Shared care is provided in parts of Wales where referrals for domiciliary dental care are triaged by the CDS and the less complex patients are referred onto dental domiciliary GDS teams and the more complex to the CDS. Opportunities may also arise in the future working with Primary care networks (PCNs), Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) to address this vital need.

For further information visit www.gerodontology.com.

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