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Case report: A decision not to treat in the era of COVID

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Introduction

Older people are at significantly increased risk of developing severe disease from COVID.[1] In addition to this direct risk, COVID has indirectly created both new barriers to accessing oral care, and exacerbated existing barriers for the older population.

As this patient's journey unfolded from initial referral, multiple barriers to care were experienced which impacted the decision making process for this patient.

Case Overview

A 74 year old female patient with advanced dementia living in a nursing home was initially referred to the special care dental team by their general medical practitioner in April 2020 with reports of changes in eating pattern and a query of dental pain. The patient was assessed to lack capacity to consent for dental treatment.

In September 2021 the patient presented with poor oral health and a history of intermittent changes in behaviour and eating. The patient had experienced a facial swelling on the right side of suspected dental origin which was treated by the general medical practitioner (GMP) with antibiotics and analgesics. This led to another domiciliary dental assessment and best interests meeting.

Timeline

April 2020 - Referred by general medical practitioner (GMP).

June 2020 - Offered two clinic appointments but the patient was too distressed to enter transport on both occasions.

October 2020 - Teleconsultation with registered general nurse (RGN).

October 2020 - Domiciliary assessment. Changes to eating were assessed not to be dentally related. Planned to monitor with 3/12 recall.

February 2021 - Teleconsultation with RGN. Distressed behaviour had escalated and the patient refused medications. Domicillary visit offered but the care team contacted GMP due to visit the same day.

March 2021 - Teleconsultation with registered nurse. The GMP had prescribed risperidone and co-codamol. The patient had settled and resumed eating.

September 2021 - The care team reported a facial swelling to the GMP who prescribed amoxicillin and metronidazole. The patient was reviewed on dental domiciliary visit and swelling had resolved. IMCA appointed.

October 2021 - Domiciliary dental review and best interests meeting.

Covid related barriers to care

Accessibility

Initial visual assessment was delayed.

- The patient was not initially referred as requiring domiciliary care.
- Domiciliary care was initially restricted to urgent and emergency care only.[2]
- Once restrictions on domiciliary care were reduced[3], routine domiciliary care was less available due to a backlog following the national postponement of elective dental care early in the pandemic.
- The care home initially restricted visiting, requiring the residents to be seen outside. Visiting staff are now required to provide a negative lateral flow test.

Dental Availability

- Urgent care centres[2] were not local or familiar to the patient, and travelling caused the patient distress.
- Recall appointments were delayed due to a Covid related backlog.
- GA availability was reduced and the most local hospital with an amber pathway would be an unmanageable journey for this patient (approximately 1.5hours).

COVID Transmission

The direct risk of COVID to this vulnerable patient was considered with any additional interaction or proposed travel outside of the home or treatment.

- Treatment under general anaesthetic carries increased risk when COVID positive. This patient unable to swab so her COVID status was unknown, therefore treatment carries greater risk. It has been recommended that the threshold for surgery should be higher during the pandemic especially in patients over 70.[6]
- Dental teams had to develop new Local Standard Operating Procedures for domiciliary care to reduce the risks of COVID transmission.
- Many care homes also required residents to isolate in their rooms for 2 weeks following a clinic visit to protect other residents, which could have been distressing for this patient.
- It was not possible for all key parties to meet face to face best interests meeting.

Staff Wellbeing

- Living and working in uncertainty of the pandemic affected staff wellbeing and psychological needs.[4] Dental teams had to acknowledge and support staff experiencing COVID related anxiety when visiting an environment where there was risk of COVID transmission in either direction between vulnerable patients and staff. Poor staff wellbeing has been associated with an increased risk of patient safety incidents, reduced patient satisfaction and poorer quality of care.[5]

Communication

- Communication with the patient. Additional PPE created a barrier to communication with the patient and maximising her involvement in the decision making process. Teleconsultation would have been too unfamiliar for the patient, and therefore initial communication was only via her care team.
- Communication between the multidisciplinary team. A perceived lack of access to dentistry due to the COVID-19 pandemic resulted in dental concerns being managed at times by the GMP. Separate clinical records create a barrier and delay in requesting information.
- Communication with patient advocates. Due to restrictions in family visiting related to COVID-19, the care team initially stated the patient's family were not involved. Therefore an IMCA was appointed as the best interest decision related to potentially serious medical treatment. However the GMP later reported that they were in regular contact with the patient's sister, who was then able to give the patient a voice in this process.

Examination

The patient was observed eating in her bedroom on a domiciliary visit and had no extra-oral signs of dental pathology. However the patient became distressed if intraoral dental examination was suggested. Severe wear and discolouration were visible on the anterior teeth. Staff were concerned about dental pain and had seen multiple broken teeth, but the patient reported that there was nothing wrong with her teeth. A clinical frailty score of 7 was assessed.

It was identified that the only way to carry out treatment would be under general anaesthetic (GA), or anaesthetist administered conscious sedation, both of which would require a hospital visit.

A best interests meeting was held with the care team and two dentists present, with prior input from GMP, independent mental capacity advocate (IMCA) and the patient's sister. The two most viable treatment options were discussed: treatment under GA which may entail multiple extractions, or minimally invasive symptomatic treatment at home with analgesics and antibiotics.

Treatment Options

Option 1: Treatment under GA

Benefits	Risks
Treat source of pain and infection	Distress of potential overnight stay Distressing journey COVID transmission GA Risks and recovery Invasive dental treatment recovery

Option 2: Minimally invasive

Benefits	Risks
Less distressing for patient Avoids all risks outlined with active treatment	Pain and infection which could impact on eating and quality of life

Best Interests Decision

It was concluded that the risks and potential distress posed by invasive treatment outweighed the benefits. The decision was therefore made to provide minimally invasive symptomatic treatment at home with analgesics and antibiotics.

Best Interests Decision

The COVID Pandemic has disproportionately affected the older population; not only is this patient more vulnerable to serious disease from COVID itself, but precautions relating to the virus have created additional barriers to accessing oral care. These barriers had an impact on this patient's care pathway and the decision making process. However it is possible that the same best interests decision would have been reached regardless of these additional COVID related factors.

References

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3. *Office of Chief Dental Officer England. Standard operating procedure Transition to recovery. 4th June 2020*
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5. *Panagioti et al. Association Between Physician Burnout and Patient Safety, Professionalism, and Patient Satisfaction: A Systematic Review and Meta-analysis. JAMA Intern Med. 2018;178(10):1317-1331.*
6. *COVIDSurg Collaborative. Mortality and pulmonary complications in patients undergoing surgery with perioperative SARS-CoV-2 infection: an international cohort study. Lancet. 2020 Jul 4;396(10243):27-38.*