Could dental therapists have a role in domiciliary dentistry? A discussion of barriers and considerations for domiciliary practice

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Introduction

Dental therapists are a fundamental part of the dental team and are able to support the provision of operative clinical care to a number of patient groups including those with vulnerabilities. One such group of vulnerable people is older patients who through chronic illness and disability are often unable to attend general dental practices to access their dental care.[1] As with medical care for these groups of patients, a domiciliary or 'home visit' may be required to deliver this care in a non-clinical setting. Allied health professionals are already used in medical practice with GP home visits being supplemented by paramedics and from the Community Trusts, community nurses, who both supply an essential care function. For paramedics though, this is a fairly recent change of practice which has yet to be fully evaluated.[2]

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Domiciliary care in dentistry

Although many older people are living longer with chronic illness and require dental care as many are retaining their teeth longer, there arguably appears to be a decline in domiciliary care.[3] A recent freedom of information request to the NHS Business Services Authority (NHSBSA) identified a 37% reduction in domiciliary visits carried out between 2008 and 2019.[4] This decline appears in part to be explained by the continued effect of the 2006 dental contract where the additional fee for visiting housebound patients was removed from NHS dentists and where domiciliary care was rebranded as a 'specialist service' with the need for a specialist contract for practices to receive remuneration for the care provided. The outcome of this change was that activity whereby dentists who may have visited a nearby nursing home occasionally as an add-on to their day, or visited an older patient who may have been a regular attender, and recently became homebound, stopped.

Domiciliary care has now become an area of dentistry which seems to be the preserve of the Special Care Dental Service (SCDS) or a small number of dedicated providers. Unlike general medical practice (GMP), the concept of care being 'from cradle to grave' is less likely to be available in primary dental care unless you include the involvement of SCDS/Community services, which in themselves have only limited resource to offer care to an increasingly larger number of patients.

Domiciliary care and dental therapy

In order to effectively deliver domiciliary care for older patients, dental therapists would be required to safely provide a range of dental procedures, within their scope of practice, outside of the dental clinic.

The Sussex Community NHS Foundation Trust (SCDS) provides domiciliary dentistry from multiple sites across West Sussex and Brighton areas. Table 1 ranks the top ten most carried out dental services (by dentists) over a one-year period from October 2020 to October 2021. On examination of these clinical procedures, dental therapists have the potential to carry out seven out of these ten items in place of a dentist.

Thorough clinical examination is within the scope of practice of dental therapists, and a recent review has reported comparable abilities of dental therapists in comparison to dentists when identifying periodontal disease, dental caries and recognising suspicious oral pathology.[5] In addition, dental therapists are trained to take and interpret patient social,

Table 1 Most frequent performed procedures during domiciliary visits carried out by SCFT dentists

Rank	Procedure	Within the scope of practice of a dental therapist?
1	Clinical examination	Yes
2	Prevention advice	Yes
3	Writing prescription of 2800/5000 ppm sodium fluoride toothpaste	No
4	Glass ionomer filling/temporary dressing	Yes
5	Extraction (of secondary tooth)	No
7	Professional Mechanical Plaque Removal	Yes
8	Primary denture impression	Yes
9	Denture fitting	No
10	Composite restoration	Yes

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dental and medical histories.[6] Therefore, it could be suggested that dental therapists are well placed clinicians to undertake the initial assessment appointment for domiciliary patients. In this appointment it is also likely that prevention advice in the form of oral hygiene instruction and diet advice can be provided. However, unlike dentists, dental therapists are unable to prescribe any medicines, such as fluoride toothpaste, antimicrobials, antifungals or any other medicines, which may be required at the initial visit.

Much of the ongoing dental treatment could also be provided by a dental therapist as long as it within the scope of practice of a dental therapist. This would include treatments such as professional mechanical plaque removal, simple restorations and even primary denture impressions, which could be completed either under direct access, or under prescription of a dentist.[7,8] Patients who require more complex treatment, such as permanent dentition extractions, would need referral to a dentist to provide treatment, so suitable referral pathways to qualified and experienced dentists should be in place to take forward this care.

As stated above, much primary care dental care provided to patients in the domiciliary setting is provided by professionals working as part of the Salaried or SCDS. Special care dental services is likely to remain the ideal setting for releasing the potential that dental therapists have to undertake domiciliary visits. This is due to the in-house expertise of gerodontology as well as multi-disciplinary working already existing in these services. In addition, the close availability of special care specialists and consultants lends itself to the setting up of 'refer-up' clinical pathways where dental therapists can refer onward for treatment outside their scope of practice.

Regulatory barriers

Perhaps one of the biggest barriers facing dental therapists being fully involved in domiciliary care is the current NHS regulations. For instance, under the current NHS contracting regulations dental therapists are unable to bid for or hold contracts for Units of Dental Activity (UDAs). It is only dentists, dental body corporates, or a partnership of these, who are able to be providers for UDAs. Therefore, if a dental therapist's business model included NHS domiciliary care, they would only be able to carry this out under a contract holder's direction.

Dental therapists are able to own and manage dental practices and are able to register with the Care Quality Commission (CQC). However, the 2009 CQC Regulation 13, 1.a) details that if the dental therapist was to have a purely domiciliary dental practice, they are required to demonstrate financial viability to provide dental services.

Creating close working professional relationships with dentists is currently essential for some aspects of the dental therapist's scope of practice, such as prescribing controlled drugs. Controlled drugs such as midazolam or local anaesthetics are only available to dental therapists through a dentist. It can be challenging to develop working relationships to such an extent to overcome the prescribing regulations. The dependency on dentists to prescribe restricts even simple, preventive domiciliary dentistry such as applying topical fluoride or prescribing fluoride toothpastes.

Direct access was introduced in 2013

Fig. 1 Spare domiciliary emergency kit and drug box (minus defibrillator and oxygen)

Fig. 2 Simple motor and selection of handpieces

by the General Dental Council (GDC) and was welcomed to improve equality to offer patients more choice when it came to accessing dental services.[8] While direct access has certainly improved access for patients who are able to attend multidisciplinary general dental practices, the question remains how it has affected access for patients who require domiciliary visits.

Operational barriers

Providing dental care, especially if that care involves an element of operative treatment, can involve a number of practical and operational barriers, discussed below.

Capacity

By travelling to visit patients at home, fewer patients can be seen in a day than in a surgery setting. The exception to this statement may be if a clinician visits a nursing/care home and caries out an assessment of all residents at the same time. In this case you can perhaps see for assessment a large volume of patients, but their need for further visits for treatment is also likely to be high and may well then rely on many additional visits to ensure all necessary care is provided.

Health and safety barriers

A common barrier expressed by dental professionals to carrying out domiciliary care is the assumption that one has to take out the whole emergency drug kit for any type of visits. The CQC/GDC have produced a 'myth buster' document to challenge this and to explain what is actually expected.[9] In essence, dental professionals would be expected to carry a level of urgent medications similar to other health professionals who may also attend to a patient at home. In addition, a risk assessment should be carried out taking into account clinical risks based on environment (eg if visiting a nursing home, what equipment/drugs may they, themselves have available); patient's medical history; and type of treatment planned (eg invasive such as fillings with local anaesthetic or extractions, or non-invasive, such as assessment, prevention or denture work). Therefore, a full complement of emergency equipment isn't needed for every visit.

It is perhaps prudent to recommend that if more invasive work plays a larger proportion of care provided, then provision for a spare kit for domiciliary care is recommended (Fig. 1).

Many other potential health and safety hazards exist for domiciliary care but can be largely mitigated by careful risk assessment as recommended by the British Society for Disability and Oral Health (BSDH) in their Guidelines for the delivery of a domiciliary oral health care service.[10]

Things to consider

Understanding compromise

What needs to be appreciated when carrying out domiciliary care is that the options of treatment for patients are perhaps more limited when compared to what can be provided in the surgery, but can still help secure oral health in the medium to long term. In general, those involved in providing care are able to understand the need for compromise. A study by Sweeney *et al.* in Scotland showed that more than 60% of both general and community dentists who routinely carried out visits surveyed, were happy to place dressings and carry out simple extractions. Seventy-four percent of community dentists were happy to provide glass ionomer restorations.[11] Pal and Farrar provide a useful list of what treatments can be considered as appropriate to provide in a domiciliary setting.[12] The selection of handpieces and subsequent motors to complete simple fillings and denture adjustment can be kept to a minimum (Fig. 2).

The use of minimally invasive dentistry techniques

The use of minimally invasive dentistry techniques has become ever more popular in the treatment of dental caries. These techniques include Atraumatic Restorative Technique (ART) or modified ART; both lend themselves to the management of carious lesions with the use of no or only minimal rotary instrumentation, often without the need of local anaesthetic which can be exceptionally useful in the treatment of caries in a domiciliary setting.[13,14]

Shared care – Domiciliary/surgery interface

One way of ensuring that patients seen routinely as domiciliary patients receive optimal care is by occasionally requesting them to come in to the dental surgery

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setting where possible for items of treatment deemed too risky to be carried out at home. This could include radiographs, more complex extractions and restorations. This mix and match idea for domiciliary care is well regarded as normal practice in those undertaking domiciliary care as it enables a flexible approach which can be customised to meet the needs of the patient.[15]

Scope for the future

In the future it would be beneficial for patients as a whole to have better access to dental care, especially provided by the NHS. In this post/continuing pandemic world, NHS dental services are still struggling with less readily available appointments due to the backlog of check-ups and other routine care leftover from extended periods of reduced activity. Access to primary care is once again struggling to keep up with demand and the prospects of older patients, unable to leave their house or residing in a care home, readily accessing dental care is looking increasingly bleak.

If dental therapists were to be awarded performer numbers and able to hold NHS dental contracts, it has the potential to broaden direct access and therefore increase access to dental services amongst a growing group of patients who have not benefitted thus far from the development of dental therapists.

What NHS dentistry needs is to develop a group of professionals who will relish the challenges of providing gerodontology to older patients. The idea of appropriate skill mix and using dental therapists for domiciliary care has the benefits of a greater number of clinicians with which to share the clinical responsibility for care for this vulnerable group, as well as ensuring the professional satisfaction for dental therapists in knowing that their scope of practice is being fully utilised.

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