GAIN

GUIDELINES AND AUDIT
IMPLEMENTATION NETWORK

GUIDELINES FOR THE ORAL HEALTHCARE OF OLDER PEOPLE LIVING IN NURSING AND RESIDENTIAL HOMES IN NORTHERN IRELAND

October 2012

CONTENTS

INTRODUCTION

The necessity for prevention of dental disease in older adults* in care facilities has never been more pertinent. This is because older adults are keeping more of their teeth longer into old age; coupled with the fact that life expectancy in general is increasing during 2007. In Northern Ireland life expectancy for men was 76.3 years, and for women 81.2 years in 2007[1]. By 2009, there were 346,535 adults aged over 60 years living in Northern Ireland, 95,000 more than 30 years ago[2]. Older people now account for 19.3% of the population of Northern Ireland compared to 16.1% in 1978[2]. This percentage is projected to rise significantly whereby in 2041 it is expected that the number of people aged 65 years and over will double that of what it is today[2].

Currently 15,408 of our older adults are cared for in 492 residential and nursing homes in Northern Ireland (source RQIA NI), accounting for 4.5% of the elderly population (Appendix 1 Table 1). Two thirds of these older adults occupy nursing home beds compared with one third who occupy residential home beds.

In the mid 90s only 20% of care home residents in Great Britain were likely to have had any of their own teeth; in comparison to 50% of older adults living independently in their own homes[3]. However retention of natural teeth has been increasing for each of these subgroups of the older population, each decade. Improvement in the oral health of adults of all ages across England, Wales, and Northern Ireland has been reported in the 2009 decennial UK Adult Dental Health Survey[4]; 60% of 65-74 year olds, and 40% of 75-84 year olds had '21 or more' of their own natural teeth. The equivalent figure for Northern Ireland adults aged 65-74 years- although requiring cautious interpretation - is somewhat lower at 48% [5] (Appendix 1, Table 2).

Although these findings are very encouraging it should be remembered that 'care home residents' in England, Wales, and Northern Ireland were excluded from any

* For the purpose of this document 'older' adults refers to those aged over 65 years, unless defined otherwise within the text.

of the decennial dental surveys in 1979, 1988, 1998, and 2009. Irrespectively the figures from the 2009 Adult Dental Health Survey suggest that the predictions for 2025 will indeed materialise. By this time we can expect that only one in five elderly adults (65 years+) will be without their own natural teeth[3] and approximately half of all people aged over 65 years will have 21 or more natural teeth[6].

The picture today of older adults with teeth in care facilities is a dramatic change from 20 years ago. Historically, provision of oral care for residents was straightforward, largely limited to cleaning dentures and mouths without teeth. This meant that promoting good oral hygiene practices and associated training for care staff was usually low on the list of priorities for care homes[7, 8]. In contrast care staff are now required to support dentate patients with their oral hygiene and assist them in maintaining good oral health.

Irrespective of age, or domicile, the same basic approach to maintaining optimum oral health applies; good daily oral hygiene and mouth care, limited use of sugary foods and drinks, and regular dental check-ups. By using this approach the potential for unwanted consequences like dental pain, dental decay, gum disease, and infection are minimised and other interrelated aspects like nutrition, quality of life and self-esteem are optimised.

Although there is no published research in Northern Ireland describing the state of oral health of residents in care homes to-day, UK research has shown that the worst levels of oral health are found in elderly residents of care homes[3, 6, 4, 9, 10]. This is in part related to other factors such as chronic ill health, and the influence of socio-economic status. Nevertheless older adults looked after in care facilities largely depend on care staff to organise their dental care, and indeed ensure appropriate daily oral care is provided. Unfortunately care staff report that they have had little or infrequent oral health care training [8, 10, 11, 12, 13, 14, 15].

METHODOLOGY

In June 2009, a regional multidisciplinary group was convened to develop these guidelines. From June 2009 to December 2010, the group met bi-monthly. Although a 'user representative' participated on the Guideline Development Group initially, this arrangement unfortunately did not continue for the duration of the process. Therefore in order to ensure the guideline content was acceptable and relevant to older people, direct consultation with Rathcoole Patient and Client Council, and Age Sector Platform NI was organised. Other consultation events were held with the Independent Health and Care Providers NI (IHCP) - a representative body of care home owners across the Region, and Four Seasons Health and Care Providers, which is the largest provider of nursing home care in Northern Ireland. The group also took the opportunity to visit two elderly care facilities to gain a closer understanding of how services are provided in a care setting.

As part of the guideline development process, a questionnaire about the amount of time dental clinicians spend providing dental treatment for dependent care home residents was developed and sent to all CDS clinicians working in Northern Ireland (2010). A short summary is available as Appendix 2.

Another task involved the development and piloting of the dental assessment and referral forms; (pages 19, 20, 21) for use in care facilities, and to accompany any associated staff training.

The literature review was restricted to research from within the UK and undertaken in the last decade. This was obtained by searching Medline, Pubmed, and Cochrane databases, and was supplemented by specific trawling of the Journal of the British Society of Gerodontology. Strategic documents[3, 6, 16] and 'standards documents' [17, 18, 19] were also reviewed to inform the development of these guidelines.

The limited local information available regarding provision of dental treatment to older adults in Northern Ireland has also been examined.

In keeping with GAIN requirements these guidelines will be reviewed in 2016 or sooner in light of any emerging evidence.

CONSEQUENCES OF INADEQUATE DENTAL CARE

Inadequate oral hygiene can result in gum disease. Poor attention to the sugar content and frequency in diets will result in tooth decay and ultimately tooth loss, all of which can have a detrimental effect on an older person's quality of life. Factors such as reduction in manual dexterity, use of medications and adjustments to diet type and consistency compound these dental diseases. A diminished oral function resulting in an inability to eat meat, fresh fruit, and vegetables can lead to a reduced nutritional status, weight loss, and poor recovery from illness [3, 6, 20] and the associated concerns of malnutrition. There is now also a substantial body of research to demonstrate that poor oral health can impact significantly on general health[3, 20]. Infrequent visits to the dentist mean that oral pathology, or indeed oral cancer which can be painless in the early stage may be unnoticed for lengthy periods of time. As this can result in poorer outcomes for patients, lifelong regular dental checkups are recommended for all[21].

There are specific associations between poor oral hygiene and aspiration pneumonia[20] which accounts for up to 48% of all chest infections in nursing home residents and which can be fatal [22]. In recent review articles[23, 10] the authors state that there is good evidence that improved oral hygiene and frequent professional oral healthcare reduces both the progression and incidence of respiratory diseases in high risk elderly adults living in nursing homes. In fact it is suggested that where regular oral hygiene is not provided for residents, the odds of pneumonia associated death are tripled[24]. There is also mounting evidence to link poor oral health and various forms of cardiovascular and cerebro-vascular disease[20]. Poor oral health can also complicate the management of some systemic illnesses e.g. diabetes[20].

CLINICAL NEED

In the last decade a number of English studies highlight the poor oral health status of care home residents[3, 25]. A study involving 22 Nursing Homes in the Avon Health Authority (England) reported that 70% of care home residents had not seen a dentist in 5 years and dental decay was evident in 63% of residents. It was also reported

that 75% of residents who were assessed as requiring help to clean their teeth did not receive it[25]. Overall the oral health status of residents was described as 'depressingly low in an environment where complete personal care of the individual is assumed and expected '.

In Scotland, oral health care provision in care facilities has been included in a monitoring program by the Scottish Care Commission (Regulators of Health Provision) since 2005. Despite this one third of all Scottish care home managers recently reported that they were not implementing the oral health best practice standards expected[8]. Only half provided oral health care training for their staff, and less than half reported that annual dental screening occurred in their facilities[8].

In Northern Ireland there is no published research, and little local information about the oral health status of older dependent adults looked after in care homes across the province. Therefore quantification of the needs of this sub group of the older population cannot be made. However, there is no reason to believe that it is any better than in neighbouring UK regions where the oral health of the elderly in general is better than it is in Northern Ireland. In addition in trusts where dental assessment and treatment of care home residents is routinely undertaken by the CDS there is already comment that 'treatment need' will soon outweigh 'service capacity'.

CURRENT DENTAL SERVICE PROVISON IN NORTHERN IRELAND

Within Northern Ireland, as in the rest of the UK, dental care for the elderly is provided by three different branches of dentistry within Health and Social Care, General Dental Service (GDS), Community Dental Service (CDS) and Hospital Dental Service (HDS).

The vast majority of the population in Northern Ireland receive their routine dental care from 1075 General Dental Practitioners (GDPs/family dentists) who are independent contractors providing care from their own premises. Patients must be registered with a GDP in order to access services. The current health service registration period is 2 years, after which re-registration is required.

It is a well recognised fact that older adults do not seek regular dental care and exhibit low levels of dental registration[26]. UK trend data (2003) suggests that dental check up attendance falls significantly after age 64 years[27]. This is consistent with registration patterns in Northern Ireland where only 36.7% of older adults (65 years+) were registered with a dentist in 2010 (source BSO). Unfortunately there are no figures available for the numbers of dental registrations held by elderly adults in care facilities in Northern Ireland but they are likely to be lower again.

GDPs can provide a range of dental treatments e.g: fillings, cleaning, extractions, bridges, crowns, and dentures, for elderly patients within their high street practices, or at a care facility on a domiciliary basis. The dental clinic however is the preferred setting for anything other than the most basic treatment, as this is where the dentist has optimal working conditions, and can provide the best quality care. It is also much more cost-effective for patients to travel to the dentist rather than the reverse. Even so older people's associated medical conditions and often their mobility problems affect where and by whom it is provided. These complicating factors are also associated with longer treatment appointments and increased cost. Therefore the GDS and CDS alike aim to see patients at the dental clinic/practice.

The CDS in Northern Ireland is a relatively small service of approx 90 dentists (65.8 whole time equivalent (WTE) at 2010) based within the Health and Social Care Trusts. The CDS primarily provides dental care to adults and children with special needs such as learning disability and physical disability. Also included in the remit of the CDS is an undertaking to provide oral healthcare for those unable or unwilling to attend a GDP, for example the socially deprived and excluded, the housebound, and elderly residents of care homes. In addition to dentists, some community dental services employ dental hygienists and therapists who can provide some types of dental treatment in clinic or on a domiciliary basis to older adults in care homes, under the direction of the dentist.

The HDS see the most complex cases and these tend to involve patients with significant medical complications or those requiring oral medicine or oral surgery interventions e.g. suspected oral cancer.

Domiciliary dental treatment will always be required for a percentage of the population, however, overwhelmingly CDS clinicians responding to a regional survey cite the 'sub optimal working environment' and the 'high risk nature' of these patients as the most pressing barriers when considering providing domiciliary dental treatment in care homes[28]. Other pertinent factors that must be considered include: the type of treatment required, the associated equipment needs, cross infection constraints, and compliance with current professional guidelines[29].

DENTAL CARE IN RESIDENTIAL AND NURSING HOMES IN NORTHERN IRELAND

Currently information relating to the amount and type of dental treatment provided in care homes in Northern Ireland comes from 2 different sources:

- BSO provides information relating to general dental practitioners
- Individual trusts provide information about community dental clinicians.

In 2008/09, 760 NHS family dentists in Northern Ireland provided 1180 domiciliary dental visits to registered elderly patients over 60 years (n=136,000) across the Province (source BSO).

In contrast in 2009/2010 1,666 domiciliary visits were undertaken by 8.58 WTE community dentists in the Southern Trust[30], most of which (77%) were provided in care homes. In the same financial year over 5000 domicilaries were undertaken by 20 WTE community dentists in the Northern Trust, half of which were provided in elderly care facilities (source LCID Information System Northern Health & Social Care Trust - NHSCT). Unfortunately comparable information from each CDS Trust is currently unavailable.

Information collated from questionnaires sent to all community dental clinicians in Northern Ireland last year confirms the significant amount of dental care they provide for nursing/residential home residents both in the clinic and at care facilities

(Appendix 2), although there is some trust variation. In contrast almost 70% of community dentists did not know of any family dentists who provided domiciliary dental services to care home residents, in their local areas[28].

In conjunction with low dental registration figures, increasing life expectancy and higher proportions of older dependent adults with teeth, it is apparent that our dental services will soon face significant challenges if they are to meet the increasing needs of these older residents in the near future. Solutions that enhance GDS and CDS commitment to providing NHS dental care to these dependent older people require exploration. The future work force requirements should also be investigated.

ORAL HEALTH STANDARDS

The importance of providing older people with oral health care and advice on oral health care was first highlighted in the 2001 UK National Service Framework for Older People[31]. In response the Department of Health (England) produced their strategy[20] documenting the importance of preventive strategies and recommending that good oral health for older people should be achieved before they become frail. The 2007 Oral Health Strategy Northern Ireland[32] acknowledges the importance of good oral health for the older population and specifically recommends that:

1. An oral health assessment tool/form should be introduced for use on admission to care homes

2. A list of simple indicators to measure oral health care in nursing/residential homes is developed

3. Attempts at increasing service utilisation by older adults should be investigated.

In 2008 Minimum Care Standards for Older Adults looked after in Care Facilities were introduced in Northern Ireland by DHSSPS NI[17]. These include some statements about the level of oral health care provision expected in residential and nursing

homes. However in light of our increasingly dentate care home population more detailed guidance is required, and commitment to ongoing care staff training in the oral health of older adults must be consolidated.

EXPECTED LEVEL OF SERVICE PROVISION

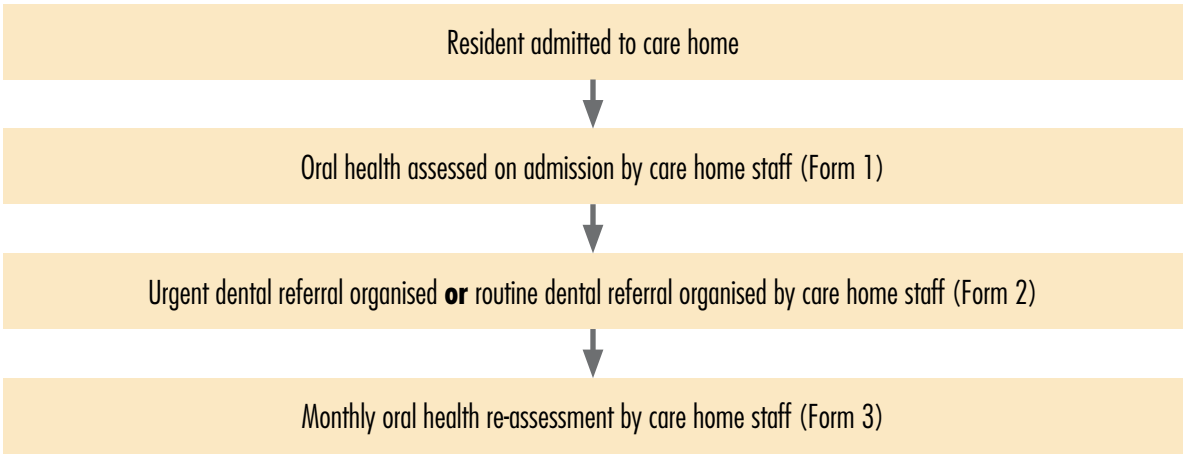
In residential and nursing homes improvement in the oral health of residents is dependent on following a standardised approach to the provision of oral health care[33]: therefore the following minimum standards are expected:

1. Ensure that regular and emergency dental care is available for all residents
2. Encourage dental registration with family dentists
3. A model of 'best practice' for oral care provision should be adopted. This will include the necessity to identify each individual's oral health requirements, subsequently recorded on an individual care plan (Appendix 3)
4. Ensure that each resident's oral health is maintained at an optimum level by supporting twice daily oral hygiene, with availability of toothbrushes and toothpaste containing at least 1,450 ppm fluoride for dentate residents. For those with dentures twice daily mouth care is also appropriate, ensuring availability of denture cleaning materials and equipment. Staff should be available to support residents assessed as unable to perform adequate oral hygiene, and this should be re-assessed on an ongoing basis
5. Ensure that resident's diet plans reflect their oral health status by avoiding excessive and/or frequent consumption of sugary foods and drinks where this is appropriate
6. Ensure that regional nutritional guidelines for older people e.g. 'Promoting Good Nutrition. A Strategy for Good Nutritional Care for Adults in all Care Settings in Northern Ireland'. 2011 - 2016 is implemented
7. Oral health care training for staff should be provided at induction, and updated regularly thereafter
8. Care homes should undertake internal audit of the oral health care provided in their facility year on year.

BEST PRACTICE MODEL

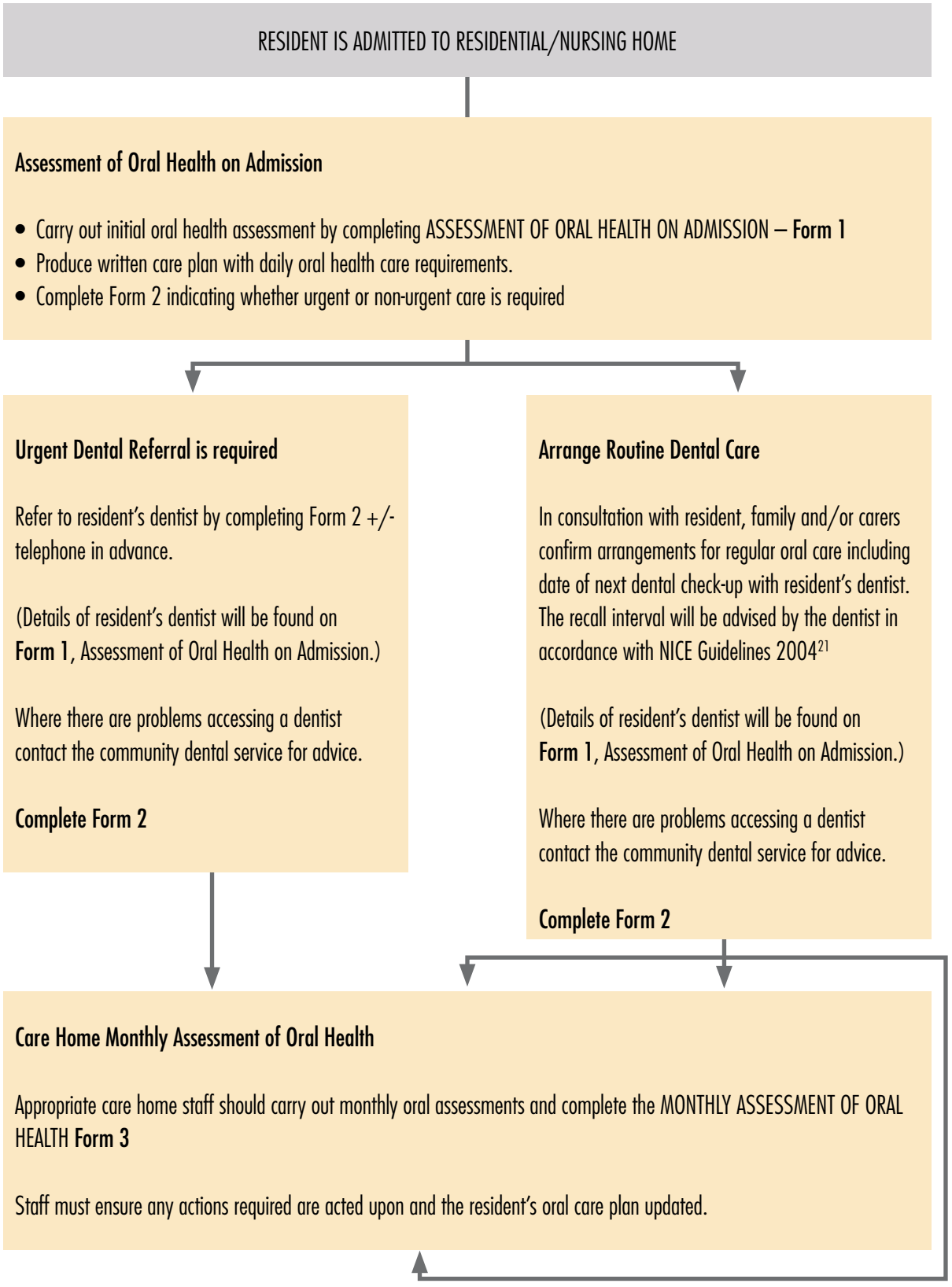
In the context of oral healthcare for older adults in care home settings, best practice[34, 19, 35] (Figures 1 & 2) includes recording of an oral health assessment for each new resident on admission by care staff. This informs the resident's written care plan (Appendix 3). Arrangements should then be made for provision of either routine or emergency dental care. Thereafter regular recording/monitoring of each resident's oral health is undertaken and recorded by care staff.

Figure 1



In our experience written oral health assessments are not universally recorded in care settings in Northern Ireland therefore Forms 1 (oral health on admission, page 19) and 3 (monthly assessment of oral health, page 21) have been included for this purpose. A dental referral form is also included (Form 2, page 20). Use of each form assists care staff with an element contributing to the overall management of an individual's oral health. By using these forms care staff awareness about oral health will be improved. (These forms were piloted by care staff in a sample of Nursing Homes across Northern Ireland from September to December 2010).

Figure 2 - Oral Health Care in Care Homes- Best Practice Model



CARE STAFF TRAINING

We recognise that regular staff training, and update training in care homes is extremely important. Research indicates that even as little as one hour of oral health care training in care home settings improves staff knowledge and attitude towards the provision of oral care[15]. It can also be effective in reducing the number of residents left to undertake their own oral care[36]. However, in the absence of additional resources, a generic oral health training program for care home staff is accessible on the GAIN website. We have included a pre training baseline questionnaire for care staff about oral health, a power point presentation and reference an oral health care training DVD. A new Scottish training program designed to improve the oral health of dependent older people is also signposted[37].

To supplement this online training resource we have designed simple written instructions for care staff about tooth brushing (Carer's Information Sheet 1, page 22) and denture cleaning (Carer's Information Sheet 2, page 24). These will assist care staff in provision of optimal daily oral health care for their residents and raise their awareness of current best practice.

AUDIT

A sample audit tool is included as Appendix 4. It is designed to assess care home performance in oral health care provision. It lists a series of simple indicators against which oral health in care facilities can be easily measured and could be used by care home staff as an internal audit tool year on year. Use of the tool would therefore satisfy the requirement to monitor care home performance in relation to oral care provided. Equally, in the absence of an alternative it could be used by the RQIA Inspectorate to gauge the standard of oral health care currently provided in care homes in Northern Ireland.

WORKING WITH RESIDENTS AND FAMILIES

During the process of writing this document, we have consulted user groups who have asked that information suitable for residents and families about the oral health of older people is made available in care homes. In order to address this we have sourced patient/family friendly information which has been designed by the UK Relatives and Residents Association. This is a UK charity aiming to promote the wellbeing of older people living in care homes. They have produced a wide variety of resources designed for families and residents which include a book about the oral health of older people[38].

They also produce information leaflets about oral health which are available to download free of charge from their website **www.relres.org**

ROLES AND RESPONSIBILITES

Each member of the care home team has a role to play in implementing the minimum standards and best practice model for oral care that are presented in this document. Ideally, this will be led by the care home manager, undertaken by their registered nurses, and healthcare assistants, and implemented with immediate effect. In this way we hope to achieve the consistent and standardised approach that is required to effect improvement in care home resident's oral health status. It is also important that progress regarding implementation of these guidelines is audited on an ongoing basis, initially in house, and in due course by the RQIA inspectorate.

It is expected that these guidelines will be widely available to dentists in the Community Dental Service, General Dental Service, Hospital Dental Services, and to other interested health professionals who, alongside other stakeholder organisations, will play a central role in supporting their implementation. It is also anticipated that this guideline will serve as a reference document at RQIA, and at DHSSPSNI, in the latter case it could be used to inform future regional policy.

For the purposes of clarity, the roles and responsibilities of each staffing group have been listed below:

Nursing and Care Staff in facilities should:

- Assess the oral health of each new resident on admission using Form 1 page 19 (or equivalent) and record on resident's care plan
- Ensure that each resident's nutrition plan optimises potential for good oral health by avoiding excessive and/or frequent sugary foods and drinks
- Ensure care plans include individual instructions for optimal oral health
- Ensure care plans are updated following each professional visit; any actions identified have been recorded and followed
- Use written referral Form 2 page 20 (or equivalent), to arrange regular or emergency dental care for their residents
- Monitor the oral health of each resident using Form 3, page 21 (or equivalent) and take action accordingly
- Ensure the instruction sheets on toothbrushing and denture cleaning are available to all care staff, (Information Sheet 1 page 22 and Information Sheet 2 page 24) and are referenced in care plans as appropriate
- Use the suggested training resources to increase their awareness of oral health issues pertinent to the oral health of older residents in their care
- Work with relatives, families, and carers to find ways of encouraging and facilitating residents going to dental appointments where this is appropriate
- Report any problems encountered in accessing regular or emergency dental care for residents to the Facility Manager.

Managers of Care facilities should:

- Ensure these guidelines are available to all staff in their facility
- Implement these guidelines and follow best practice suggested (including use of written paperwork) with immediate effect
- Utilise the suggested training resources to ensure all of their staff; nurses, and healthcare assistants (HCAs) receive oral health awareness training at induction, and thereafter on a regular basis, which is recorded. In the long term managers should consider adoption of a mandatory training module in oral health for care staff
- Encourage development of nominated link nurses for oral health within the facility who will receive and cascade oral health training to other care home staff
- Monitor staff performance in relation to oral health care provision for residents
- Use suggested audit tool annually
- Develop relationships with local dentists, both in the CDS and GDS, to ensure that adequate provision of oral health care is available for their residents
- Encourage their residents to register for dental care at local dentists
- Ensure information suitable for residents/families and carers is available about dental care for older people
- Highlight where there are problems accessing regular or emergency care for residents by contacting the Assistant Director Integrated Care (Head of Dental Services) at the Health and Social Care Board, Northern Ireland
- Ensure visiting dental staff have access to a suitable environment to treat the patient, have access to all patient information needed, and are assisted by care staff when requested

- Ensure that suitable arrangements (including transport) are in place when residents are required to attend a dental surgery

- Ensure any new build takes cognisance of the requirement for an appropriate multi professional treatment room

- Promote healthy food choices for dependent older adults in their care homes consistent with achieving optimal oral health for each resident

- Implement Regional Nutritional Guidelines for this age group.

RQIA should:

- Check that these guidelines are available to all care staff when inspecting care facilities, and promote their adoption/implementation

- Ensure care facilities understand the standard of oral health care provision expected

- Adopt the audit tool provided for use at facility inspections as an interim measure

- Audit the extent of implementation of guidelines in care facilities.

Residents, Families and Carers should be aware that:

- Provision of regular dental care is a lifelong requirement

- Dental treatment is not universally free to all older people

- Helping a relative with tooth brushing and mouth care is very beneficial

- Avoiding frequent use of sugary foods and drinks reduces risk of dental decay

- Accompanying a relative to dental appointments outside of the care facility may be required.

FORM 1 – ORAL ASSESSMENT ON ADMISSION

Date of Assessment: / /		
Staff Signature:		Job Title:
Residents Name: Room Number:		DOB: / / Health & Care Number
RESIDENTS DENTISTS DETAILS		
Dentist Name _____ Address _____ Tel Number _____ Date of last visit to dentist / /		
As Registration with a dentist lasts 24 months it is important to establish if the resident is still registered with their dentist by telephoning the Practice. Registration can be renewed at this time.		
Registration confirmed/renewed Y/N **Or** Registered with new dentist Y/N **(if the resident's registration has lapsed or problems are encountered obtaining registration please contact local community dental service for advice)**		
Does the resident have any of their own natural teeth?	Y/N	• Observe resident's ability to clean teeth • Determine the level of staff assistance required • Ensure individual named toothbrush and recommended toothpaste is available. **ACTION - Complete care plan**
Does the resident wear Dentures? Upper Lower	Y/N Y/N Y/N	• Observe resident's ability to clean dentures • Determine the level of staff assistance • Ensure named denture pot, denture brush, and cleaner are available • Ensure dentures marked with resident's name **ACTION - Complete care plan**
IMPORTANT ACTION		
Where resident has: Dental Pain, Ulceration, Red/White Patch, Lump/Gum Boil, or Facial Swelling complete an URGENT referral for family dentist/local dentist/dental access centre/community dentist by Completing Form 2 (Urgent) **Or** Arrange regular dental care in consultation with the patient, carer, relative, and respecting patient's choice by : Completing Form 2 (non urgent)		

Date For Monthly Oral Health Assessment Date: / /

FORM 2 – URGENT/NON-URGENT DENTAL REFERRAL*

*Please delete as appropriate

If the resident is registered with a dentist, it is important that this is the first point of contact.

NAME OF RESIDENT	DOB Health & Care Number
NEXT OF KIN	HOME TEL
RELATIONSHIP TO RESIDENT	MOBILE TEL
CARE HOME ADDRESS & TEL NUMBER	FAMILY DOCTOR ADDRESS & TEL NUMBER

*REASON FOR URGENT REFERRAL:

Dental pain	☐	Facial swelling	☐
Ulceration	☐	Gum boil/abscess	☐
Red/white patch	☐	other- please describe _____	

Does the resident have any of their own natural teeth? Y/N
Can the resident travel to the dental clinic? Y/N
If yes, who will accompany the resident? _____
If no, why is this? _____

PLEASE LIST THE RESIDENT'S MAIN HEALTH PROBLEMS, AND CURRENT MEDICATIONS (ATTACH COPY OF KARDEX)

PLEASE DESCRIBE ANY SPECIAL NEEDS RELEVANT TO THE RESIDENT, OR TICK ALL THAT APPLY E.G.

☐ Unable to consent/impaired understanding/communication difficulties		☐ PEG feeding/unsafe swallow
☐ Requires hoist to transfer	☐ Infection risk e.g. MRSA/C Difficile	☐ Challenging behaviour
☐ Other, please describe		

Signature of referrer _____ Job Title _____
Date _____/_____/_____

Send referral to family dentist/local dentist/dental access centre/community dentist (circle 1)

FORM 3 – MONTHLY ORAL HEALTH ASSESSMENT

Room No:_____ Resident's Name: _____DOB: ____/____/___
Name of Person Completing Form:_____
Job Title: _____ Date: ____/____/____

	Observation	NO	YES -Action Required Please ensure care plan is updated
Pain	Any verbal, physical or behavioural signs of pain?	☐	**Refer to resident's dentist – URGENTLY* Complete Form 2**
Facial swelling	Any sign of external swelling on face?	☐	**Refer to resident's dentist – URGENTLY* Complete Form 2**
Lips	Dry and cracked ? Swelling, lump, white/red/ulcerated patch, bleeding or ulcerated at corners?	☐ ☐	Clean with water-moistened gauze and protect with lubricating gel on a daily basis. Review daily if concerns refer to the dentist **Refer to resident's dentist – URGENTLY* Complete Form 2**
Teeth	Evidence of tartar/plaque/food debris on the teeth or at the gum margin (where the teeth and gum meet). Any recent decayed/broken/sharp teeth? Does the resident need a new toothbrush or toothpaste?	☐ ☐ ☐	Reassess resident's ability to carry out own oral care and consider staff intervention in daily care. **Refer to resident's dentist* Complete Form 2** Ensure that toothbrush and recommended toothpaste are available**
Gums	Dry, shiny, red, swollen gums prone to bleeding or unpleasant mouth odour?	☐	Reassess resident's ability to carry out own oral care and consider staff intervention in daily care
Saliva	Does resident complain of dry mouth or does the mouth seem quite dry?	☐	Offer frequent sips of water and use high dose fluoride toothpaste** if resident has natural teeth. If problem persists consider referral to dentist
Tongue & oral tissues	Dry, sticky, with debris accumulating Ulcer that has not healed in 2 weeks, white / red patches, generalised redness, tenderness	☐ ☐	Clean with water-moistened gauze or gentle tooth brushing on daily basis. Review daily , if concerns refer to the dentist **Complete Form 2** **Refer to resident's dentist – URGENTLY* Complete Form 2**
Denture(s)	Do dentures need to be labelled with the patient's name? Evidence of plaque/tartar on denture(s) that is difficult to remove? Denture(s) broken, resident complaining of poor fit or taking dentures out frequently? Does the resident need a named denture pot and cleaning materials? Is the resident wearing his/her dentures 24/7?	☐ ☐ ☐ ☐ ☐	Label using denture naming kit Reassess resident's ability to carry out own denture care and consider staff intervention in daily oral care **Refer to resident's dentist* Complete Form 2** Ensure named denture pot, denture brush and denture cleaner are available. Remember do not use toothpaste to clean dentures Dentures need to be removed, cleaned thoroughly and stored in water in named denture pot, ideally at night
Any other concerns?	For example, is there any significant change to the resident's diet or is a PEG to be placed?	☐	**Refer to resident's dentist* Complete Form 2**
Any barriers to providing oral care?	For example, refuses assistance, bites toothbrush, will not remove dentures, resident has poor dexterity	☐	Record when the resident refuses assistance with tooth brushing , or any other difficulties .Seek advice from resident's dentist*

* *Details of the resident's dentist can be found on the ASSESSMENT OF ORAL HEALTH ON ADMISSION (Form 1).*

** *Resident's with their own teeth may benefit from using high fluoride toothpaste such as Duraphat 2800ppm toothpaste. This toothpaste is only available on prescription following a dentist's recommendation. It may not be suitable for those with a compromised swallow*

CARERS INFORMATION SHEET 1 - TOOTHBRUSHING INSTRUCTIONS

Good oral hygiene improves general health and well being and reduces the risk of chest infections. Toothbrushing removes harmful dental plaque from the teeth and gums and should be undertaken twice daily, or once daily as a minimum standard.

- Prepare equipment;
  - Small toothbrush and toothpaste with a Fluoride content of at least 1450 ppm (parts per million). A higher dose fluoride toothpaste may be recommended e.g. Duraphat 2800[39]
  - Waste receiver e.g. disposable kidney dish
  - Mirror if available
  - Use of light e.g. pen torch is very beneficial when observing and cleaning the mouth
- Wash and dry hands before and after carrying out any mouth care and wear appropriate personnel protective equipment – gloves, apron, and eye protection
- Explain the procedure to the patient and ensure he/she is in a comfortable position, preferably with some head support.
- Remove any dentures and place in water.
- Apply pea-sized amount of toothpaste onto toothbrush.
- Use the toothbrush and toothpaste to remove 'plaque' (soft debris) from the teeth and gums. It takes at least two minutes to ensure all areas are cleaned thoroughly.
- Place toothbrush at 45 degree angle to gum margin i.e. where tooth and gum meet.

- Start with upper teeth; remove plaque by cleaning all teeth; front and back. First brush the outside surfaces of the upper teeth, then all inside surfaces, finishing with a gentle scrub action on the chewing surfaces of the back teeth. Repeat the same procedure on the lower teeth.

- It is important to brush gums even if they bleed. If there is no improvement after two weeks seek dental advice.

- Finally, gently brush the tongue, cheeks and palate. This is especially important for residents with no remaining natural teeth who do not wear dentures.

- Allow and assist the patient to spit out and rest as required

- Follow denture cleaning procedure before returning any dentures to the mouth

- After use toothbrushes should be rinsed in water, excess shaken off and stored to 'air dry'.

- Dispose of all equipment used, appropriately.

- Wash and dry hands at end of procedure.

- Replace toothbrush every three months or sooner if bristles become worn.

- *Pink foam sticks should not be used for cleaning teeth as the foam head may become damaged or detached whilst in the mouth and cause choking.

If the patient's condition changes e.g. changes to the consistency of their food, or their swallow deteriorates necessitating Enteral Feeding (Peg Feeding) a dentist should reassess the resident's oral health.

***Alert** - Pink Foam Sticks – available at **www.mhra.gov.uk/ - ref MDA/2012/020**

CARERS INFORMATION SHEET 2 - INSTRUCTIONS FOR DENTURE CARE

It is important to treat dentures like natural teeth as harmful dental plaque (a film of soft debris, and bacteria) continuously builds up on the surfaces of the denture, in the same way as it does on natural teeth. Plaque can cause inflamed gums, bad breath, bacterial and/or fungal infections (eg Candida), or where there are remaining teeth, dental decay. Some people also build up tartar on their dentures just as they would on their natural teeth making the denture uncomfortable and unsightly. For all of these reasons it is important to clean dentures at least once daily.

- Wash and dry hands before and after carrying out any mouth care and wear appropriate personnel protective equipment - gloves, apron and eye protection.

- All mouth care equipment (toothbrush, denture brush, denture cleaning paste, toothpaste, denture pot etc) should be identified with the resident's name.

- Clean thoroughly at least once a day (preferably at night) and rinse under water after meals.

- All dentures, both partial and complete, should be removed from the mouth for cleaning.

- Dentures are very delicate and can break easily if dropped. When handling dentures, always hold them over a towel or basin of water.

- Rinse dentures thoroughly to remove loose food particles and brush immersed in warm water to prevent splatter - hot water can warp dentures.

- Use denture cleaning paste or liquid soap on a toothbrush or denture brush. Avoid very stiff bristles as these may damage the denture. Toothpaste is not recommended as this can be abrasive and damage the denture.

- Rinse dentures well to remove all traces of cleaning paste or soap before putting them back in the mouth.

- Brush all surfaces of the denture thoroughly paying particular attention to the surfaces that fit directly onto the roof of the mouth, or the lower jaw, and to any metal clasps on the denture.

- Brush gums, tongue and palate with a soft-bristled regular toothbrush to remove plaque and stimulate circulation.

- Dentures should be removed overnight but where this is not possible then they should be removed for a short period during the day. This will allow the mouth to rest from the pressure of the dentures.

- When out of the mouth (either at night or during the day) dentures should be stored in water as this helps to keep them from drying out and changing shape.

- Loose or ill-fitting dentures can cause problems such as ulceration, therefore a dental assessment may be appropriate.

- Dentures should be clearly labelled with the individual's name.

- Bleaching products, eg Miltons can be very effective for denture cleaning but dental advice should be sought about an appropriate protocol for its use in the 'care home setting'.

- Where the mouth looks very red or sore, or where there is 'thrush' (usually white and speckled) the denture can be soaked in chlorhexidine solution for the recommended time and then rinsed thoroughly. Dental advice should also be sought.

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APPENDICES

APPENDIX 1

STATISTICS

Table 1: Current number of older adults in NI 2009, and the number of residential and nursing home beds by Health and Social Care Trust (HSCT) Area 2010

	WHSCT	SHSCT	BHSCT	SEHSCT	NHSCT	Total
NI-Population/ 60+yrs by HSCT area	52,107	62,419	67,608	72,126	92,275	**346,535 – 19.3% of total NI population**
Population **65yrs+** By HSCT area	37,400	45,284	51,972	52,016	67,808	**254,480**
Residential beds by HSCT area	765	481	1,289	1,267	1,025	**4,827**
Nursing home beds by HSCT area	1,622	2,120	2,160	1,997	2,682	**10,581**
Total RNH & PNH beds by HSCT area	2,387	2,601	3,449	3,264	3,707	**15,408**

Source; NISRA – Mid Year Estimates[2], and Regulation Quality & Improvement Authority NI 2010

Table 2: Proportion (%) of N Irish Adults **without** any natural teeth by age; 1979-2009[5]

AGE	1979	1988	1998	2009
65-74 yrs	67%	57%	44%	17%
75 and over	74%	78%	60%	50%

APPENDIX 2

SUMMARY OF CDS QUESTIONNAIRE REGARDING DOMICILIARY DENTAL CARE

Between March and June 2010, as part of the guideline development process, a questionnaire was issued to all dental clinicians (dentists, therapists, and hygienists) employed in the community dental services in Northern Ireland (n=90; 65.8 WTE). The aim was to ascertain the amount of time community dentists (and other dental clinicians) spend providing dental treatment to care home residents both in the dental clinic and at the care homes on a domiciliary basis.

There was a 68% response rate (61/90) to the questionnaire, mainly from dentists (57/61) who mostly work part time (56%) in the CDS. Other responders were dental hygienists or therapists. The results highlight that the majority (92%) of community dental clinicians in Northern Ireland provide dental treatment for elderly adults of care facilities, although varying amounts of resource are dedicated to this depending on trust area.

On average, across the trusts 50% of clinicians report seeing care home residents frequently; (on a daily basis or a couple of times per week, or on a weekly basis).

Each clinician undertakes an average of 9 domiciliary visits to care homes per month.

Some clinicians (65% - 40/61) reported spending up to 50% of their clinical time providing care for older adults resident in care homes: of these, half spent 75% or more of this time providing this care on a domiciliary basis.

A small number of CDS clinicians reported they had no elderly patients on their case load, indicating that within the CDS in Northern Ireland there is some regional variation in service provision.

Overall the information returned in the questionnaire highlights that the CDS provides a large amount of dental care for nursing/residential home residents.

It is acknowledged within the dental profession that whilst the need for dental treatment amongst this group has risen, the workforce capacity of the CDS has not enjoyed a similar increase, and indeed this was reflected in the responses whereby a small number of community dentists report 'regular nursing home screenings (oral assessment program) are not universally provided on account of staffing shortages'.

42% of CDS clinicians were not aware of any other input from GDS dentists in their local care homes, and a further 24% did not know either way - almost 70% of community dentists did not know of any local family dentists who provided domiciliary dental services to care home residents, in their local areas.

It seems that the same constricting factors to provision of domiciliary dental care in Northern Ireland was also identified by Scottish dentists in a recent National Survey about Domiciliary dental care provision[40]. These findings are also consistent with the 2009 Primary Care Dentistry Research Forum report which stated that in the UK similar barriers to accessing dental care for the frail elderly are being reported now as were reported 20 years ago[41].

APPENDIX 3

ORAL HEALTH INFORMATION IN CARE PLANS- MINIMUM REQUIREMENTS

Each resident's care plan should include summary information about his/her oral health.

This information will be found on the oral health admission form (Form 1 page 19), which is completed when the resident first enters the facility. The minimum amount of information regarding oral health in individual care plans includes;

- Whether the resident has natural teeth or not, or dentures, or neither or both

- The name and contact details of the resident's dentist and indicate when their next dental check up is due.

- It should indicate the appropriate daily oral hygiene practice required, and reference the toothbrushing +/- denture cleaning information sheets as appropriate (pages 22 - 25).

- It should indicate if staff support is required to provide daily oral hygiene, and where this is necessary that this has been discussed and agreed with the resident or their family.

- The care plan should be signed and dated by an appropriate member of the facility staff, the resident, and/or their relative/representative.

Date		Activity of Living Problem	Goal	Intervention	Date & Time of Evaluation	Prescribers Signature	Discontinued Date and Signature
	1	Mobility					
	2	Washing and dressing					
	3	Continence					
	4	Physical conditions					
	5						
	6	Sleeping					
	7	Eyesight					
4.10.11	8	Oral health and hygiene	To promote good oral health and hygiene	EXAMPLE ENTRY: Has upper denture with about 10 teeth on it plus some of her own. Lower teeth are her own with some missing. Requires encouragement and supervision to clean them. Registered with Bovally dental practice. Commenced dental appointments 26.7.11. Some fillings required. Attended series of appointments up to Sept '11 to complete treatment. Daughter escorts to dentist. Encourage to brush teeth at sides of upper plate where plaque has built up and to use Duraphat toothpaste prescribed by dentist. Able to do this herself but needs reminded after breakfast and at bedtime. Supervise and remind her not to rinse mouth after cleaning teeth. To attend dentist again in 6 months.		KC	
	9	Diet/Nutrition					
	10	Skincare					
	11	Orientation					
	12	Communication					
	13	Emotional and psychological needs					
	14	Responding to resident's behaviour					
	15	Previous lifestyle, history					
	16	Social needs and links with community and friends.					
	17	Spiritual needs					
	18	Finance					
	19	Medication					

Resident's Name: _____ Key Worker's Name: _____

Resident's Signature: _____ Date: _____/_____/_____ Staff Signature: _____

If resident unable to sign relative/representatives signature: _____ O.I.C Signature: _____

Copy to resident: YES/NO Copy to relative/representative: YES/NO

APPENDIX 4

SAMPLE AUDIT TOOL FOR RESIDENTIAL AND NURSING HOMES

Guidance on Scoring Audit Tool

Add the total number of "Yes" answers and divide by the total number of questions answered (including all "Yes" and "No" answers) excluding the "N/As. Then multiply by 100 to get the percentage.

Formula: $\frac{\text{Total number of yes answers}}{\text{Total number of yes and no responses}} \times 100 = \%$

Residents with own teeth	Yes	No	N/A	Comments
Evidence that each resident has toothbrush and toothpaste available	X			
Evidence that equipment is stored correctly	X			
Documented evidence that each resident has daily oral health care carried out		X		No evidence available

The score for the above table would be calculated as follows:

$\frac{2 \times 100}{3} = 66.6 = 67\%$

Level of compliance

Percentage scores can be allocated a level of compliance using the compliance categories below. The categories are allocated as follows:

Compliant	85% or above
Partial compliance	76 to 84%
Minimal compliance	75% or below

Weighting criteria

Weighting of the criteria has not been attempted as it has been reported that this does not significantly influence overall scores.[42]

Feedback of information and report findings

The auditor should verbally report both areas of good practice and any of concern to the manager in charge of the residential/nursing home. This should be followed up with a written report which clearly identifies areas requiring action. The manager is responsible for developing an action plan and allocates responsibility to individuals who address the issues identified issues within a given timescale.

ORAL HEALTH AUDIT TOOL	Date		Auditor Name	

	INITIAL ORAL HEALTH ASSESSMENT ON ADMISSION	Yes	No	N/A	Comments
1	Documented evidence that each new resident has had an initial oral health assessment within first week of moving to residential/nursing home.				
2	Documented evidence that each resident has a written oral health care plan devised from initial assessment.				
3	Evidence that staff have established who resident's dentist is and that the name and details of resident's dentist is clearly documented.				
4	Date of next dental review with dentist documented				
5	Date of next monthly oral health assessment documented				
	DAILY ORAL CARE – RESIDENTS WITH THEIR OWN TEETH	**Yes**	**No**	**N/A**	Comments
1	Evidence that each resident has toothbrush and toothpaste available				
2	Evidence that equipment is stored correctly.				
3	Documented evidence that each resident has daily oral health care carried out.				
4	Evidence that staff are aware if resident needs help with daily oral care and assist the resident.				

DAILY ORAL CARE – RESIDENTS WITH DENTURES		Yes	No	N/A	Comments
1	Evidence that each resident has denture brush, denture pot and denture cleaning agent available.				
2	Evidence that resident's denture(s) is marked with their name/initials.				
3	Documented evidence that each resident has daily oral health care carried out.				
4	Evidence that staff are aware if resident needs help with daily oral care and assist the resident.				
DAILY ORAL CARE – RESIDENTS WITH NO TEETH OR DENTURES		**Yes**	**No**	**N/A**	**Comments**
1	Evidence that each resident has mouth cleaned daily with moistened gauze/ soft toothbrush.				
2	Evidence that staff are aware if resident needs help with daily oral care and assist the resident.				
MONTHLY ASSESSMENTS		**Yes**	**No**	**N/A**	Comments
1	Documented evidence that monthly assessments are carried out and any issues actioned.				
2	Evidence that staff continually assess the resident's ability to carry out their own oral care effectively on a regular basis				
TRAINING		**Yes**	**No**	**N/A**	**Comments**
1	Evidence that oral health care training is included in staff induction training				
2	Evidence that all staff have received training in delivery of oral care				Date of last training session;

Summary/Feedback Sheet

Residential/Nursing Home		Date	
Location		Auditor(s)/Designation	
Audit Tool		% score for compliance/compliance rating	
Evidence of quality care and best practice			
Summary of areas of non-compliance			
Action plan	Action taken by whom	Action taken by when	Target date for review

APPENDIX 5

RESOURCES

Downloadable resources include:

- Educational presentation
- Baseline questionnaire for care staff (about their oral health knowledge)
- Form 1 – Oral Assessment on Admission
- Form 2 – Urgent/Non-Urgent Dental Referral
- Form 3 – Oral Health Monthly Assessment
- Carers Information Sheet 1 – Toothbrushing Instructions
- Carers Information Sheet 2 – Instructions for Denture Cleaning
- Sample Audit Tool
- Summary of the Regional CDS Clinician's Questionnaire, 2010

Scottish Training Programme

Caring for Smiles: Guide for Trainers. Better oral care for dependent older people
Available online **http://www.healthscotland.com/documents/4169.aspx**

DVD

Bagg J, Sweeney MP. 'Making Sense of the Mouth'. Partnership in Oral Care
Further information available at **www.gla.ac.uk/school/dental/publications/books**

Suction Toothbrushes

Available from Iskus Health - Interventional Patient Hygiene Catalogue
www.iskushealth.com

Voluntary Sector

Relatives and Residents Association - **www.relres.org**
Age NI **www.ageni.org**
Age Sector Platform, NI – **www.agesectorplatform.org**
Patient and Client Council NI – **www.patientclientcouncil.hscni.net**

Publication

Keep Smiling. Dental Care and Oral Health for Older People in Care Homes. A Guide for Staff Relatives and Residents. 2009 (includes oral health resources available to download)

ALERTS

Pink Foam/sponge sticks **www.mhra.gov.uk ref MDA/2012/020**

Accidental ingestion of Steradent Tablets

Laidlaw S. Accidental Ingestion of Steradent Tablets in a patient with Cognitive Impairment Scottish Medical Journal. 1986: 31:131

Barcley GR, Finlayson ND. Severe Oesophageal Injury caused by Steradent. Postgrad Medical Journal.1985: 61:335-336

MacKenzie IJ. A Denture Cleansing Tablet Swallowed. Brit Dent J 1982; 153 (1): 6-7

Nutritional Guidelines

Eating Well for Older People – Practical & Nutritional Guidelines for Food in Residential and Nursing homes and for Community Meals. (The Caroline Walker Trust) **http://www.cwt.org.uk/**

Eating Well in Care Homes for Older People. Care Commission Scotland .2009
http://www.carecommission.com

Promoting Good Nutrition. A strategy for good nutritional care for adults in all care settings in Northern Ireland 2011-2016. **http://www.dhsspsni.gov.uk/index/index-good-nutrition/gn-appendices.htm**

Oral Health Guidelines

DHSSPSNI Oral Health Strategy 2007
http://www.dhsspsni.gov.uk/2007_06_25_ohs_full_7.0.pdf

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Australian Document - Better Oral Health in Residential Care available online:
http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-better-oral-health.htm

British Society Gerodontology - www.gerodontology.com

Guidelines for the Oral Health of Stroke Survivors 2010
Guideline - Caring for Your Dentures
Guidelines for the development of local standards of oral health care for people with Dementia. 2006
Meeting the challenges of oral health for older people: A strategic review 2005

Irish Society of Disability and Oral Health- www.isdh.ie

British Society Disability and Oral Health www.bsdh.org.uk

These BSDH guidance documents can be downloaded as Adobe Acrobat (pdf) files.

Clinical Holding Guidelines 2009

Guidelines for the Delivery of a Domiciliary Oral Healthcare Service revised 2009

The Provision of Oral Care under General Anaesthesia in Special Care Dentistry - Professional Consensus Statement 2009

Principles on Intervention for People Unable to Comply with Routine Dental Care

Multi-disciplinary Guidelines for the Oral Management of Patients following Oncology Treatment

Clinical Guidelines & Integrated Care Pathways for the Oral Health Care of People with Learning Disabilities

Guidelines for Oral Health Care for Long-stay Patients and Residents

Guidelines for the Development of Local Standards of Oral Health Care for Dependent, Dysphagic, Critically and Terminally Ill Patients

Oral Health Care for People with Mental Health Problems: Guidelines and recommendations

Guidelines for Oral Health Care for People with a Physical Disability

General Guidelines

Service Framework for Older People Northern Ireland (under development), with associated Nutritional Strategy: 'Promoting Good Nutrition. A Strategy for good nutritional care for adults in all care settings in Northern Ireland' (2011 – 2016).

APPENDIX 6

GLOSSARY OF TERMS

Definition of good Oral Health

The World Health Organisation (WHO) definition of oral health is: The ability to eat, speak function without pain or discomfort, have good aesthetics, and be free from life threatening disease **or**:

As is stated in Better Oral Health in Residential Care (2009) - *'Older adults need to eat and talk comfortably, to feel happy with their appearance, to stay pain free, to maintain self-esteem and to maintain habits/standards of hygiene and care that they have had throughout their lives'*.

BDA	British Dental Association
BHSCT	Belfast Health & Social Care Trust
BSDH	British Society for Disability and Oral Health
BSO	Business Service Organisation
Cardiovascular Disease	Diseases that affect the heart and blood vessels
CDS	Community Dental Service
Cerebro-vascular Disease	Any disease that affects an artery within the brain, or supplies blood to the brain
Dental Caries	Tooth decay
Dental Hygienist	Dental Care Professional who has both clinical and health promotion responsibilities and work to the direction of a dentist
Dental Therapist	Dental Care Professional who has both clinical and health promotion responsibilities and work to the direction of a dentist
Dentate	Having one or more natural teeth
DHSSPSNI	Department of Health, Social Services & Public Safety NI
Edentulous	Without any natural teeth
FSHC	Four Seasons Health Care Group of Nursing Homes
GDS	General Dental Service (family Dentists)
HDS	Hospital Dental Service
IHCP NI	Independent Health Care Providers NI

Mucosal	Tissues lining the mouth
NHS QIS	NHS Quality Improvement Scotland
NISAT	Northern Ireland Multi-professional Single Assessment Tool
NHSCT	Northern Health & Social Care Trust
NICE	National Institute for Health & Clinical Excellence
NVQ	National Vocational Qualification
Older Person	Adult aged over 65 years
Plaque	A soft sticky film composed mainly of bacteria which forms on teeth and gums
PCD	Profession Complimentary to Dentistry (clinical dental technicians, dental nurses, dental hygienists, dental technicians, dental therapists and orthodontic therapists)
PDS	Personal Dental Service
PFA	Priority for Action annual targets from the Department of Health (NI)
PNH	Private Nursing Home
PPE	Personal Protective Equipment
PROSTHETIC	Relates to Crowns, Bridges, Dentures, Partial Dentures, Implants
QFC	Qualifications Framework Certificate
RQIA NI	Regulation Quality and Improvement Authority NI
RNH	Residential Nursing Home
SEHSCT	South Eastern Health & Social Care Trust
SHSCT	Southern Health & Social Care Trust
WHO	World Health Organisation
WHSCT	Western Health & Social Care Trust

APPENDIX 7

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Membership of the GAIN Sub-Group looking at Guidelines for the Oral Healthcare of People Living in Nursing and Residential Homes

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