



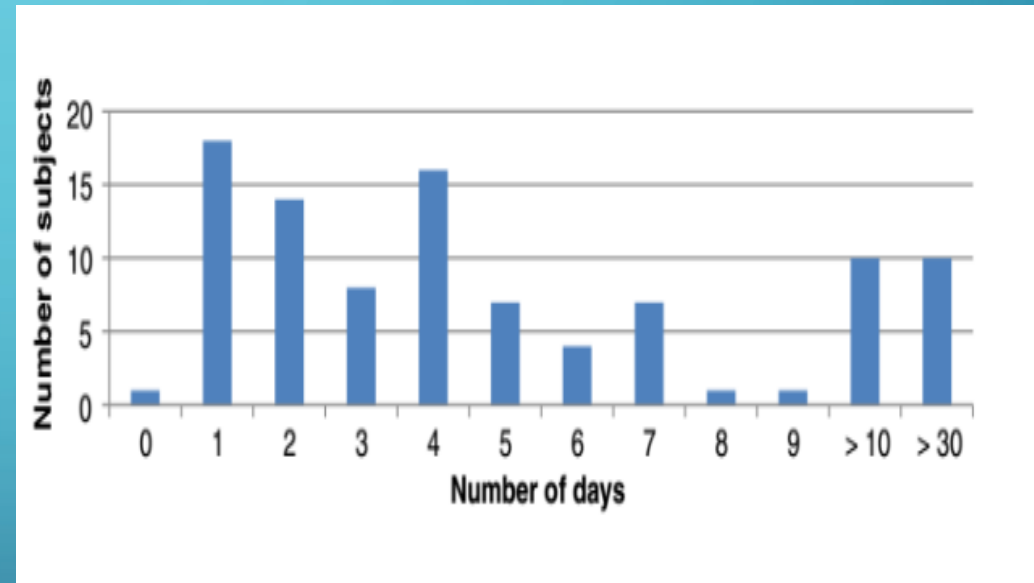
EMERGENCY CARE OF THE SPECIAL CARE PATIENT

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SENIOR DENTAL SURGEON HSE MIDWEST

SATISFACTION VS EXPECTATIONS IN HEALTHCARE

- During the 1990s the perceived problem of emergency dental care, and out-of-hours services in particular, led to a considerable number of studies of emergency and out-of-hours dental services. Austin et al (2009)
- the public expects that emergency dental services should exist, and that they should be accessible
- No of days in pain before attending emergency
- Hommez(2017)



SATISFACTION VS EXPECTATIONS IN HEALTHCARE

- 12% of world population suffers from toothache at any given time
- Was generally accepted that necessary treatment will be provided for registered patients within 24 hours and that a verbal response will be made within 6 hours. Austin et al 2009
- evidence of multiple attempts before obtaining emergency dental care.(Austin et al)
- Effective communication, willingness to listen, willingness to adapt to the child's individual needs(Thomas et al 2018)

WHAT DO PATIENTS/CARERS WANT?

- Relief from symptoms,
- Greater certainty regarding the cause of their problem-need to be free from pain was in order to regain normal functioning (sleep or work routines
- Encouragingly, a desire or specific expectation for antibiotics was rarely mentioned
- *HSE guidelines on Antibiotic prescribing 2018*

EMERGENCY OR URGENCY?

EVANS ET AL (2001)

4 HOURS

- Haemorrhage following tooth extraction
- Trauma to the teeth or jaws
- Swelling around the eye or swelling resulting in difficulty swallowing

24 HOURS

- Severe dental and facial pain not controlled by over the counter preparations
- Dental and soft tissue acute infection

- Dentists also have a role in keeping patients' service expectations realistic, but alongside efforts to increase awareness about the existence and contact arrangements for emergency dental services.
- There is therefore an efficiency argument to supplement all 'walk-in' emergency dental clinics with some form of telephone access and consultation prior to attendance (Austin et al 2009)

EXPECTATION VS REALITY

- 'ideal expectations' (what they want to happen) than their 'practical expectations' (what they anticipate will happen).
- The need for advice and reassurance as much as relief from symptoms must be better recognised in service design, care protocols and professional development
- the quality of dentists' communication — whether at the chair-side or over the telephone — should be a key dimension in any evaluation of the effectiveness of such services.
- telephone advice prior to seeking care.?

ACCESS

- Barriers and enablers
- An important indicator of health system performance
- Identifying barriers and enablers allows policy and care pathways to be created
- Ravenwood ER 1998

BARRIERS

- Relevance of TDI was higher in CSHCN,
- with increased overjet and incompetent lips.
- Uncomplicated crown fracture was the most common injury.
- In both groups, the main reason for not seeking treatment was lack of dental awareness among parents/caregivers;
- difficulties in getting an appointment and availability of dental clinics willing to see children were more prominent in the CSHCN group
- Waldman et al(2017)

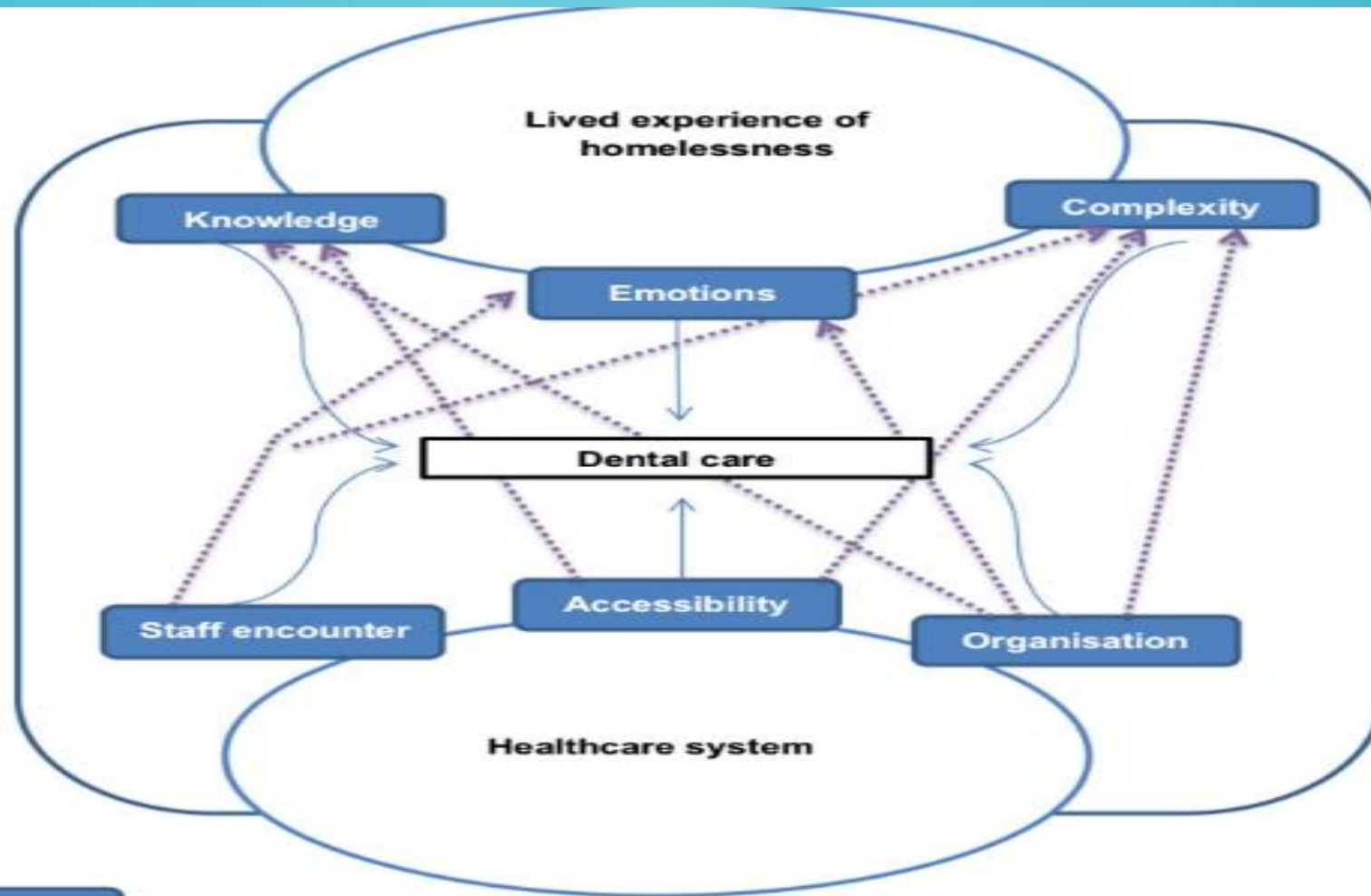
BARRIERS

- Accessibility, Affordability, and lack of dental awareness are key barriers and predictors for accessing dental care for patients with cardiovascular disease

(Paisi et al -Australia 2019)

In the US there is an oral health curriculum being rolled out to cardiac nurses.

(*sanchez et al 2019*)



• Paisi et al (2019)

ACCESS CONCEPTUALIZED AS:

- Characteristics of the potential users(Complexity) versus the processes of the dental healthcare system(organisational)
- An interface between characteristics of the population and those of the healthcare resources
- Individual and contextual determinants do not operate individually.
- Improvements to access must come from the service itself

ENABLERS

- Flexibility
- Staff training
- Establishing partnerships
- Multidisciplinary approach
- Outreach/domiciliary care

THE TEAM

- Allowed time to build relations- improves quality of care
- Time to take your time
- Holistic approach
- Empathy compassion and patience in equal amounts
- Ensure training and tools and protocols are in place
- Standards of high excellence required

THINK ABOUT PROCESS

- Ask, look decide, act and document
- The burden should not be on the patient to coordinate the transition of care
- What to do what to expect who to contact
- High standard of communication and information sharing

SPECIAL CARE POPULATION

- The high level of oral diseases in the special needs populations requires increased intervention in the planning of services for prevention, emergency care, and definitive and long-term oral healthcare
- Some dentists have been shown to be reluctant to treat special needs patients which has increased the burden of oral disease and unmet dental need
- Equity in health requires that people with equal need should have equal access and equal treatment and treatment outcomes
- *Quinn et al (2015)*

CONCEPTUAL MODEL

- Reflects the flexibility of the dental team
- Flexibility of the environment
- Confidence of the parents to advocate
- Importance of the continuation of the service after the initial encounter
- All held together by effective communication
- Clear referral pathways to specialist services thus reducing stress –best practice



Dental team flexibility

Communication

Clear pathway to specialised dental service

Parent carer confidence

Continuation of service

ORAL HEALTH ASSESSMENT- WHEN TO DO IT?

- For patients who attend only for urgent care (e.g. pain relief), this approach is not appropriate. Instead, a basic assessment that enables the management of the patient's immediate needs is sufficient. This should also always include taking a medical history and examination of oral mucosal tissue. Such irregular symptomatic attenders should be invited to attend for regular care, which would begin with a comprehensive OHA.

<http://www.sdcep.org.uk/wp-content/uploads/2013/03/SDCEP+OHAR+Guidance+in+Brief.pdf>

AUTISM

- Parents are the experts and advocates for their children with autism in everyday life
- They may have the potential answers for many problems that might arise in the surgery
- Barrier to their ability advocate due to a perceived medical authority
- Hyper empathy – the whole team needs to have an awareness
- Positive social encounters modelled by those in authority

AUTISM

- Accepting and verbalizing our limitations on our knowledge of the patient
- Family centred approach(*kuhlthau et al 2011*)
- Actively seeking council from parents- this can also spread to other health services
- Lack of knowledge and confusion in referral process to specialists
- Due to the greatly varied services , there is questions over who is responsible for the protocols and pathways !!
- *International Journal of Paediatric Dentistry(2018)*

PREPARATION AND COMMUNICATION

- Much preparation is pre appointment
- Involvement of the whole team
- Risk assessment
- Alerts on patient files- avoids repeated explanations
- Documentation
- Acceptance for change
- Being unfairly judged
- Coming to dental from other bad public services encounters

NEUROLOGICAL DISORDERS

- Do you have all the data- general health conditions ,social supports ,oral health conditions
- General health conditions- systemic diseases, medication lists, disease status, level of autonomy, communication skills, ability to accept treatment and maintenance
- Social supports, transports systems, legal guardian, policy of institutions for oral care, chief caregivers, expectations and attitudes of the whole team.
- Oral health conditions- periodontal disease, caries, xerostomia

QUESTIONS

- What data is most relevant for treatment plan?
- What will happen if I do nothing?
- Rapid oral health deterioration
- What treatment alternatives are available? High fluoride, silver diamine, glass ionomers
- What is the best treatment option for this patient and what is its justification?- concept of rational treatment planning, patient and carer expectations and perspectives
- How will this treatment plan be communicated to the carers?
- Self assessment by the dentist?- effectiveness of communication plan

ASSESSMENT OF PAIN

- Certain diagnosed groups differ in pain presentation
- DS- may not have a motor reaction or spontaneous report of pain
- ASD- display more intense facial reactions to pain than counterparts
- Facial rxns are the most typical displays of pain by children with special needs
- In schools nurses and teachers are alerted to any pain that might cause patients to impact on learning
- Some children with disabilities experience pain daily

PAIN

- Observing physiological changes-breathing, skin colour, sweating urinating, blood pressure and heart rate
- Observing behavioural changes- Facial expressions and aggressive behaviour are common indicators of pain.
- Vocal expressions and body posture may also indicate pain
- Need to use full team for pain assessment including parents teachers, SNAs, other care providers
- Need to look for common pain behaviours and the pain identification process



PAIN DIARIES

- 75% children with cognitive impairment experience pain for at least 1 day per week for 10 hours
- 88% experience pain for more than one consecutive day
- Decrease pain sensitivity and greater pain tolerance than their counterparts(parent report)

ASSESSMENT TOOLS

- Wong baker faces pain rating scales
- The ability to understand concepts necessary for tool use is often overestimated by care providers
- 64% understood- general population, 21% mild cognitive impairment.
- No practice guidance or strong evidence base for assessing pain and thus lack of efficient interventions

RESULTS WE KNOW

- 50% of carers believe the health care provider makes an accurate pain assessment of their child.
- In absence of self report parents can act as a proxy
- Internalised and individualised mental checklist- holding ,talking with child discrete cues for pain, parental instinct
- Parents believe formal pain assessment require parent involvement

Pain Assessment Tools that can be Used to Assess Pain in non-Communicating Intellectually Disabled People

Pain Assessment Tool, Authors	Description of Categories to be Observed
NCCPC-PV (non-communicating children's pain checklist, postoperative version) Breau <i>et al.</i> , 2002	Vocal, social, facial, activity, body and limbs, physiological signs
NCCPC-R (non-communicating children's pain checklist-Revised) Breau <i>et al.</i> , 2003	Vocal, social, facial, activity, body and limbs, physiological, eating/sleeping
r-FLACC (revised-face, legs, activity, cry, consolability) Voepel-Lewis <i>et al.</i> , 2008	Face expressions, leg position/movement, activity, cry/vocal, consolability
NAPI (nursing assessment of pain intensity) Voepel-Lewis <i>et al.</i> , 2008	Verbal/vocal, body, movement, facial, response to touch

- ❖ The **Abbey Pain Scale** For assessment of pain in patients who cannot verbalise i.e. patients with dementia or communication difficulties Use of the Abbey Pain Scale
- ❖ The Abbey Pain Scale is best used as part of an overall pain management plan.
- ❖ Objective The Pain Scale is an instrument designed to assist in the assessment of pain in patients who are unable to clearly articulate their needs.
- ❖ Ongoing assessment The Scale does not differentiate between distress and pain, so measuring the effectiveness of pain-relieving interventions is essential.

PAIN ASSESSMENT IN NURSING STAFF

- Documentation of pain assessment and management provides the basis for continuity of care .
- Nurses identify pain in their clients with intellectual disabilities by observing behavioural changes.
- Reassess 30 minutes after pain relief
- Nurses assess the pain mainly by observing moaning, whining, whimpering or flinching or moving the body part away, or being sensitive to touch.
- Pain assessment tools are very seldom used by the nurses.
- Kankkunen et al(2010)

DEMENTIA

- It is an acquired organic mental disorder that is characterised by a loss of intellectual abilities that is of sufficient severity to interfere with daily activities
- No single cause or cure
- Worldwide, dementia population is 50 million.
- In Ireland the number of people with dementia is estimated to be 55,266 .
- By 2030 it will reach 104,000 in Ireland estimated

PAIN ASSESSMENT IN PEOPLE WITH DEMENTIA

- More challenging and complex in patients with dementia
- Self report is no longer available
- Unable to report, anticipate or describe pain type , its onset duration
- Unable to understand questions related to pain evaluation
- Non – verbal behavioural manifestations of pain must be identified and interpreted
- Difficult to identify pain related behaviour from behavioural symptoms which commonly occur in dementia called behavioural and psychological symptoms of dementia – BPSD, i.e. apathy, aggression and agitation
- Corbett et al reported- 90% - experience BPSD – common in late stages and pain is a major contributor

PAIN ASSESSMENT TOOL

AMERICAN GERIATRIC SOCIETY GUIDELINES 2002

1. Facial expression
2. Verbalisations/vocalisations
3. Body language
4. Changes in activity or pattern
5. Mental status changes
6. Changes in interpersonal interactions

SPECIFIC OROFACIAL /DENTAL PAIN INDICATORS: (LOBBEZOO ET AL)

1. Holding/rubbing orofacial area
2. Limiting mandibular movement
3. Modifying oral behaviour e.g. (eating)
4. Uncooperative or resistant to oral care

TOOLS FOR ORAL PAIN ASSESSMENT IN DEMENTIA

- The Mobilisation-Observation-Behaviour-Intensity in Dementia pain scale (MOBID)
- The Oral Hygiene Assessment Tool (the OHAT)
- The Pain Assessment in Impaired Cognition (PAIC) Metatool
- The Orofacial Pain Scale – Non Verbal Individuals (OPS-NVI)

OPS –NVI

- OPS-NVI pain scale is designed specifically to estimate the presence and severity of orofacial pain in nonverbal patients.
- The OPS-NVI consists of four subscales namely, “resting”, “drinking “, “chewing” and “oral care”.
- Each subscale contains a total of 16 items of observed behaviour that are classified into four categories, namely, “facial activities”, “body movements” , “vocalizations” , and “specific behaviour”.

ITEMS FOR OBSERVED BEHAVIOUR FOR EACH SUBSCALE OF THE OPS-NVI

- **Facial Activities**

- (1) Frowning: lowering and drawing brows together.
- (2) Narrowing or closing eyes: narrowed eyes with tension around the eyes, not just blinking.
- (3) Raising upper lip: upper lip raised, nose may be wrinkled.
- (4) Opened mouth: the lips are parted and jaw is dropped.
- (5) Tightened lips: lips are pressed together and appear more narrow.

- **Body Movements**

- (6) Resisting care: resisting care, being uncooperative.
- (7) Guarding: protecting affected area, holding body part, avoiding touch, and moving away.
- (8) Rubbing: tugging or massaging affected area.
- (9) Restlessness: fidgeting, wringing hands, and rocking back and forth.

- **Vocalizations**

- (10) Using offensive words: cursing, sweating, or using foul language.
- (11) Using pain-related words: using pain words, like “ouch,” “ow,” or “that hurts.”
- (12) Screaming/shouting: using a loud voice to express
- (13) Groaning: making deep, inarticulate sounds.

- **Specific Behaviour**

- (14) Restricting jaw movement: making smaller jaw movements than possible.
- (15) Refusing prosthetics: removing prosthetics again and again.
- (16) Drooling: flowing of saliva outside the mouth.

THE PROCESS

- History, Proxy report , Self Reported Pain, Pain diary
- Emotional status, Functional status ,contextual status
- Modifying, eating, drinking, Limiting mandibular movement Avoiding oral hygiene care Holding or rubbing orofacial area
- Dental Examination –comprehensive extra-oral and intra oral exam
- Assessment before and after pain management intervention (i.e. analgesic trial , dental intervention)

TO CONCLUDE

- Revisit your service provision for emergencies in vulnerable groups
- Focus on communications with all stakeholders and teams
- Train and educate
- Justification and documentation
- Use the concepts of pain assessments tools in line with the individual patients
- Advocate



- Thank you Any Questions?

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