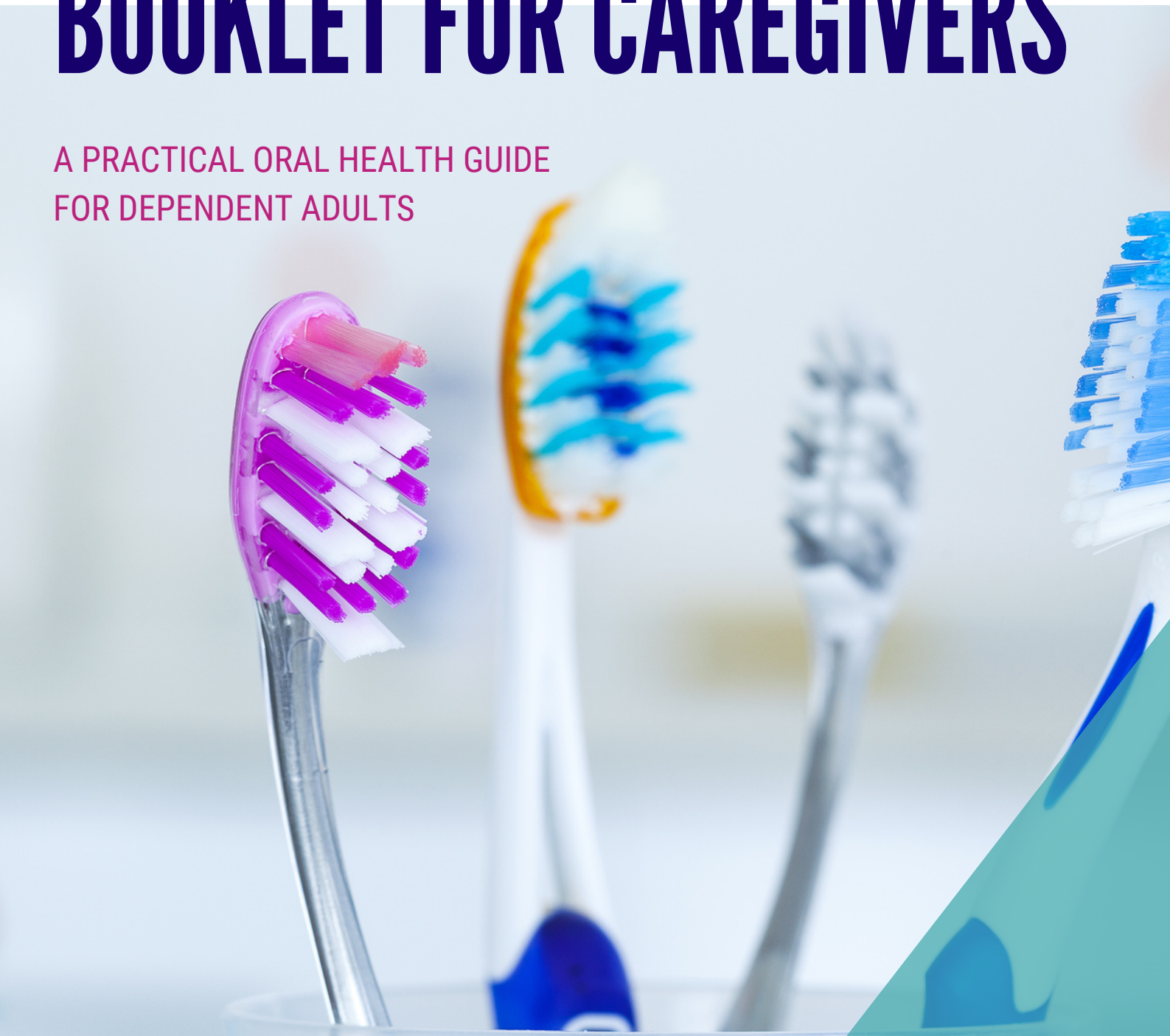
ORAL HEALTH CARE BOOKLET FOR CAREGIVERS

A PRACTICAL ORAL HEALTH GUIDE FOR DEPENDENT ADULTS



Knowledge Oral Healthcare
Every mouth matters

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CONTENT

INTRODUCTION TO ORAL HEALTHCARE

The term 'Oral Health' means far more than just good teeth, it is integral to general health and essential for well-being.

This oral healthcare training session is designed to help any carer who is involved in the daily routine of oral care and outlines the importance of healthy mouths and good oral care.

Vulnerable groups such as the elderly with dementia and/or nursing and people with Learning Disabilities living in care homes are certainly more at risk from poor oral health. We know that these groups tend to have more untreated decay and more periodontal (gum) disease than society at large. For some people, this requires that additional action and support is in place to improve oral health. Oral health needs to become integrated into holistic health policy at all levels and should be included in every individual care plan.

Effective integration of oral health into the mainstream health agenda is required to ensure that oral health issues are not omitted or dealt with separately and seen as 'the dentist's problem'.

Mouth care is personal and sensitive so confidence in carrying it out needs training and practice. If someone is unable to look after their own mouth then you have a duty of care to support them. It is very importance to prevent oral disease and it is your knowledge and understanding of the person you care for and the day to day practical care you give which matters most.
(Keep Smiling R&RA)

People are keeping their natural teeth a lot longer so oral healthcare will almost certainly become a more common task for care staff. Oral care should be carried out as an integral aspect of personal care, however, mouth care is often overlooked due to demands on staff time and priority is placed on other seemingly more urgent tasks. Some care staff report being nervous about brushing someone's teeth in case they hurt the person, being reluctant to persist in trying to care for a resident who resists or is uncooperative because of dementia.

KEY POINTS STAFF SHOULD BE AWARE OF

Good oral health will contribute positively to overall health and wellbeing

• Dental decay and gum disease are entirely preventable.

•Effective daily oral care can prevent oral disease.

•Looking after oral soft tissues is just as important as looking after the teeth.

• Early detection of mouth cancer is important so 'if in doubt, get checked out'.

• Oral care is the responsibility of every member of the care staff. Care is required 24 hours a day, so this includes both night and day staff.

• Tooth brushing, diet and dental visits are the main steps towards good oral health.

• Oral care should be enhanced if 'less abled' people need or prefer a higher intake of food or drinks containing sugar.

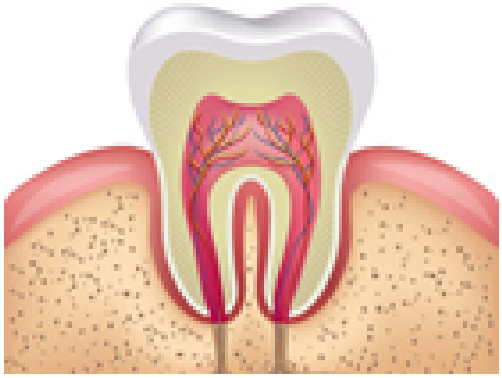
• Oral health risk assessments, care plans and documentation of daily care should be carried out for every resident

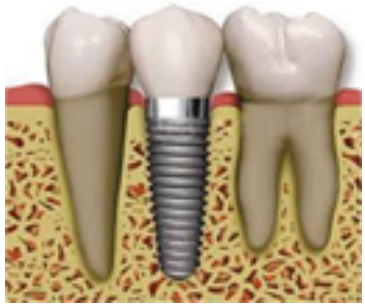
• When a resident becomes uncooperative and won't let you near their mouth – think! Are they in pain?

• Swallowing problems are common among people with learning disabilities and require special assessment and care.

• In palliative and end-of-life care, mouth care must be carried out regularly to ensure a person is kept as comfortable as possible

THE MOUTH





TOOTH STRUCTURE

• ENAMEL

Is the hard white outer shell of a tooth visible above the gum.

DENTINE

Lies underneath the enamel. It is the yellow part of the tooth. It may be sensitive to hot, cold and sweet.

NERVES (pulp)

Located in the centre of the tooth and provides blood supply and nerve sensation to each tooth.

The teeth are held in the jaws in bone. It is important that we keep the supporting structures healthy.

WHAT IS PLAQUE?

• As the aging population's awareness of the importance of good oral health increases we find people are keeping their teeth for longer.

Residents may present at care homes having had advanced and complex treatment

carried out previously and it is important to recognise that it exists. For example;

crowns, bridges, acrylic and chrome cobalt (metal clasp) dentures and implants.

Dental plaque is a sticky film of BACTERIA which starts forming just hours after brushing

• It can form on all surfaces of the teeth. It can stick to any hard surface in the mouth

• It contributes to decay and is the major cause of gum disease.

• If it is left in the mouth it can harden and become tartar (calculus)

Dental plaque is a sticky film of BACTERIA which starts forming just hours after brushing

If it is not removed it can cause:

- Bad breath
- Gum disease
- Tooth decay

Loose teeth and eventually tooth loss

BLEEDING GUMS (GINGIVITIS)

Even if the gums bleed slightly, continue to brush them. The bleeding is usually the result of plaque build-up and continued brushing will improve gum health.

Unhealthy

Gums bleed when brushed. This is called gingivitis and simply means inflamed gums.

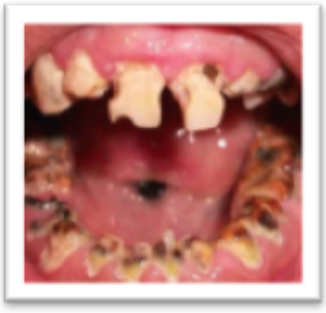
Healthy Gums do not bleed when brushed.

Plaque irritates the gums if not removed by brushing.

Gingivitis is reversible - unhealthy gums can become healthy again.

If a resident's gums bleed when brushing them do not be alarmed. This is an indication that plaque has been collecting at the gum margins and caused inflammation. Gently brush the gum margins to remove the plaque; you will notice that after a few days the bleeding will stop.

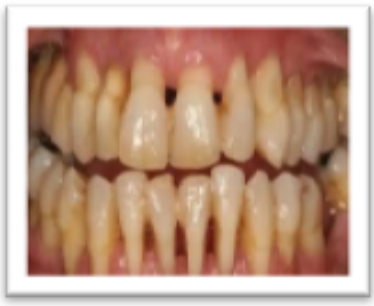
DECAYED AND BROKEN TEETH



Some residents will have broken teeth (this should be noted at the oral assessment visit).

It is important that these areas get brushed as they are more likely to trap plaque. If a resident is complaining of any oral discomfort this must be noted and the care manager informed.

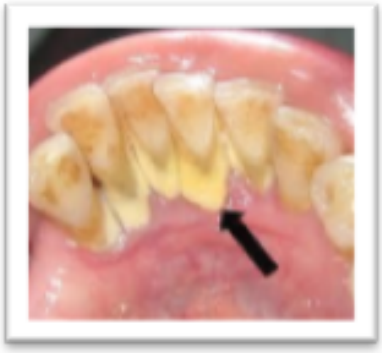
LOOSE TEETH



If plaque bacteria are allowed to remain around the teeth at the gum margins it can destroy the underlying bone support around the teeth over time, leading to loose teeth and finally tooth loss.

This may cause difficulty with brushing if the teeth are moving.

CALCULUS (TARTAR)



Calculus is calcified plaque and you will not be able to remove this with a toothbrush.
Calculus can be removed by scaling but it is the plaque that can build up on the surface of the calculus that causes damage.

It is advised that you brush over the calculus with a toothbrush to try and prevent it building up anymore.

DRY MOUTH (XEROSTOMIA)

Causes of reduced saliva flow:

- Medications
- Stress
- Cancer therapy

Consequences:

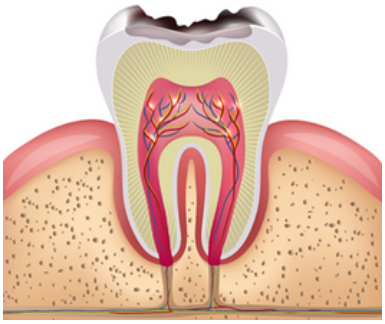
- food sticks to the roof of the mouth
- difficulty swallowing
- difficulty talking
- taking dentures in and out will be more difficult

A person needs regular sips of water and beverages in order to keep the mouth well lubricated and tissues healthy.
Saliva substitutes are available as gels, sprays, rinses and lozenges, these substitutes can be particularly helpful for people in palliative/end of life care.

ORAL CANCER

Record any soft tissue abnormality in the resident's care plan
Report suspicious ulcers and swellings (non-healing, painful, large) to the Care Manager.
Notify the resident and/or next of kin and contact either a Dental Professional to see the resident or refer directly to the hospital.

TOOTH DECAY (CAVITY)



PLAQUE + SUGAR = DECAY

When sugar is eaten it causes the environment of the mouth to become acidic.

It takes approximately 30 minutes before the mouth goes back to neutral again.

If you have plaque on your teeth, the plaque becomes acidic and starts to soften the enamel. Over time this can cause a cavity.

How often (frequency) sugar is eaten is more relevant than how much (quantity) is eaten.

DIET

When a high calorie intake is recommended to maintain nutritional status, intensive preventive techniques are recommended. For people on long term sugar based medication, wherever possible sugar free medicine should be prescribed as an alternative as it is not only detrimental to oral health, but can also have a negative impact on general health (C.O.M.A., 1989)

It is recommended that there is a reduction in both the frequency and amount of added sugars consumed. It is important that both parents and carers are aware that honey, fresh fruit juice and dried fruit all contain
decay producing sugars. For children at risk of dental decay.

The National Guidelines recommend completion of a 3-4 day dietary diary, dietary counselling with
limited achievable targets and regular monitoring of compliance (Royal College of Surgeons, 1999). A
diet diary should establish the following information:

- Number of food/drink intakes per day
- Number of sugar containing intakes (excluding those found in whole fruit)
- How many sugar foods consumed between meals
- How many sugar foods consumed within one hour of bedtime

*Dietary supplements should be given at meal times, whenever possible.

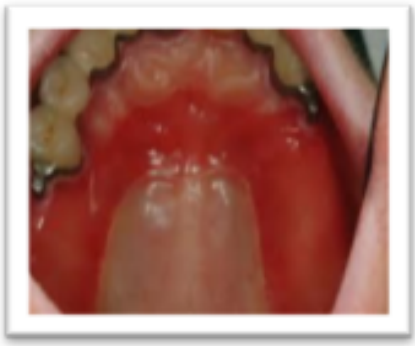
SUGAR SUBSTITUTE

xylitol - is a sugar alternative which is generally manufactured from birch and other hardwood trees. The benefits of xylitol is on dental health as it has been found to neutralize plaque acid and repair enamel. Studies show
that Xylitol can reduce decay as much as 30- 85%. Excessive consumption may have a laxative effect. Unfortunately this sugar substitute is not readily available in supermarkets but can be purchased in health shops or online

ORAL FINDINGS

Oral problems often go undetected because care staff lack the confidence to look into residents' mouth. Care staff are not expected to be able to identify oral problems by name, but if they are regularly checking a resident's mouth then they will be able to note changes or problems.
Observe and report – to a nurse or person in charge when something looks problematic. Some oral conditions can initially progress without any pain to the resident but can be very harmful if left undetected. Any changes should be reported to the person in charge who will record the detail within the resident's personal plan and take appropriate steps for the resident to be seen by a dentist.

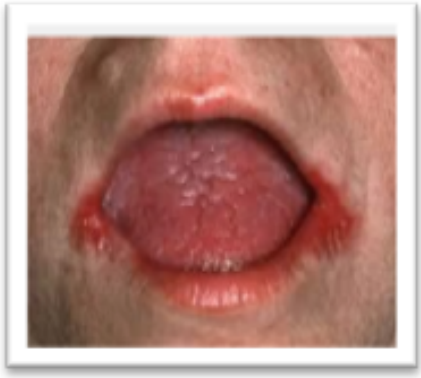
DENTURE STOMATITIS



It is a fungal or bacterial caused by leaving dentures in the mouth for too long.

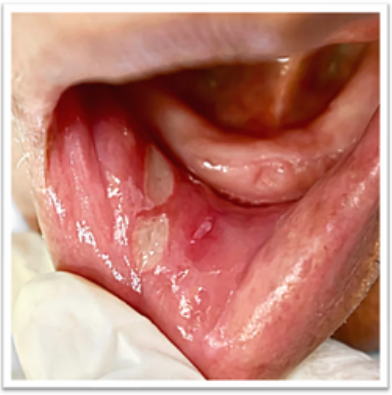
The palate appears red and spongy. It is not often associated with pain. Encourage residents to leave dentures out overnight to avoid this.

ANGULAR CHEILITIS



This is a bacterial or fungal which appear as cracks or sores in the corners of the mouth.
It is recommended to clean the corners of the mouth daily with antibacterial soap and keep dry.
It can be resolved by topical medication (cream) prescribed by a medical or dental professional.

MOUTH ULCERS



Mouth ulcers have various causes (often traumatic due to broken teeth).
All ulcers must be recorded in the resident's care plan. If an ulcer does not heal within 14 days it must be reported to the Care Manager for referral to a Dental Care Professional.

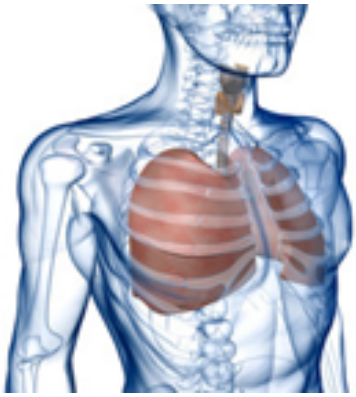
THE EFFECTS OF POOR ORAL HEALTH ON THE BODY

Poor oral health will impact on an individual:

- Nutrition
- Communication
- Appearance
- Overall health

Research has shown there to be a link between poor oral health and its effect on the body. If bacteria are not removed from the mouth it can escape into the bloodstream. Ensuring that plaque is removed from the teeth and dentures on a daily basis will not only help prevent teeth and gum problems but it will help reduce the risk of other health complications.

ASPIRATION PNEUMONIA



Aspiration pneumonia is a life-threatening condition where plaque and food debris from around the teeth and dentures get inhaled into the lungs and cause an infection.
This can be avoided by simply removing plaque from the teeth and dentures daily.

SYSTEMIC LINKS

Infections from the mouth can affect general health and vice versa.
Oral bacteria can cause specific heart damage (endocarditis) in people who have pre-existing
heart valve problems Poor oral hygiene is a key risk factor for pneumonia and respiratory tract infections in vulnerable people.

Oral bacteria has been linked to:

- Heart disease
- Diabetes
- Rheumatoid Arthritis
- Dementia

DENTURE CARE

Wearing a denture for long periods of time may lead to denture stomatitis - inflammation underneath the denture. With denture stomatitis the soft tissues can appear red but quite often the resident does not complain of pain or discomfort.

All dentures should be cleaned twice daily; morning and night. While the dentures are out of the mouth, the person should rinse their mouth with water to remove any food debris.

It is NOT advisable to use any denture cleaning / soaking solutions overnight as this can cause the denture to become brittle and porous over time causing it to become more likely to fracture and break.

CLEANING DENTURES

Dental plaque will stick to any hard surface meaning that not only will it adhere to teeth but to dentures too. So dentures like teeth require mechanical cleaning!

1. Use a soapy detergent such as a mild soap and denture brush or toothbrush. Ensure that you rinse it thoroughly under running water! Alternatively use a denture cleaning product that effectively cleans the dentures. NB. Toothpaste is discourage because this can scratch the denture.

2. Dentures can be soaked in a denture-cleansing solution after mechanical cleaning for 20mins or as directed. This seems to be beneficial for preventing denture stomatitis and the potential risk of pneumonia events in these groups of people.[DO NOT soak dentures overnight as this damages the denture material].

3. Place in a clean named denture pot DRY.

DO NOT..

- use any type of bleaching product to clean your dentures. Bleaching can lead to weakening of the dentures as well as making them look unsightly.
- use very hot water to soak your dentures as it can weaken the dentures causing them to break
- remove tartar yourself as you may damage the denture material. Contact a dental technician or dentist to have them professionally cleaned.

ASSISTING WITH TOOTHBRUSHING

Residents are encouraged to brush independently for as long as they are able to do so. It is important to keep a person's independence for as long as possible. Reminding a person to brush is sometimes what is needed.
This oral care guide gives practical skill required to deliver good oral care.

TOOTHBRUSHING PROCEDURE

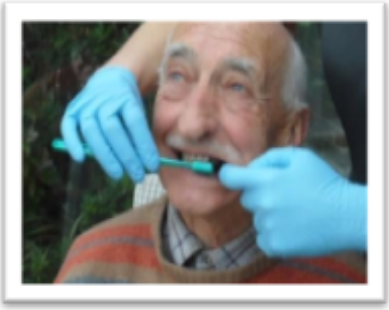
The technique itself, is less important than the effectiveness of plaque removal. Support and assistance for toothbrushing may be required

1. Ensure resident's privacy and comfort and explain procedure
2. Ideally it is better to carry out brushing with the person sitting down or in bed with the bed at 40-50 degrees brushing from the back/side of the person so that you have better access and visibility.
3. Place towel under chin
4. Place a flannel in the sink and part fill with cold water
5. Remove denture/s brush with mild soap or denture cream and water place in a denture pot (if cleaning teeth at night).
6. Ask resident to open mouth or open gently with your hand a. If nil by mouth or resident with dysphagia, swab with damp gauze or Moutheze (MC3) over tongue, around inside of cheeks and around the gums and teeth.
7. Apply a pea size amount of fluoride toothpaste to the resident's toothbrush (manual or electric)
8. Brush surfaces starting with the outer surfaces in a gentle back and forth motion.
9. Get resident to spit out excess but try not to get the resident to rinse unless they suffer from a dry mouth so that fluoride remains in the mouth for longer, helping to protect the teeth.
10. Check for any sores or any changes whilst brushing.
11. Use interdental aids such as floss or interdental brushes if you have been advised by a dental professional or requested by the resident or next of kin. It is most important that you brush and remove as much plaque as possible from the teeth surfaces.

Talk to the resident at each stage and ensure that he/she understands what you are doing

FLUORIDE TOOTHPASTE

Fluoride is a mineral and occurs naturally in water in some parts of the world.
Fluoride toothpaste has been shown to help reduce the incidence of cavities and help arrest (stop) decay from progressing. Fluoride is added to toothpaste to help strengthen the enamel. A dentist may prescribe toothpaste which has a higher concentration of fluoride - Duraphat 2,800 and 5,000ppm or prescribe fluoride varnish to be applied to the teeth as a preventive measure every 3 months for high dental risk individuals.



POSITIONING

If the individual is able, have the person sat up in bed or in a chair.
If seated in a chair, a high-backed chair is preferable. Greet the person from in front and explain what you are doing.
As people decline with dementia they often have problems with spatial awareness, therefore it helps when greeting the person to place your hand on their shoulder or arm to give the person awareness of where you are. Then stand to the side or behind the person when toothbrushing as you will find this less stressful on your back.

ORAL HEALTH ASSESSMENT AND CARE PLANS

QUALITY STANDARD (QS151) July 2017

ALL new residents require an Oral Health Assessment. You should have an Oral health assessment completed and a care plan outlining daily mouth care following the assessment.

ORAL HEALTH ASSESSMENTS

When carrying out an Oral Assessment you need to assess the lips, teeth, tongue, palate,
floor of the mouth (under the tongue).
Oral assessments need be carried out upon admission and a care plan must be created accordingly.
Any changes in he mouth (for example a broken tooth or ulcer) must be recorded in the resident's notes and reported to the care manager if causing pain, discomfort or does not heal within 2 weeks refer to a GDP or dentist.

To conduct an oral assessment you will need;

Essential

✓ Gloves
✓ Toothbrush
✓ Oral Health Assessment form

Desirable

✓ Torch
✓ Mouth mirror

The assessment should then record

- the name and contact details of the dentist if they have one
- How they normally care for their teeth
- Whether they have any natural teeth and their condition
- Whether the person has dentures and if so details
- The level of assistance the person will require
- Whether the person is experiencing any problems and if so details
- Whether the person needs urgent check up or treatment
- Any mouth care products which they will need and who will provide this
- Date of next review

The assessment will form the basis of the mouth care plan that will follow

ORAL CARE PLANS

An oral care plan is developed as a result of the findings of the oral health risk assessment. The completed risk assessment should highlight any need for a dental referral. Information on the referral process in your area is included in the Local information section of this guide.

DAILY DOCUMENTATION OF ORAL CARE

Record-keeping by care staff is essential and this requirement to document care often acts as a
useful prompt. It is also important that any reasons for non-cooperation on the part of the resident are recorded in notes in a way that highlights any NB. Assessment of a person's oral hygiene skills by the
carer may be necessary to ascertain that person's manual dexterity and ability to be self-caring. However, all people should be encouraged to brush their own
teeth, even if support and assistance are required..

DEMENTIA

The number of residents with dementia who have their own teeth is expected to significantly rise. People with dementia are most likely to present care staff with the greatest challenges as these people are more likely to resist brushing.

- If oral care is not carried out a vicious circle of pain and discomfort leading to increased resistance becomes likely.
- Those with advanced dementia maybe unable to communicate that they are in pain or have discomfort in their mouth. They may do this in other ways such as crying, pulling or hitting their face, hitting out at care staff, or being very passive.
- Resistance to oral care by people with dementia is often a response to fear.

View this behaviour as a sign of distress rather than thinking the resident chooses to be aggressive and uncooperative.

MANAGING PEOPLE THAT ARE RESISTANT TO DAILY MOUTH CARE

Unfortunately, there is not one magic solution for individuals that resist mouth care but there are a number of strategies and tips you may find helpful.

- Approach from in front, kneel down so that your face is at the same level or lower than theirs.
- Say what you are going to do before you do it – for each step. You may need to show them what you will do – on yourself.
- Give reasons for what you are doing. Give positive feedback and encouragement. Reflect on how good it feels to have a fresh mouth.

TIPS AND COPING STRATEGIES FOR PEOPLE THAT RESIST MOUTH CARE

Vulnerable adults living in care homes are at higher risk of oral health problems and related conditions due to high levels of dependency and dementia. As people advance with dementia they tend to become more resistant to mouth care making toothbrushing particularly challenging for carers and consequently result in carers are less likely to want to approach and carry out this part of personal care.

Below are some Tips & Coping strategies from Mouth Care Without A Battle [University of North Carolina]. Unfortunately there is no one solution, and techniques which are found to be helpful may need to be adapted as a persons mental or physical health declines.

Encourage Independence

Do all you can to encourage as much independence as possible. Residents may exhibit less resistance when care staff encourage them to carry out their own oral care as it gives them a sense of control.
[NHS Scotland tips and coping strategies]

When assisting someone with mouthcare, try and carry out brushing sitting down as you will be able to see better. Come in front to greet the individual and talk and then deliver care from the side as this is better on your back and visibility.

- **Bridging** – 'Follow my leader style'. Describe and show the toothbrush to the resident, mimic brushing your own teeth, give a spare toothbrush to the resident, and the resident may mirror your behaviour and brush their own teeth
- **Chaining** – this involves gently bringing the resident's hand to the mouth whilst explaining what you are doing. Let the resident continue if they are able.
- **Hand over hand** – if chaining is not successful, then place your hand over the resident's and gently brush the teeth together.
- **Distraction** – Try singing or giving the person something to hold or do by placing a familiar item in the resident's hand while you brush the resident's teeth.
- **Rescuing** – Sometimes having someone new (rescue) take over the task works bringing a different approach, different manner which may encourage the resident to cooperate.
- **Timing** – The morning may simply not be the best time. Having oral care after medication and breakfast may be better.
- **Breaking the task down** – It maybe that one side of the mouth gets brushed in the morning and the other side in the evening? Ensure that you note what area has been brushed so other staff are aware.

Tips. If someone refuses to open

They may not understand you or may not want to have their teeth brushed.

- If the person is agitated then come back another time.
- If someone doesn't open then stroke the side of the cheek to encourage them to open their mouth
- Be reassuring.
- Say what you are going to do before you do it. Touch the mouth, or teeth gently with the brush to prompt opening.
- Place the back of the toothbrush against the lips and gently twist it so it opens the lips and touches the front teeth Start by cleaning the outer surfaces of the front teeth. Then move to the outer surfaces of the back teeth
- Or….with a smile, say that you'll come back later.

Hand on Shoulder Distraction Technique

Teepa Snow's Hand on Shoulder Distraction Technique has received positive feedback from caregivers.

1.Stand to the side dominant side of the resident. If the individual is right handed stand to the right side as this is where all the brain history is for fine motor skills and automatic behaviour. The resident will also look and pay more attention if you are on their dominant side.

2.Put the toothbrush in the resident's dominant hand so the resident thinks they are brushing their own teeth.

3.Place your hand over theirs to guide their hand to their mouth [you are the tool manipulator]

4.Place your other hand on the resident's shoulder closest to you, applying downward pressure. This technique is tricking the brain not to pay so much attention to the mouth.

If someone shows physical aggression

Come back later; pick another time of day when the person is calmer and more receptive.

- Try someone the person is more familiar and relaxed with.
- Be patient, take time and be reassuring.
- Do not talk about the person but always to the person.
- Explain what you are going to do and why you are going to do it.
- Stay calm and quiet yourself.

Look in the mouth for any signs of soreness, infection, broken teeth etc.

If someone grabs your hand

Grabbing the hand is most common in the middle stage of dementia.

- Stop what you are doing. They may not understand so explain what you are doing or they may be in pain.
- They may want to do the brushing themselves. Give them the toothbrush, put your hand over theirs and guide them.
- If you notice bleeding, ulcers or sores be gentle and keep an eye on them.

Biting the toothbrush

- If someone bites down on the toothbrush whilst brushing have another brush handy to continue brushing the teeth. This gives you access to the inside of the teeth
- Gently rubbing the cheek or jaw - relaxes jaw to release the toothbrush

Sucking the toothbrush

This is an instinctive reflex.

- Explain what you are doing, be gentle assure them you will be quick.
- Gently rub cheek to relax jaw muscle.
- Start by cleaning the outer surfaces of the front teeth. Then move to the outer surfaces of the back teeth.
- Ask the person to say 'ah' for cleaning the biting and inside surfaces.
- Give positive feedback and encouragement

A dry, sore mouth will be uncomfortable which may also contribute to a person resisting mouth care. Be gentle, use a soft brush, run it under warm water.

If unable to spit

- Dampen the toothbrush in mouthwash or use a smear of toothpaste, preferably non foaming.
- Put a cup under mouth although they may associate the cup with drinking and not spit into the cup but over it. If this is the case then put the person near a sink for spitting.
- Do not put addition fluid mouth in the mouth
- Ensure that the individual is sat up
- Use a gauze to remove excess fluid or use a suctioning toothbrush.

What to do if someone continually refuses mouthcare

If a resident refuses mouth care on several consecutive attempts, this should be escalated to a senior nurse or their medical team

Who should consult with one of the following:

• dementia Liaison or Community Mental Health teams
• the resident's dentist if they have one or healthcare professional
• your local NHS Dental Helpline for advice and information on which dentists in your area can help.

FOR LEARNING DISABILITIES (PEOPLE LESS ABLE)

Vulnerable groups in particular Learning Disabilities are certainly more at risk from poor oral health. We know that children and adults with disabilities and people with mental illness tend to have fewer teeth, more untreated decay and more periodontal (gum) disease than society at large.
For people of learning disabilities, for some, this requires that additional action and support is in place to improve oral health.good practice guide for improving the oral health of disabled children and adults

DENTAL PAIN

The majority of people with a learning disability have poor verbal skills and are restricted in their ability to communicate their needs (Howells, 1986), possibly only being able to manifest their discomfort or pain through changes in behaviour. Very young children also lack verbal skills and so may not be able to explain toothache or complain of pain (Low et al., 1999).

Fear and anxiety are the most common barriers to dental care and people with learning disabilities are no different from the wider population in this respect.
However, it may be harder to discuss and resolve those fears. Inability to cooperate with treatment leads to Clinical Guidelines and Integrated Care Pathways for the Oral Health Care of People with Learning Disabilities 2012.

FOR SOMEONE UNABLE TO EXPRESS DISCOMFORT THEY MAY EXHIBIT A CHANGE IN BEHAVIOUR WHICH MIGHT INCLUDE ANYONE OF THE FOLLOWING:

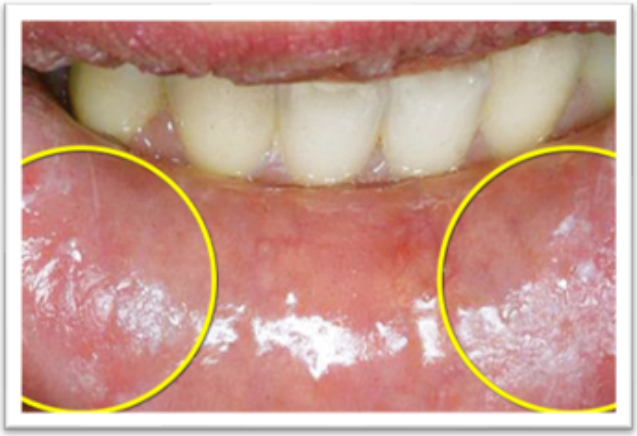
- LOSS OF APPETITE
- UNWILLINGNESS TO PARTICIPATE IN USUAL ACTIVITIES
- DISTURBED SLEEP
- IRRITABILITY
- SELF INJURY

ORAL CARE FOR PEOPLE WITH NEURO-DISBAILITY

People with profound neuro-disability due to brain damage affection require a special approach to oral care due to people in this group often exhibit exaggerated oral reflexes.

Some people may exhibit..

- A dry mouth - OFTEN CAUSED BY MEDICATION OR MOUTH BREATHING
- Reduced saliva control OR drooling
- Difficulty in opening the mouth [trismus]
- Lip biting or tongue biting
- A build-up of dried secretions in their mouth
- Difficulties wearing dentures
- Hypersensitivity to mouth care



MANAGEMENT

• Difficulties with swallowing (dysphagia)
Increase risk of aspiration pneumonia
If pools of saliva in the mouth, an aspirating toothbrush maybe required to suction saliva and toothpaste. Sit person upright and put chin down and head to one side.

• Trauma from lip/tongue biting
Biting the lip is common in people with neuro-disability.
Management - Keep area clean and manage pain . Difflam for pain (antiseptic and anaesthetic properties)
Refer to the dentist for possibility of making a bit guard

Trismus (reduced Jaw-opening)
Use a small headed toothbrush with a long handle to reach the back teeth such as a single tufted toothbrush

ORAL HYPERSENSITIVITY

Oral Hypersensitivity is a reduced tolerance around the face and mouth which can make the mouthcare difficult to perform. It is common in people with neuro- disability and is can be caused by a combination of oral sensory and motor impairment following a brain injury . People may withdraw from mouth care, therefore trying to desensitize someone but building tolerance to toothbrushing using the following techniques may help [Royal Hospital for Neuro- Disability]

MANAGEMENT [desensitizing technique]

- Ensure patient is sitting upright with optimal positioning for a stable base. You may need to give extra support with pillows etc.
- Explain what you are going to be doing for each step. E.g. "I am going to stroke your cheek now". Try to use a calm, reassuring voice.
- In order to gradually get accustomed to touch, start with the hands. Touch the person's hands firmly.
- Then touch the top of the arms, again firmly.
- Touch the shoulders firmly with both hands.
- Support the jaw from the front with one hand. Maintain this contact throughout the oral care procedure, as this will give stability.
- Press firmly above upper lip before you introduce the toothbrush in the mouth.
- Press firmly below lower lip before you introduce the toothbrush in the mouth at the lower gums.
- If patient shows hypersensitivity at any stage, stop, go back to the previous step and continue. This technique is designed to build tolerance and should not be rushed.

MOUTH CARE MANAGEMENT FOR PEOPLE WITH DYSPHAGIA

A dental hygienist's perspective in supporting an individual to maintain good oral hygiene while minimising the risk of aspiration and supporting quality of life

Mouth care is particularly important for people who have difficulty swallowing (dysphagia). Patients who are nil by mouth or on limited oral intake are at increased risk of poor oral hygiene and require thorough mouth care. Being dependent on others for mouth care, alongside a swallowing difficulty can increase the risk of developing pneumonia. [Royal Berkshire Hospital NHS Foundation Trust]

Common guided principles

Due to the levels of swallowing difficulties there is no single mouthcare management that can be applied to all individuals with dysphagia. Outlined are common guiding principles and procedures that can be adapted to the needs and situation of the individual.

Adults with dysphagia are more likely to present with poor oral health, gum disease and decay (Ortega et al, 2014)

Oral Care Management for people that require assistance

1. **Sit as upright as possible** during mouthcare to prevent aspiration
2. **Inspect the mouth:** Remove dentures, any loose material or debris with a damp non fraying gauze.
3. **. Attend to dry cracked lips** with application of water-based products
4. Depending on the ability to manage fluid, smear a small amount of non-foaming toothpaste onto a **small, soft headed toothbrush or electric toothbrush**.
5. Direct bristles towards areas likely to accumulate plaque and food debris 1st (around gums and on biting surfaces) . Attempt to clean all surfaces of teeth.
6. **If unable to spit,** use a damp non fraying gauze to remove excess toothpaste and debris
7. **Toothbrushing is recommended twice a day**. Cleaning after the last meal of the day is most crucial. If meal supervision is required, **simple oral care after each meal** to reduce aspiration of food & oral disease.
8. If an electric toothbrush can be tolerated consider an **Electric suction toothbrush.** The led light helps for better vision. Aspirating fluid provides more confidence with toothbrushing to this group. Alternatively, manual aspirating toothbrushes can be used if there is availability of a portable suction unit which most care facilities do not have.

9. **Brush the tongue** if coated with a soft toothbrush
10. If the mouth is particularly 'dirty' or you notice the gums are bleeding **consider dipping the toothbrush in chlorhexidine mouthwash or gel** and applying to the teeth and soft tissues.
11. **Interdental brushes** may be used to remove food debris from in-between the teeth. Follow recommendations from an oral health professional.
12. To remove dried mucus secretions, from soft tissues. Apply water or water-based gel to a toothbrush, 360 toothbrush or MC3 stik.
Gently rub in a circular motion to loosen the secretions and remove with a damp gauze.

daily oral hygiene regime in conjunction with regular review by an oral health professional is considered best practice management in this population. (Mathew AWT Lim Nov 2018)

Guidance is based on literature reference:
Basic oral care for patients with dysphagia - A Special Needs Dentistry perspective 2018
Mouth Care Matters (HEE 2018)
Palliative mouthcare management NICE 2018

Delivering mouthcare to someone with profound dysphagia & nil by mouth

Carrying out mouthcare for someone with severe dysphagia or Nil By Mouth is an obvious concern with the risk of an individual inhaling debris, fluid or toothpaste. Providing adequate mouthcare can be a challenge for carers.

- **Keep the lips moist** with water-based balm
- As indicated before using a **dry small, soft headed toothbrush** with a smear of non foaming toothpaste or no toothpaste (dry brush)
- Using a piece of damp gauze to remove any debris
- To hydrate the mouth, dampen the toothbrush or dampen gauze with water or mouthwash
- **Brush tongue** with Chlorhexidine to hydrate and clean if coated.
- Inspect the mouth for sores and secretions
- **Remove dried mucous secretions** as indicated in ref 12.

Electric suction toothbrush

Guidance on End of Life ORAL CARE

People at the end of life are often dependent on staff for their mouth care. Unfortunately mouth hygiene practices are often neglected at the end of life as it often gets forgotten or eliminated, this can contribute to halitosis and can impact on contact with friends and family members as an unpleasant aroma from the mouth can be off putting causing loved ones avoid having close contact or kiss the person.

Best mouth care practices include consensus-based practices as published by:

- NICE Clinical Knowledge Summary: Palliative care - End of life care (National Institute for Health and Care Excellence)1 March 2021
- Scottish Palliative Care Guidelines - Mouth Care in the last days of life (Healthcare Improvement Scotland and NHS Scotland)2
- Palliative Care Wales: Palliative Care (Adult) Network Guidelines

Care plan

All aspects of mouth care that will provide comfort and improve quality of life should be included in the patient's care plan for example, pain relief, management of dry mouth, removing dry secretions, frequency of mouth rinsing. This should ensure continuity of care between care settings and amongst different carers.

Assessment

Oral healthcare should focus on improving the quality of life of the patient instead of striving for curative treatment approaches.

- It is essential to carry out an assessment of the mouth using a glove, torch and tongue depressor.
- Remove denture before examining the mouth
- Assess for pain. Look for signs of dryness, coating, ulceration, infection or tooth decay.

Dry mouth

People at the end of life often breathe through their mouth causing the mouth to become very dry. It is essential to keep the mouth hydrated and comfortable with frequent attention to avoid secretions in the mouth to become too dry and sticky, as not only do they become difficult to remove but are uncomfortable for the person.

A dry mouth may become progressively worse as days near death and can be a debilitating symptom.

- Hydrate the mouth with water using a toothbrush or dry mouth gel, apply with a small, soft headed toothbrush, 360 toothbrush or MC3 stick
- If the person is conscious, ensure their mouth is hydrated and comfortable every 30 minutes
- If the person is unconscious moisture the mouth at least every hour
- Keep the lips soft with lubricant such as a water based gel or lip balm.

Dried sticky secretions

As people near the end of life their swallow and cough reflex becomes weaker. As they lose their ability to swallow and clear salivary and bronchial secretions there becomes a build up of oral secretions. If not removed regularly, these secretions become dry and stick to the tongue and palate of the mouth as people near the end of life breathe their mouth. Once dried, these sticky secretions become difficult to remove.

Management
Regular removal with a soft small headed toothbrush, 360 toothbrush or Moutheze can minimize the build up and keep the mouth more comfortable. A clean and hydrated mouth contributes to comfort and dignity.

Involving loved ones

By involving families and friends to participate in the mouth care regime at the end of life enables them to feel like they are making a difference by feeling useful, supportive and caring.

Guidance on End of Life mouth care management

The focus is on oral hygiene, alleviation of symptoms and ensuring the patient is appropriately hydrated.

- Assess the mouth daily for changes
- Remove any denture/s. Clean with mild soap and water and store dry in a named pot.
- Clean teeth using a soft, small-headed toothbrush and mild non foaming toothpaste .
- Carry out mouth care as often as necessary to maintain a clean mouth.
- If the person is able, ensure help is offered to clean teeth and/or denture/s.
- Damp gauze may be used if the individual is unconscious or unable to tolerate a toothbrush. Damp the non-fraying gauze in water or mouthwash wrapped round a gloved finger. This can help hydrate the mouth and remove debris from the sulcus and teeth.
- To prevent cracking of the lips, a water-soluble lubricant should be applied.
- Consider changing or stopping medicines that are causing a dry mouth.
- In people who are conscious, ensure the person is hydrated and comfortable every 30 minutes
- In unconscious people, moisten the mouth frequently, every hour or when possible, with water.

Word of caution

Hydrating the mouth with alcohol

'Keeping the mouth hydrated at the end of life with a person's favourite flavour. Whilst there is not a problem with hydrating someone's mouth with flavoured beverages such as flavoured squash, tea and coffee. Hydrating the mouth with a person's alcoholic preference is likely to dehydrate the inner lining of the mouth so whilst this seems like a comforting thing to do we would advise you to do use any alcohol beverage in end of life, sparingly.

The use of sponge swabs

Foam swabs should not be used as a method to clean or hydrate the mouth. There is a risk the sponge head may detach from sponge sticks if the adhesive fails. This poses a choking risk. Consider safe alternatives to moisten or clean a person's mouth.

Glycerine swabs

Glycerine is used to stimulate the production of saliva and aid in hydrating the mouth. Unfortunately glycerine is very drying to the oral mucosa! Use a swab that is PH neutral eg. Moi- Stik
Or try simple salivary stimulating measures such as water, unsweetened drinks and sprays.

Oral Swabs are not effective in removing plaque from the teeth.

Oral care tools

small headed toothbrush

360 toothbrush

MC3 Stick

damp gauze

Foam free toothpaste

SPONGE SWABS

Dysphagia is a difficulty with swallowing, where there is a problem with the passage of food and liquids from the mouth, into the throat and down the oesophagus. Some people with dysphagia are more anxious about oral care and dental treatment because they believe it could cause them to choke. They may also lack confidence in their ability to swallow. Body position is very important. Ensure safe body and head positioning before carrying out any mouth care procedures. If a person is supine, the head and body should be raised to a position of 30- 45 degrees or the head tilted carefully to one side.

SWALLOWING DIFFICULTIES

Make sure the person is awake and sitting upright before you begin.

- Use a ½ pea-sized amount of toothpaste.
- Have the person tilt head forward (over the bowl) to encourage spitting / dribbling of saliva, food residue and toothpaste.
- Do not give person any liquid for rinsing; clean away any residue with a damp brush, then dab lips dry gently.
- Apply a smear of mouth moisturising gel to the lips, tongue and cheeks if they are very dry.

Use a tool such as an MC3 stick , 360 degree brush or tooth brush rather than your finger if there is any risk of the person biting down.

Sponge swabs

• These are not recommended, as there is a risk of the foam head detaching from the stick during use. This presents a serious choking hazard.

• They do not remove plaque from tooth surfaces. If they are used, it should only be to moisten the mouth or clean the soft tissues. They must never be left to soak as this increases the risk of detachment. See Medical Device Alert no. MDA/2012/020 (13 April 2012)

Pink sponge swabs are banned in Wales!!

• If they are used, it should only be to moisten the mouth or clean the
soft tissues.
See Medical Device Alert no. MDA/2012/020 (13 April 2012)

Safe replacement (Moutheze) see
www.kohc.co.uk/recommended-products

360 Degree toothbrush see
www.kohc.co.uk/recommended-products

Public Health England

Protecting and improving the nation's health

Mouthcare for patients with COVID-19 or suspected COVID-19

Supporting seriously ill patients' mouthcare is an important part of overall patient care. If oral hygiene is neglected, the mouth rapidly becomes dry and sore. The aim of good mouthcare for patients in hospital is to maintain oral cleanliness, prevent additional infection and reduce the likelihood of developing bacterial pneumonia[1-5]. On admission include the mouth in the patient's assessment and care plan (an example of a form to record this can be found here).

This guidance outlines mouthcare for hospitalised adults and children with COVID-19 or suspected COVID-19 who are non-ventilated, ventilated and those having step down or end of life care.

When providing mouthcare for patients with COVID-19 wear personal protective equipment (PPE) to prevent contact and droplet transmission. This means wearing disposable gloves, plastic apron, eye protection and a fluid resistant surgical mask. Delivering mouthcare is not an aerosol generating procedure. However, the environment you are working in may require the use of enhanced PPE (e.g. if working where patients are ventilated).

Mouthcare for non-ventilated patients

- if patients are having oxygen via a face mask, check with the nurse in charge before removing this for the time needed to carry out mouthcare
- assess the patient and consider if they can brush their own teeth, or if you need to help them to keep their mouth moist and clean
- these patients are more likely to cough when performing mouth care, be gentle, stand to the side or behind them, take breaks to allow the patient to rest and swallow
- if possible, sit the patient upright
- if the patient has a dry mouth, encourage sips of fluid (unless nil by mouth), hydrate with a toothbrush dipped in water or apply available dry mouth product to their tongue, inside of their cheeks and roof of their mouth
- make sure the patient's lips are kept moist (with products available) particularly before cleaning
- if the patient can brush their own teeth give them a soft, small headed toothbrush with a smear of toothpaste (use non-foaming toothpaste if available)
- do not use an electric toothbrush as this may cause droplets and splash
- if the patient can spit, give the patient a disposable bowl to spit into
- if the patient is unable to spit and bedside suction is available, and you are trained to use it, then use gentle oral suctioning to remove excess saliva and toothpaste

- after brushing rinse their brush, and store with their toothpaste in a sealed named container or washbag
- if a patient has false teeth (dentures) encourage them to remove these after meals to clean off debris with a toothbrush. Remove dentures at night and store dry, in a named denture pot. More detail on denture care can be found in this video.
- patients may not wish to wear dentures when unwell and it is important that they are stored in a named denture pot to avoid them getting lost
- if eating, encourage patients to have a few sips of water after meals to clear any left-over food from their mouth
- if a patient is confused, refuses, or resists care, stop and try again later. This video link may be helpful

Mouthcare for ventilated hospital patients - under the direction of the nurse in charge

Patient's with COVID-19 will largely be ventilated because of viral pneumonia, their mouths become very dry and will benefit from regular care to reduce the risk of getting bacterial pneumonia[1,5].

- before commencing mouthcare check with the nurse in charge that this is appropriate and for any specific care advice
- work under the direction of the nurse in charge who will make sure that the endotracheal tube cuff is inflated to prevent aspiration, it is vital that you do not displace or disconnect the tube
- moisten the patients mouth with chlorhexidine mouthwash (or Corsodyl alcohol free mouthwash) using a green general oral swab or a soft toothbrush
- keep the patients lips moist with regular applications of products available
- dentures are likely to have been removed and should be stored dry in a named pot

End of life care

- in the last days and hours of a patient's life, keeping their mouth moist and comfortable is the main aim of mouthcare.
- continue to carry out mouthcare if it is not causing distress
- if the patient has a dry mouth, hydrate with a toothbrush dipped in water or apply a dry mouth product to the tongue, inside of their cheeks and roof of mouth.
- keep the patients lips moist with products available

Step down care- patients no longer ventilated

- continue with mouth care as for non- ventilated patients
- if patients are transferred to step down care it is important to facilitate continued mouthcare and where relevant safe transfer of dentures