Providing care for those with special needs
We all look after patients with special needs…but do we do it well? asks Mhari Coxon

I had the pleasure of attending a study day in Dorset with the Oral Health Promotion Unit of Special Care Dentistry at Dorset County Hospital NHS Foundation Trust recently. Philips were supporting the day, along with Henry Schein, Dentisply and Survival 52. The day was run by Debbie Chandler and Richard Valle-Jones.

The first speaker was Kerry Martin of Dorset People First, a charity group who support people with disability and who campaign for respect and quality treatment for their members. Kerry is herself disabled and gives a wonderful, eloquent insight into how we as healthcare professionals deal with them as patients. Embarrassingly, there tends to be common mistakes we make which make it very difficult for the patient. Kerry videoed other members of Dorset People First to help highlight the issues for the delegates. These same members offered solutions to the common problems also.

The three most common errors were:
• Talking to the patient like a child or idiot. Learning disability does not mean no brain whatsoever!
• Rushing the treatment and not explaining well what is going to happen. Not communicating effectively generally.
• Not explaining the choices well and allowing for informed choice.

“Embarrassingly, there tends to be common mistakes we make which make it very difficult for the patient”

I am so glad to report that Kerry had recently had a hygienist session where the hygienist had worked with Kerry to make sure she was comfortable and checked regularly that what she was saying was understood. She also spoke to Kerry on an equal level and that was well received also.

I then spoke on treating patients with Pervasive developmental disorders (PDD) and how to communicate and plan for successful treatment sessions. PDD is often referred to as the umbrella term Autistic Spectrum Disorders (ASD) by parents and professionals.

Here I was trying again to show the patients’ point of view and give an understanding into what can trigger a bad experience for the patient and result in no treatment being possible.

Again we looked at healthcare professionals’ assumptions of non verbal meaning not able. Non verbal patients can and do often have high understanding and should still be given the right to choose and give consent in these situations. I talked about Makaton, a simple signing, picture language to accompany speech which is used a lot for people with learning dis-
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I also discussed PECS - Picture exchange Communication System, and how using pictures and words to form a story book and order of treatment can reduce anxiety and increase compliance.

This topic led nicely into the third speaker of the day Paul Greening who discussed the Mental Capacity Act. Here he discussed the learning difficulty and communication issues when it came to many patient groups, including those with dementia. With one in three over 65s going to die with some form of dementia, this is a real and relevant topic for discussion with all dental professionals, not just those in Special Needs Units. He explained the three criteria for consent very well and in an easy to understand form.

The criteria he discussed were:
- Can I understand what you are saying to me?
- Can I remember it for a period of time and weigh the information?
- Can I come to a conclusion?
- Can I communicate this to you?

If the answer is no to any of these questions then you cannot assume patient consent. In this situation, you either need to seek consent from a party with authority, not always the parents, family or carers, or ask for someone to come and act as an independent on the patients behalf. They would ask the questions and help you to come to the right choice for the patient. There are exceptions to this rule. When the patient’s life is in immediate danger then the healthcare professional will be allowed to make the decision in their patient’s best interests. I would feel this would be a rare occurrence in dentistry. There are also the considerations required for when the patient was able to decide previously but is now no longer able.

That patient may have had very clear opinions on certain forms of treatment and if aware of their condition its rate of deterioration, made and Advanced Capacity for Treatments document with their attorney where they documented their wishes while still able.

All of the talks and problems they looked at were resolved with good understanding and communication with the patient. Communicating with someone with a disability and or learning difficulty cannot be achieved by speaking louder and more slowly!

The day was incredibly positive and showed a great respect and desire for good quality treatment for this ever expanding patient group. What it also highlighted to me was a need for good postgraduate lectures, workshops and training in this field to better serve us in the dental profession which in turn will better serve the patient and maintain a good level of oral health; our ultimate goal.

“*If the answer is no to any of these questions then you cannot assume patient consent.*”

About the author

Mhari Coxon, Mhari has 20 years experience in dentistry, working as a nurse, receptionist, oral health advisor and ultimately hygienist in a variety of practice environments. She is passionate about her profession. An innovator, she works as Senior Professional Relations Manager for Philips Oral Healthcare and clinically as a hygienist in central London.

In 2006 she was the Dental Awards hygienist of the year, and was highly commended in 2010. 2011 saw her placed 15 in the Dentistry Top 50 most influential people in the UK.